19-021 ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
MAY 20 2019
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: The Rehabilitation Institute of Southern Illinois		
Street Address: 2001 Frank Scott Parkway East		
City and Zip Code: Shiloh, IL 62269		
County: St. Clair	Health Service Area: 11	Health Planning Area:

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	The Rehabilitation Institute of Southern Illinois, LLC
Street Address:	9001 Liberty Parkway
City and Zip Code:	Birmingham, AL 35242
Name of Registered Agent:	Corporation Trust Center
Registered Agent Street Address:	1209 Orange Street
Registered Agent City and Zip Code:	Wilmington, DE 19801
Name of Chief Executive Officer:	Douglas E. Coltharp (President, The Rehab Institute)
CEO Street Address:	9001 Liberty Parkway
CEO City and Zip Code:	Birmingham, AL 35242
CEO Telephone Number:	205.967.7116

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name(s):	Mark J. Silberman and Juan Morado
Title:	CON Counsel
Company Name:	Benesch Law
Address:	333 W. Wacker, Suite 1900, Chicago IL 60606
Telephone Number:	312.212.4952 and 312.212.4967
E-mail Address:	MSilberman@beneschlaw.com and JMorado@beneschlaw.com
Fax Number:	312.767.9192

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

Name(s):	Greg Bratcher
Title:	Director of Public Policy
Company Name:	BJC HealthCare

Address:	4901 Forest Park Avenue
Telephone Number:	314.323.1231
E-mail Address:	gregory.bratcher@bjc.org
Fax Number:	
Name:	Walter Smith
Title:	Director, State Regulatory Affairs
Company Name:	Encompass Health
Address:	9001 Liberty Parkway
Telephone Number:	205.970.7926
E-mail Address:	walter.smith@encompasshealth.com
Fax Number:	(205) 262-7155

Facility/Project Identification

Facility Name: The Rehabilitation Institute of Southern Illinois		
Street Address: 2001 Frank Scott Parkway East		
City and Zip Code: Shiloh, IL 62269		
County: St. Clair	Health Service Area: 11	Health Planning Area:

Co-Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	BJC Health System d/b/a BJC HealthCare
Street Address:	4901 Forest Park Avenue, Suite 1200
City and Zip Code:	St. Louis, MO 63108
Name of Registered Agent:	CSC-Lawyers Incorporating Service Company
Registered Agent Street Address:	221 Bolivar Street
Registered Agent City and Zip Code:	Jefferson City, MO 65101
Name of Chief Executive Officer:	Steven H. Lipstein
CEO Street Address:	4901 Forest Park Avenue, Suite 1200
CEO City and Zip Code:	St. Louis, MO 63108
CEO Telephone Number:	314.286.2030

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
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Fax Number:	312.767.9192

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

Name(s):	Greg Bratcher
Title:	Director of Public Policy
Company Name:	BJC HealthCare
Address:	4901 Forest Park Avenue
Telephone Number:	314.323.1231
E-mail Address:	gregory.bratcher@bjc.org
Fax Number:	

Facility/Project Identification

Facility Name: The Rehabilitation Institute of Southern Illinois		
Street Address: 2001 Frank Scott Parkway East		
City and Zip Code: Shiloh, IL 62269		
County: St. Clair	Health Service Area: 11	Health Planning Area:

Co-Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Memorial Regional Health Services, Inc.
Street Address:	4500 Memorial Drive
City and Zip Code:	Belleville, IL 62226
Name of Registered Agent:	Illinois Corporation Service Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Mark J. Turner
CEO Street Address:	4500 Memorial Drive
CEO City and Zip Code:	Belleville, IL 62226
CEO Telephone Number:	618.257.5641

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
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- ☐ Other
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- ☐ Governmental
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E-mail Address:	MSilberman@beneschlaw.com and JMorado@beneschlaw.com
Fax Number:	312.767.9192

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

Name(s):	Greg Bratcher
Title:	Director of Public Policy
Company Name:	BJC HealthCare
Address:	4901 Forest Park Avenue
Telephone Number:	314.323.1231
E-mail Address:	gregory.bratcher@bjc.org
Fax Number:	

Facility/Project Identification

Facility Name: The Rehabilitation Institute of Southern Illinois		
Street Address: 2001 Frank Scott Parkway East		
City and Zip Code: Shiloh, IL 62269		
County: St. Clair	Health Service Area: 11	Health Planning Area:

Co-Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Metro East Services, Inc.
Street Address:	4500 Memorial Drive
City and Zip Code:	Belleville, IL 62226
Name of Registered Agent:	Illinois Corporation Service Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Mark J. Turner
CEO Street Address:	4500 Memorial Drive
CEO City and Zip Code:	Belleville, IL 62226
CEO Telephone Number:	618.257.5641

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Fax Number:	312.767.9192

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

Name(s):	Greg Bratcher
Title:	Director of Public Policy
Company Name:	BJC HealthCare
Address:	4901 Forest Park Avenue
Telephone Number:	314.323.1231
E-mail Address:	gregory.bratcher@bjc.org
Fax Number:	

Facility/Project Identification

Facility Name: The Rehabilitation Institute of Southern Illinois		
Street Address: 2001 Frank Scott Parkway East		
City and Zip Code: Shiloh, IL 62269		
County: St. Clair	Health Service Area: 11	Health Planning Area:

Co-Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Encompass Health Corporation
Street Address:	9001 Liberty Parkway
City and Zip Code:	Birmingham, AL 65242
Name of Registered Agent:	Corporation Trust Center
Registered Agent Street Address:	1209 Orange Street
Registered Agent City and Zip Code:	Wilmington, DE 19801
Name of Chief Executive Officer:	Mark J. Tarr
CEO Street Address:	9001 Liberty Parkway
CEO City and Zip Code:	Birmingham, AL 35242
CEO Telephone Number:	205.967.7116

Type of Ownership of Applicants

- ☐ Non-profit Corporation
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Additional Contact [Person who is also authorized to discuss the application for permit]

Name(s):	Walter Smith
Title:	Director, State Regulatory Affairs
Company Name:	Encompass Health
Address:	9001 Liberty Parkway
Telephone Number:	205.970.7926
E-mail Address:	walter.smith@encompasshealth.com
Fax Number:	(205) 262-7155

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]**

Name:	Walter Smith
Title:	Director, State Regulatory Affairs
Company Name:	Encompass Health
Address:	9001 Liberty Parkway
Telephone Number:	205.970.7926
E-mail Address:	walter.smith@encompasshealth.com
Fax Number:	(205) 262-7155

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:
Progress East HealthCare Center (a wholly owned subsidiary of BJC HealthCare)

Address of Site Owner: 4901 Forest Park Avenue, St. Louis, Missouri 63108

Street Address or Legal Description of the Site:
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

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: The Rehabilitation Institute of Southern Illinois, LLC

Address: 2001 Frank Scott Parkway East, Shiloh, IL 62269

- ☐ 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.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity 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 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, 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.

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

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

In the space below, provide 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.

The Rehabilitation Institute of Southern Illinois, LLC ("The Rehab Institute" or "Rehab Institute of Southern Illinois"), proposes to establish a new 40-bed freestanding comprehensive physical rehabilitation ("Rehab" or "rehab") hospital to be located in Shiloh, St. Clair County, HSA 11. The proposed project addresses the Illinois Health Facilities and Services Review Board ("HFSRB" or "Review Board") identified need for seven (7) additional rehab beds. This is a 'substantive' project because it proposes the establishment of a healthcare facility.

The proposed project will be a 50/50 joint venture between BJC HealthCare ("BJC") and Encompass Health Corporation ("Encompass"). Metro East Services, Inc., a subsidiary of BJC Health System d/b/a BJC HealthCare, will have a fifty percent (50%) ownership interest in the Licensee, The Rehabilitation Institute of Southern Illinois, LLC. BJC is a Missouri nonprofit corporation. Encompass Health also will have a fifty percent (50%) ownership interest in the Licensee, The Rehabilitation Institute of Southern Illinois, LLC. Encompass is a Delaware corporation.

The proposed project will include all private rooms and will be the only freestanding rehab hospital (non-hospital based unit) in HSA11. The total project cost estimate for the new 40-bed freestanding hospital is $30,998,250.

The Rehab Institute will be located on an 8.9 acre vacant property at 2001 Frank Scott Parkway East, Shiloh, IL 62269. The site is easily accessible for all of HSA 11 because of its location on I-64 and its close proximity to State Roads 4, 161, and 159, U.S. Highway 50, and Interstates 55 and 255.

The anticipated completion date of the project is March 31, 2021.

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-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation	$ 790,524	$ 263,508	$ 1,054,032
Off Site Work			
New Construction Contracts	$ 14,462,059	$ 4,820,687	$ 19,282,746
Modernization Contracts			
Contingencies	$ 1,505,207	$ 423,068	$ 1,928,275
Architectural/Engineering Fees	$ 1,100,291	$ 366,764	$ 1,467,055
Consulting and Other Fees	$ 933,708	$ 311,236	$ 1,244,944
Movable or Other Equipment (not in construction contracts)	$ 3,648,489	$ 1,216,163	$ 4,864,652
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	$ 808,409	$ 348,137	$ 1,156,546
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$ 23,248,687**	**$ 7,749,563**	**$ 30,998,250**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$ 23,248,687	$ 7,749,563	**$ 30,998,250**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$ 23,248,687**	**$ 7,749,563**	**$ 30,998,250**

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 $ 890,824.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

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):
March 31, 2021

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment will occur after permit issuance.

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

State Agency Submittals [Section 1130.620(c)]

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

NOTE: These representations relate to co-applicants BJC, Memorial Regional Health Services, Inc., Metro-East Services, Inc. and Encompass, as the Rehab Institute of Southern Illinois is not an existing facility, thus these requirements are not applicable to it. **Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.**

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. 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**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	$ 23,248,687		35,812 BGSF	35,812 BGSF			
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical	$ 7,749,563		11,937 BGSF	11,937 BGSF			
TOTAL	**$ 30,998,250**		**47,749 BGSF**	**47,749 BGSF**			

APPEND DOCUMENTATION AS ATTACHMENT 9, 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 the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

NOT APPLICABLE (PROJECT IS FOR A NEW 40-BED INPATIENT REHAB HOSPITAL)

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 manager 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 is filed on the behalf of The Rehabilitation Institute of Southern Illinois, LLC* **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 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 fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE

PATRICK DARBY
PRINTED NAME

EVP + GC
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 13th day of May, 2019.

Lisa Cornett Golden
Signature of Notary

Seal

SIGNATURE

DAVID KLEMENTZ
PRINTED NAME

VP
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 13th day of May, 2019

Lisa Cornett Golden
Signature of Notary

Seal

LISA CORNETT GOLDEN
MY COMMISSION EXPIRES
OCTOBER 31, 2022
NOTARY PUBLIC
STATE OF ALABAMA

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 manager 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 is filed on the behalf of Encompass Health Corporation * **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 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 fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE

PATRICK DARBY
PRINTED NAME

SEVP + GC
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 13th day of May, 2019

Lisa Cornett Golden
Signature of Notary

Seal

SIGNATURE

ANDREW PRICE
PRINTED NAME

CAO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 13th day of May, 2019

Lisa Cornett Golden
Signature of Notary

Seal

LISA CORNETT GOLDEN
NOTARY PUBLIC
STATE OF ALABAMA
MY COMMISSION EXPIRES
OCTOBER 31, 2022

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- 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 is filed on the behalf of _BJC Health System d/b/a BJC HealthCare_* 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 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 fee required for this application is sent herewith or will be paid upon request.

David R Aylward	
SIGNATURE	SIGNATURE
David R. Aylington	Richard J. Liekweg
PRINTED NAME	PRINTED NAME
Sr. V.P. and General Counsel	President + CEO
PRINTED TITLE	PRINTED TITLE
Notarization:	Notarization:
Subscribed and sworn to before me this 14th day of May, 2019	Subscribed and sworn to before me this 14th day of May, 2019
Daphne R. Wilcut	Daphne R. Wilcut
Signature of Notary	Signature of Notary
Seal	Seal
DAPHNE L. WILCUT My Commission Expires February 21, 2023 St. Louis City Commission #15146250	DAPHNE L. WILCUT My Commission Expires February 21, 2023 St. Louis City Commission #15146250

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- in the case of a limited liability company, any two of its managers or members (or the sole manager 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 is filed on the behalf of _____Memorial Regional Health Services, 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 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 fee required for this application is sent herewith or will be paid upon request.

Mark J Turner
SIGNATURE

MARK J TURNER
PRINTED NAME

PRESIDENT
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15th day of May, 2019

Carol A. Musser
Signature of Notary

Seal

"OFFICIAL SEAL"
CAROL A. MUSSER
NOTARY PUBLIC — STATE OF ILLINOIS
MY COMMISSION EXPIRES JULY 11, 2020

Janet K Gusmano
SIGNATURE

Jane K Gusmano
PRINTED NAME

VP- Finance
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15th day of May, 2019

Carol A. Musser
Signature of Notary

Seal

"OFFICIAL SEAL"
CAROL A. MUSSER
NOTARY PUBLIC — STATE OF ILLINOIS
MY COMMISSION EXPIRES JULY 11, 2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 manager 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 is filed on the behalf of ___Metro-East Services, 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 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 fee required for this application is sent herewith or will be paid upon request.

Mark J Turner
SIGNATURE

MARK TURNER
PRINTED NAME

PRESIDENT
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15th day of May, 2019

Carol A. Musser
Signature of Notary

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MY COMMISSION EXPIRES JULY 11, 2020

M. M. 2
SIGNATURE

MICHAEL MCNAMARA
PRINTED NAME

VICE PRESIDENT OPERATIONS
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 15th day of May, 2019

Carol A. Musser
Signature of Notary

Seal

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*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION *NOT APPLICABLE*

This Section is applicable to the discontinuation of a health care facility maintained by a State agency.
NOTE: If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.290 – Discontinuation (State-Owned Facilities and All Relocations)

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.290(b) for examples.

IMPACT ON ACCESS

1. Document whether or not the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

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

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

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

1110.110(a) – Background of the Applicant

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, and certification if applicable.

2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. Authorization permitting HFSRB 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 HFSRB.**

5. 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 that the information was 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 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

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 relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the 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 **as appropriate**.

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

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

   Alternative options **must** include:

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

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

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

   D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, 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. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

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

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

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

Criterion 1110.120 - 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. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF 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 and certified by the facility's Medical Director.
   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
   c. The project involves the conversion of existing space that results in excess square footage.
   d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
Rehab Hospital: Clinical Portions	**35,812 BGSF**	**>26,400 BGSF (40-bed facility)**	**+9,412 BGSF**	**Yes**
Rehab Hospital: Non-Clinical Portions	**11,937 BGSF**	**None**	**N/A**	**N/A**
Total	**47,749 BGSF**	**None**	**N/A**	**N/A**

APPEND DOCUMENTATION AS ATTACHMENT 14, 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 HFSRB has 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. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1	**Rehab Hospital**	**N/A**	**9,855 Days, 67.5% Occ.**	**85%**	**No**
YEAR 2	**Rehab Hospital**	**N/A**	**12,483 Days, 85.5% Occ.**	**85%**	**Yes**

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

UNFINISHED OR SHELL SPACE:

NOT APPLICABLE

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to 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 is 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 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

NOT APPLICABLE

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at 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 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the 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 APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.200 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

NOT APPLICABLE

1. Applicants proposing to establish, expand and/or modernize the 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
☐ **Medical/Surgical**		
☐ **Obstetric**		
☐ **Pediatric**		
☐ **Intensive Care**		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Planning Area Need - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		
1110.200(c)(2) - Maldistribution	X	X	

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(c)(3) - Impact of Project on Other Area Providers	X		
1110. 200(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.200(d)(4) - Occupancy			X
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

B. Criterion 1110.205 - Comprehensive Physical Rehabilitation

1. Applicants proposing to establish, expand and/or modernize the Comprehensive Physical Rehabilitation category 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
☒ **Comprehensive Physical Rehabilitation**		**40**

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.205(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110. 205(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.205(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.205(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.205(b)(5) - Planning Area Need - Service Accessibility	X		
1110.205(c)(1) - Unnecessary Duplication of Services	X		
1110.205(c)(2) - Maldistribution	X		
1110.205(c)(3) - Impact of Project on Other Area Providers	X		
1110.205(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.205(d)(4) - Occupancy			X
1110.205(e)(1) - Staffing Availability	X	X	
1110.205(f) - Performance Requirements	X	X	X
1110.205(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Criterion 1110.210 - Acute Mental Illness and Chronic Mental Illness

NOT APPLICABLE

1. Applicants proposing to establish, expand and/or modernize the Acute Mental Illness and Chronic Mental Illness 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
☐ **Acute Mental Illness**		
☐ **Chronic Mental Illness**		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.210(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.210(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.210(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.210(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.210(b)(5) - Planning Area Need - Service Accessibility	X		
1110.210(c)(1) - Unnecessary Duplication of Services	X		
1110.210(c)(2) - Maldistribution	X		
1110.210(c)(3) - Impact of Project on Other Area Providers	X		
1110.210(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.210(d)(4) - Occupancy			X
1110.210(e)(1) - Staffing Availability	X	X	
1110.210(f) - Performance Requirements	X	X	X
1110.210(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

D. Criterion 1110.220 - Open Heart Surgery *NOT APPLICABLE*

1. Applicants proposing to establish, expand and/or modernize the Open Heart Surgery category 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
☐ Open Heart Surgery		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

1. Criterion 1110.220(b)(1), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 1110.220(b)(2), Establishment of Open Heart Surgery

Read the criterion and provide the following information:

a. The number of cardiac catheterizations (patients) performed in the latest 12-month period for which data is available.
b. The number of patients referred for open heart surgery following cardiac catheterization at your facility, for each of the last two years.

3. Criterion 1110.220(b)(3), Unnecessary Duplication of Services

Read the criterion and address the following:

a. Contact all existing facilities within 90 minutes travel time of your facility which currently provide or are approved to provide open heart surgery to determine what the impact of the proposed project will be on their facility.
b. Provide a sample copy of the letter written to each of the facilities and include a list of the facilities that were sent letters.
c. Provide a copy of all of the responses received.

4. Criterion 1110.220(b)(4), Support Services

Read the criterion and indicate on a service by service basis which of the services listed in this criterion are available on a 24-hour inpatient basis and explain how any services not available on a 24-hour inpatient basis can be immediately mobilized for emergencies at all times.

5. Criterion 1110.220(b)(5), Staffing

Read the criterion and for those positions described under this criterion provide the following information:

a. The name and qualifications of the person currently filling the job.
b. Application filed for a position.
c. Signed contracts with the required staff.
d. A detailed explanation of how you will fill the positions.

APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

E. Criterion 1110.225 - Cardiac Catheterization ***NOT APPLICABLE***

1. Applicants proposing to establish, expand and/or modernize the Cardiac Catheterization category 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
☐ **Cardiac Catheterization**		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

1. Criterion 1110.225(a), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 1110. 225(b), Establishment or Expansion of Cardiac Catheterization Service

Read the criterion and, if applicable, submit the following information:

a. A map (on 8 1/2" x 11" paper) showing the location of the other hospitals providing cardiac catheterization services within the planning area.

b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.

c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

3. Criterion 1110.225(c), Unnecessary Duplication of Services

Read the criterion and, if applicable, submit the following information.

a. Copies of the letter sent to all facilities within the planning area that currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.

b. Copies of the responses received from the facilities to which the letter was sent.

4. Criterion 1110.225(d), Modernization of Existing Cardiac Catheterization Laboratories

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

5. Criterion 1110.225(e), Support Services

Read the criterion and indicate on a service-by-service basis which of the listed services are available on a 24-hour basis and explain how any services not available on a 24-hour basis will be available when needed.

6. Criterion 1110.225(f), Laboratory Location

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not in close proximity, explain why.

7. Criterion 1110.225(g), Staffing

Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also, provide staffing schedules to show the coverage required by this criterion.

8. Criterion 1110.225(h), Continuity of Care

Read the criterion and submit a copy of the fully executed written referral agreement(s).

9. Criterion 1110.225(i), Multi-institutional Variance

Read the criterion and, if applicable, submit the following information:

a. A copy of a fully executed affiliation agreement between the two facilities involved.

b. Names and positions of the shared staff at the two facilities.

c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.

d. A cost comparison between the proposed project and expansion at the existing operating program.

e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.

f. The number of catheterization laboratories at the operating program.

g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.

h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT 22 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

F. Criterion 1110.230 - In-Center Hemodialysis ***NOT APPLICABLE***

1. Applicants proposing to establish, expand and/or modernize the In-Center Hemodialysis category of service must submit the following information:

2. Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations
☐ **In-Center Hemodialysis**		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.230(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.230(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.230(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.230(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.2300(b)(5) - Planning Area Need - Service Accessibility	X		
1110.230(c)(1) - Unnecessary Duplication of Services	X		
1110.230(c)(2) - Maldistribution	X		
1110.230(c)(3) - Impact of Project on Other Area Providers	X		
1110.230(d)(1), (2), and (3) - Deteriorated Facilities and Documentation			X
1110.230(e) - Staffing	X	X	
1110.230(f) - Support Services	X	X	X
1110.230(g) - Minimum Number of Stations	X		
1110.230(h) - Continuity of Care	X		
1110.230(i) - Relocation (if applicable)	X		
1110.230(j) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 23, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

4. **Projects for relocation** of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1130.525 – "Requirements for Exemptions Involving the Discontinuation of a Health Care Facility or Category of Service" and subsection 1110.230(i) - Relocation of an in-center hemodialysis facility.
NOT APPLICABLE

G. Non-Hospital Based Ambulatory Surgery *NOT APPLICABLE*

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☐ Cardiovascular
☐ Colon and Rectal Surgery
☐ Dermatology
☐ General Dentistry
☐ General Surgery
☐ Gastroenterology
☐ Neurological Surgery
☐ Nuclear Medicine
☐ Obstetrics/Gynecology
☐ Ophthalmology
☐ Oral/Maxillofacial Surgery
☐ Orthopedic Surgery
☐ Otolaryngology
☐ Pain Management
☐ Physical Medicine and Rehabilitation
☐ Plastic Surgery
☐ Podiatric Surgery
☐ Radiology
☐ Thoracic Surgery
☐ Urology
☐ Other

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	

1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

H. Criterion 1110.240 - Selected Organ Transplantation *NOT APPLICABLE*

This section is applicable to projects involving the establishment or modernization of the Selected Organ Transplantation service.

1. Applicants proposing to establish or modernize the Selected Organ Transplantation category of service must submit the following information:

2. Indicate changes by Service: Indicate # of rooms changed by action(s):

Transplantation Type	# Existing Beds	# Proposed Beds
☐		
☐		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Modernize
1110.240(b)(1) – Planning Area Need - 7 Ill. Adm. Code 1100 (formula calculation)	X	
1110.240(b)(2) – Planning Area Need - Service to Planning Area Residents	X	
1110.240(b)(3) – Planning Area Need - Service Demand - Establishment of Category of Service	X	
1110.240(b)(4) – Planning Area Need - Service Accessibility	X	
1110.240(c)(1) – Unnecessary Duplication of Services	X	
1110.240(c)(2) – Maldistribution	X	
1110.240(c)(3) – Impact of Project on Other Area Providers	X	
1110.240(d)(1), (2), and (3) – Deteriorated Facilities		X
1110.240(d)(4) – Utilization		X
1110.240(e) – Staffing Availability	X	
1110.240(f) – Surgical Staff	X	
1110.240(g) – Collaborative Support	X	
1110.240(h) – Support Services	X	
1110.240(i) – Performance Requirements	X	X
1110.240(j) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. *NOT APPLICABLE*

I. Criterion 1110.245 - Kidney Transplantation ***NOT APPLICABLE***

This section is applicable to all projects involving the establishment of the Kidney Transplantation service.

1. Applicants proposing to establish or modernize the Kidney Transplantation category of service must submit the following information:

2. Indicate changes: Indicate # of key rooms by action:

Category of Service	# Existing Beds	# Proposed Beds
☐ **Kidney Transplantation**		

3. READ the applicable review criteria outlined below and **submit required documentation for the criteria printed below in bold:**

APPLICABLE REVIEW CRITERIA	Establish	Modernize
1110.245(b)(1) – Planning Area Need - 7 Ill. Adm. Code 1100 (formula calculation)	X	
1110.245(b)(2) – Planning Area Need - Service to Planning Area Residents	X	
1110.245(b)(3) – Planning Area Need - Service Demand - Establishment of Category of Service	X	
1110.245(b)(4) – Planning Area Need - Service Accessibility	X	
1110.245(c)(1) – Unnecessary Duplication of Services	X	
1110.245(c)(2) – Maldistribution	X	
1110.245(c)(3) – Impact of Project on Other Area Providers	X	
1110.245(d)(1), (2), and (3) – Deteriorated Facilities		X
1110.245(d)(4) – Occupancy		X
1110.245(e) – Staffing Availability	X	
1110.245(f) – Surgical Staff	X	
1110.245(g) – Support Services	X	
1110.245(h) – Performance Requirements	X	X
1110.245(i) – Assurances	X	

APPEND DOCUMENTATION for "Surgical Staff" and "Support Services", AS ATTACHMENT 26 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

J. Criterion 1110.250 - Subacute Care Hospital Model *NOT APPLICABLE*

Category of Service	# Proposed Beds
☐ Subacute Care Hospital	

This section is applicable to all projects proposing to establish a subacute care hospital model.

b. **Criterion 1110.250(b)(1), Distinct Unit**

c. Provide a copy of the physical layout (an architectural schematic) of the subacute unit (include the room numbers) and describe the travel patterns to support services and patient and visitor access.

d. Provide a summary of shared services and staff and how costs for such will be allocated between the unit and the hospital or long-term care facility.

e. Provide a staffing plan with staff qualifications and explain how non-dedicated staffing services will be provided.

f. **Criterion 1110.250(b)(2), Contractual Relationship**

g. If the applicant is a licensed long-term care facility or a previously licensed general hospital, the applicant must provide a copy of a contractual agreement (transfer agreement) with a general acute care hospital. Provide the travel time to the facility that signed the contract. Explain how the procedures for providing emergency care under this contract will work.

h. If the applicant is a licensed general hospital, the applicant must document that its emergency capabilities continue to exist in accordance with the requirements of hospital licensure.

i. **Rule 1110.250©(1), State Board Prioritization of Hospital Applications**

Read this rule, which applies only to hospital applications, and provide the requested information as applicable.

j. Financial Support

Will the subacute care model provide the necessary financial support for the facility to provide continued acute care services? Yes___ No _____

If yes, submit the following information:

k. Two years of projected financial statements that exclude the financial impact of the subacute care hospital model as well as two years of projected financial statements which include the financial impact of the subacute care hospital model;

(2) the assumptions used in developing both sets of financial statements;

(3) a narrative description of the factors within the facility or the area which will prevent the facility from complying with the financial ratios within the next two years without the proposed project;

(4) a narrative explanation as to how the proposed project will allow you to meet the financial ratios;

(5) if the projected financial statements (which include the subacute impact) at the applicant facility fail to meet the Part 1120 financial ratios, provide a copy of a binding agreement with another institution which guarantees the financial viability

Subacute Care Hospital Model (continued)

of the subacute hospital model for a period of five years; and

(6) historical financial statements for each of the last three calendar years.

l. Medically Underserved Area (as designated by the Department of Health and Human Services)

Is the facility located in a medically underserved area? Yes ☐ No ☐

If yes, provide a map showing the location of the medically underserved area and of the applicant facility.

m. Multi-Institutional System

Provide copies of all contractual agreements between your facility and any hospitals or long-term care facilities in your planning area which are within 60 minutes travel time of your facility which provide for exclusive best effort arrangements concerning transfer of patients between your two facilities. **Note: Best effort arrangement means the acute care facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility.**

n. Medicare/Medicaid

Provide the Medicare patient days and admissions, the Medicaid patient days and admissions, and the total patient days and admissions for the latest calendar or fiscal year (specify the dates).

e. Casemix and Utilization

Provide the following information:

o. the number of admissions and patient days for each of the last five years for each of the following:

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnosis which included physiological monitoring on a continuous basis

(2) for multi-institutional systems provide the above information from each of the signatory facilities. If more than one signatory is involved, provide separate sheets for each one.

p. HMO/PPO Utilization

Provide the number of patient days at the applicant facility for the last 12 months being reimbursed through contractual relationships with preferred provider organizations or HMOs.

g. Notice of License Revocation/Decertification

Did IDPH issue the applicant facility a notice of license revocation Yes ☐ No ☐

Was the applicant facility decertified from a Federal Title XVIII or XIX program within the past 5 years Yes ☐ No ☐

Subacute Care Hospital Model (continued)

h. Joint Commission on Accreditation of Healthcare Organizations

Is the applicant facility accredited by the Joint Commission? Yes ☐ No ☐
If yes, provide a copy of the latest Joint Commission letter of accreditation.

q. Staffing

Provide documentation that the following staff will be available for the subacute care hospital model. Documentation must consist of letters of interest from individuals for each of the positions. Indicate if any of the individuals who will fill these positions are presently employed at the applicant facility.

- Full-time medical director exclusively for the model
- Two or more full-time (FTEs) physical therapist
- One or more occupational therapists
- One or more speech therapists

j. Audited Financial Reports

Submit audited financial reports of the applicant facility for the latest three fiscal years.

r. **Rule 1110.250©(2), State Board Prioritization-Long-Term Care Facilities**

This rule applies only to LTC facility applications. Read the criterion and submit the required information, as applicable.

s. Exceptional Care

Has the applicant facility had an Exceptional Care Contract with the Illinois Department of Public Aid for at least two years in the past four years? Yes ____ No _____

If yes, provide copies of the Exceptional Care Contract with the Illinois Department of Public Aid for each these four years.

t. Medically Underserved Area (as designated by the Department of Health and Human Services)

Is the facility located in a medically underserved area? Yes ☐ No ☐

If yes, provide a map showing the location of the medically underserved area and of the applicant facility.

u. Medicare/Medicaid

Provide the Medicare patient days and admissions, the Medicaid patient days and admissions, and the total patient days and admissions for the latest calendar or fiscal year (specify the dates).

v. Case Mix and Utilization

Provide the following information:

w. the number of admissions and patient days for each of the last five years for each of the following:

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)

Subacute Care Hospital Model (continued)

- Other complex diagnoses which included physiological monitoring on a continuous basis

(2) for multi-institutional systems, provide the same information from each of the signatory facilities. If more than one signatory is involved, provide a separate sheet for each one.

x. HMO/PPO Utilization

Provide the number of patient days at the applicant facility for the last 12 months being reimbursed through contractual relationships with preferred provider organizations or HMO's.

y. Notice of License Revocation/Decertification

Did IDPH issue the applicant facility a notice of license revocation Yes ☐ No ☐

Was the applicant facility decertified from a Federal Title XVIII or XIX program within the past 5 years Yes ☐ No ☐

g. Staffing

Provide documentation that the following staff will be available for the subacute care hospital model. Documentation shall consist of letters of interest from individuals for each of the positions. Indicate if any of the individuals who will fill the positions are currently employed by the applicant facility.

- Full-time medical director exclusively for the model
- Two or more full time (FTEs) physical therapists
- One or more occupational therapists
- One or more speech therapists

h. Financial Reports

Submit copies of the applicant facility's financial reports for the last three fiscal years.

z. Joint Commission on Accreditation of Healthcare Organizations

Is the applicant facility accredited by the Joint Commission? Yes ☐ No ☐
If yes, provide a copy of the latest Joint Commission letter of accreditation.

j. Multi-Institutional Arrangements

Provide copies of all contractual agreements between your facility and any hospitals or long-term care facilities in your planning area which are within 60 minutes travel time of your facility which provide for exclusive best effort arrangements concerning transfer of patients between your two facilities. **Note: Best effort arrangement means the referring facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility.**

aa. **Section 1110.250©(3), State Board Prioritization of Previously Licensed Hospitals – Chicago**

This section must be completed only by applicants whose site was previously licensed as a hospital in Chicago. Provide the following information:

bb. letters from health facilities establishing a referral agreement for subacute hospital patients;

cc. letters from physicians indicating that they will refer subacute patients to your proposed facility;

dd. the number of admissions and patient days for each of the last five years for each of the following types of patients (this information must be provided from each referring facility):

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnoses, which included physiological monitoring on a continuous basis.

APPEND DOCUMENTATION AS ATTACHMENT 27, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

K. Community-Based Residential Rehabilitation Center *NOT APPLICABLE*

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

A. Criterion 1110.260(b)(1), 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;
2. How special staffing circumstances will be handled;
3. The staffing patterns for the proposed center; and
4. The manner in which non-dedicated staff services will be provided.

B. Criterion 1110.260(b)(2), Mandated Services

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 1110.260(b)(3), 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 1110.260(b)(4), 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 1110.260(b)(5), 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 28, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

L. 1110.265 - Long Term Acute Care Hospital *NOT APPLICABLE*

1. Applicants proposing to establish, expand and/or modernize Long Term Acute Care Hospital Bed projects must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds
☐ LTACH		
☐ Intensive Care		
☐		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.265(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.265(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.265(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.265(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.265(b)(5) - Planning Area Need - Service Accessibility	X		
1110.265(c)(1) - Unnecessary Duplication of Services	X		
1110.265(c)(2) - Maldistribution	X		
1110.265(c)(3) - Impact of Project on Other Area Providers	X		
1110.265(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.265(d)(4) - Occupancy			X
110.265(e) - Staffing Availability	X	X	
1110.265(f) - Performance Requirements	X	X	X
1110.265(g) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 29, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

M. Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

NOT APPLICABLE

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐		
☐		
☐		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT 30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

NOT APPLICABLE

N. Freestanding Emergency Center Medical Services *NOT APPLICABLE*

These criteria are applicable only to those projects or components of projects involving the freestanding emergency center medical services (FECMS) category of service.

A. Criterion 1110.280 – Establishment of Freestanding Emergency Center Medical Services

Read the criterion and provide the following information:

1. Projected Utilization – Provide the projected number of patient visits per day for each treatment station in the FEC based upon 24-hour availability, including an explanation of how the projection was determined. [1110.280(c)(3)(B))]

2. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data. [1110.280(b)(5)(A)]

3. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated. [1110.280(b)(5)(B)]

4. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital, (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status. [1110.280(b)(5)(C)]

5. Certification signed by two authorized representative(s) of the applicant entity(s) that they have reviewed, understand and plan to comply with both of the following requirements [1110.280(b)(6)]:
   - A) The requirements of becoming a Medicare provider of freestanding emergency services; and
   - B) The requirements of becoming licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

6. Area Need; Service to Area Residents - Document the proposed service area and projected patient volume for the proposed FEC [1110.280(c)]:
   - A) Provide a map of the proposed service area, indicating the boundaries of the service area, and the total minutes travel time from the proposed site, indicating how the travel time was calculated.
   - B) Provide a list of the projected patient volume for the proposed FEC, categorized by zip code. Indicate what percentage of this volume represents residents from the proposed FEC's service area.
   - C) Provide either of the following:
     - a) Provide letters from authorized representatives of hospitals, or other FEC facilities, that are part of the Emergency Medical Services System (EMSS) for the defined service area, that contain patient origin information by zip code, (each letter shall contain a certification by the authorized representative that the representations contained in the letter are true and correct. A complete set of the letters with original notarized signatures shall accompany the application for permit), or
     - b) Patient origin information by zip code from independent data sources (e.g., Illinois Health and Hospital Association

COMPdata or IDPH hospital discharge data), based upon the patient's legal residence, for patients receiving services in the existing service area's facilities' emergency departments (EDs), verifying that at least 50% of the ED patients served during the last 12-month period were residents of the service area.

Freestanding Emergency Center Medical Services (continued)

7. Area Need; Service Demand – Historical Utilization [1110.280(c)(3)(A)]
   A) Provide the annual number of ED patients that have received care at facilities that are located in the FEC's service area for the latest two-year period prior to submission of the application
   B) Provide the estimated number of patients anticipated to receive services at the proposed FEC, including an explanation of how the projection was determined.

8. Area Need; Service Accessibility - Document one of the following (using supporting documentation as specified in accordance with the requirements of 77 Ill. Adm. Code 1110.280(c)(4)(B) Supporting Documentation) [1110.3230(c)(4)(A)]:
   i) The absence of the proposed ED service within the service area;
   ii) The area population and existing care system exhibit indicators of medical care problems,
   iii) All existing emergency services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill Adm. Code 1100.

9. Unnecessary Duplication - Document that the project will not result in an unnecessary duplication by providing the following information [1110.280(d)(1)]:
   A) A list of all zip code areas (in total or in part) that are located within 30 minutes normal travel time 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 30 minutes normal travel time from the project site that provide emergency medical services.

10. Unnecessary Maldistribution - Document that the project will not result in maldistribution of services by documenting the following [1110.280(d)(2)]:
   A) Historical utilization (for the latest 12-month period prior to submission of the application) for existing ED departments within 30 minutes travel time of the applicant's site; or
   B) That there is not an insufficient population to provide the volume or caseload necessary to utilize the ED services proposed by the project at or above utilization standards.

11. Impact on Area Providers [1110.280(d)(3)] – Document that, within 24 months after project completion, the proposed project will not lower the utilization of other service area providers below, or further below, the utilization standards specified in 77 Ill. Adm. Code 1100 (using supporting documentation in accordance with the requirements of 77 Ill. Adm. Code 1110.3230(c)(4)).

12. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (in accordance with the requirements of 1110.280(f)).

Freestanding Emergency Center Medical Services (continued)

B. Criterion 1110.280 – Expansion of Existing Freestanding Emergency Center Medical Services

Read the criterion and provide the following information:

1. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data. [1110.280(b)(5)(A)]

2. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated. [1110.280(b)(5)(B)]

3. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status. [1110.280(b)(5)(C)]

4. Provide copies of Medicare and EMS licensure, in addition to certification signed by two authorized representative(s) of the applicant entity(s), indicating that the existing FEC complies with both of the following requirements [1110.280(a)(b)(A) and (B)]:
   A) The requirements of being a Medicare provider of freestanding emergency services; and
   B) The requirements of being licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

5. Area Need; Service to Area Residents - Document the proposed service area and projected patient volume for the expanded FEC [1110.280(c)(2)]:
   A) Provide a map of the proposed service area, indicating the boundaries of the service area, and the total minutes travel time from the expanded FEC, indicating how the travel time was calculated.
   B) Provide a list of the historical (latest 12-month period) patient volume for the existing FEC, categorized by zip code, based on the patient's legal residence. Indicate what percentage of this volume represents residents from the existing FEC's service area, based on patient's legal residence.

6. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (in accordance with the requirements of 1110.280(f)).

C. Criterion 1110.280 – Modernization of Existing Freestanding Emergency Center Medical Services

Read the criterion and provide the following information:

1. The historical number of visits (based on the latest 12-month period) for the existing FEC.

2. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data. [1110.280(b)(5)(A)]

3. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated.[1110.280(b)(5)(B)]

Freestanding Emergency Center Medical Services
(continued)

4. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital, (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status. [1110.280.(b)(5)(C)]

5. Provide copies of Medicare and EMS licensure, in addition to certification signed by two authorized representative(s) of the applicant entity(s), indicating that the existing FEC complies with both of the following requirements [1110.280(b)(6)(A) and (B)]:
   A) The requirements of being a Medicare provider of freestanding emergency services; and
   B) The requirements of being licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

6. Category of Service Modernization - Document that the existing treatment areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized due to such factors as, but not limited to high cost of maintenance, non-compliance with licensing or life safety codes, changes in standards of care, or additional space for diagnostic or therapeutic purposes. Documentation shall include the most recent IDPH Centers for Medicare and Medicaid Services (CMMS) Inspection reports, and Joint Commission on Accreditation of Healthcare Organizations reports. Other documentation shall include the following, as applicable to the factors cited in the application, copies of maintenance reports, copies of citations for life safety code violations, and other pertinent reports and data.

APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

O. BIRTH CENTER – REVIEW CRITERIA *NOT APPLICABLE*

These criteria are applicable only to those projects or components of projects involving a birth center.

Criterion 77 IAC 1110.275(b)(1) – "Location"

1. Document that the proposed birth center will be located in one of the geographic areas, as provided in the Alternative Healthcare Delivery Act.

2. Document that the proposed birth center is owned or operated by a hospital; or owned or operated by a federally qualified health center; or owned and operated by a private person or entity.

Criterion 77 IAC 1110.275(b)(2) – "Service Provision to a Health Professional Shortage Area"

Document whether the proposed site is located in or will predominantly serve the residents of a health professional shortage area. If it will not, demonstrate that it will be located in a health planning area with a demonstrated need for obstetrical service beds or that there will be a reduction in the existing number of obstetrical service beds in the planning area so that the birth center will not result in an increase in the total number of obstetrical service beds in the health planning area.

Criterion 77 IAC 1110.275(b)(3) – "Admission Policies"

Provide admission policies that will be in effect at the facility and a signed statement that no restrictions on admissions due to payor source will occur.

Criterion 77 IAC 1110.275(b)(4) – "Bed Capacity"

Document that the proposed birth center will have no more than 10 beds.

Criterion 77 IAC 1110.275(b)(5) – "Staffing Availability"

Document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

Criterion 77 IAC 1110.275(b)(6) – "Emergency Surgical Backup"

Document that either:

1. The birth center will operate under a hospital license and will be located within 30 minutes ground travel time from the hospital; **OR**

2. A contractual agreement has been signed with a licensed hospital within 30 minutes ground travel time from the licensed hospital for the referral and transfer of patients in need of an emergency caesarian delivery.

Criterion 77 IAC 1110.275(b)(7) – "Education"

A written narrative on the prenatal care and community education services offered by the birth center and how these services are being coordinated with other health services in the community.

Criterion 77 IAC 1110.275(b)(8) – "Inclusion in Perinatal System"

1. Letter of agreement with a hospital designated under the Perinatal System and a copy of the hospital's maternity service; **OR**

2. An applicant that is not a hospital shall identify the regional perinatal center that will provide neonatal intensive care services, as needed to the applicant birth center patients; and a letter of intent, signed by both the administrator of the proposed birth center and the administrator of the regional perinatal center, shall be provided.

Criterion 77 IAC 1110.275(b)(9) – "Medicare/Medicaid Certification"

The applicant shall document that the proposed birth center will be certified to participate in the Medicare and Medicaid programs under titles XVIII and XIX, respectively, of the federal Social Security Act.

Criterion 77 IAC 1110.275(b)(10)- "Charity Care"

The applicant shall provide to HFSRB a copy of the charity care policy that will be adopted by the proposed birth center.

Criterion 77 IAC 1110.275(b)(11) – "Quality Assurance"

The applicant shall provide to HFSRB a copy of the quality assurance program to be adopted by the birth center.

APPEND DOCUMENTATION AS ATTACHMENT-32, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOT APPLICABLE

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VI. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall 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 from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

$30,998,250	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital

	improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions. e) Governmental Appropriations – 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, a copy of a resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$30,998,250	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

NOTE: THE PROJECT WILL BE FUNDED THROUGH INTERNAL SOURCES.

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical*			Projected
Enter Historical and/or Projected Years:	**N/A**	**N/A**	**N/A**	**CON Year 2**
Current Ratio				7.5
Net Margin Percentage				9.9%
Percent Debt to Total Capitalization**				N/A
Projected Debt Service Coverage**				N/A
Days Cash on Hand				102.7
Cushion Ratio**				N/A

*The Rehabilitation Institute of Southern Illinois, LLC is a new entity; historical data is not applicable.

**Applicant has no long-term debt.

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.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII.1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) 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. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

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

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

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

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	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
New Construction	403.84		47,749				19,282,746		
Contingency	40.38		47,749				1,928,275		
TOTALS	444.22		47,749				21,211,021		
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

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

Factor	CON Year 2
Salaries and Benefits	$ 8,190,300
Benefits	$ 2,096,700
Supplies	$ 835,100
Total Operating Costs	$ 11,122,100
Patient Days	12,483
Cost per Day	$ 891.00

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.

Factor	CON Year 2
Depreciation	$ 1,488,600
Total Capital Costs	$ 1,488,600
Patient Days	12,483
Cost per Day	$ 119.25

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

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.

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.

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

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			

Total				
Medicaid (revenue)				
Inpatient				
Outpatient				
Total				

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Please note: The applicant is a new entity; thus has no history of services. However, the Safety Net Impact of Co-Applicants' related entities is provided below.

Affiliates Safety Net Table 2016				
	Alton Memorial Alton, IL	**Memorial Hospital Belleville, IL**	**Memorial Hospital East Shiloh, IL**	**Van Matre Rehabilitation Rockford, IL**
Charity Care				
# of Patients				
Inpatients	280	916	25	-
Outpatients	4,420	8,568	144	-
Total	4,700	9,484	169	-
Cost				
Inpatient	$ 274,707	$ 1,212,675	$ 69,719	$ -
Outpatient	$ 853,465	$ 1,121,147	$ 26,981	$ -
Total	$ 1,128,172	$ 2,333,822	$ 96,700	$ -
Medicaid				
# of Patients				
Inpatient	1,590	455	117	183
Outpatient	30,779	6,164	1,021	6
Total	32,369	6,619	1,138	189
Net Revenue				
Inpatient	$ 3,916,745	$ 8,808,924	$ 704,550	$ 2,526,595
Outpatient	$ 6,662,694	$ 7,322,085	$ 1,152,745	$ 100,547
Total	$ 10,579,439	$ 16,131,009	$ 1,857,295	$ 2,627,142
Source: IL AHQ Survey Hospital Profiles.				

Affiliates Safety Net Table 2017				
	Alton Memorial Alton, IL	**Memorial Hospital Belleville, IL**	**Memorial Hospital East Shiloh, IL**	**Van Matre Rehabilitation Rockford, IL**
Charity Care				
# of Patients				
Inpatients	343	718	306	-
Outpatients	5,505	7,298	1,346	-
Total	5,848	8,016	1,652	-
Cost				
Inpatient	$ 183,204	$ 1,220,354	$ 227,043	$ -
Outpatient	$ 852,313	$ 1,337,366	$ 998,691	$ -
Total	$ 1,035,517	$ 2,557,720	$ 1,225,734	$ -
Medicaid				
# of Patients				
Inpatient	1,531	365	171	193
Outpatient	30,114	5,428	1,739	415
Total	31,645	5,793	1,910	608
Net Revenue				
Inpatient	$ 3,522,200	$ 23,073,000	$ 434,000	$ 2,357,875
Outpatient	$ 6,498,957	$ 17,266,000	$ 14,000	$ 29,581
Total	$ 10,021,157	$ 40,339,000	$ 448,000	$ 2,387,456
Source: IL AHQ Survey Hospital Profiles.				

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Please note: The applicant is a new entity; thus has no history of services. However, the Safety Net Impact of Co-Applicants' related entities is provided below.

Affiliates Charity Care 2016				
Charity Care Factor	**Alton Memorial Hospital Alton, IL**	**Memorial Hospital Belleville, IL**	**Memorial Hospital East Shiloh, IL**	**Van Matre Rehabilitation Rockford, IL**
Net Patient Revenue	$ 143,202,327	$ 234,886,125	$ 33,449,105	$ 28,705,237
Amount of Charity Care (Charges)	$ 4,759,155	$ 10,587,828	$ 241,547	$ -
Cost of Charity Care	$ 1,128,172	$ 2,333,822	$ 96,700	$ -
Charity Care Cost % of Net Pat Rev	0.8%	1.0%	0.3%	0.0%
Source: IL AHQ Survey Hospital Profile; BJC Internal Records.				

Affiliates Charity Care 2017				
Charity Care Factor	**Alton Memorial Hospital Alton, IL**	**Memorial Hospital Belleville, IL**	**Memorial Hospital East Shiloh, IL**	**Van Matre Rehabilitation Rockford, IL**
Net Patient Revenue	$ 141,936,182	$ 225,312,000	$ 69,203,000	$ 29,726,783
Amount of Charity Care (Charges)	$ 4,309,967	$ 11,598,427	$ 4,501,228	$ -
Cost of Charity Care	$ 1,035,517	$ 2,557,720	$ 1,225,734	$ -
Charity Care Cost % of Net Pat Rev	0.7%	1.1%	1.8%	0.0%
Source: IL AHQ Survey Hospital Profile; BJC Internal Records.				

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

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28	Community-Based Residential Rehabilitation Center	N/A
29	Long Term Acute Care Hospital	N/A
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Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC", FILED IN THIS OFFICE ON THE FIFTEENTH DAY OF APRIL, A.D. 2019, AT 3:50 O`CLOCK P.M.

7374713 8100
SR# 20192836935

Authentication: 202648611
Date: 04-16-19

You may verify this certificate online at corp.delaware.gov/authver.shtml

Attachment 1

State of Delaware
Secretary of State
Division of Corporations
Delivered 03:50 PM 04/15/2019
FILED 03:50 PM 04/15/2019
SR 20192836935 - File Number 7374713

CERTIFICATE OF FORMATION
OF
THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC

1. The name of the limited liability company is The Rehabilitation Institute of Southern Illinois, LLC.

2. The address of its registered office in the State of Delaware is: Corporation Trust Center, 1209 Orange Street, in the City of Wilmington, Delaware 19801. The name of its registered agent at such address is The Corporation Trust Company.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation of The Rehabilitation Institute of Southern Illinois, LLC this 15th day of April, 2019.

Patrick Darby, Authorized Person

Attachment 1

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

MAY 01, 2019

0735601-3

C T CORPORATION SYSTEM
208 SO LASALLE ST, SUITE 814
CHICAGO, IL 60604-1101

RE THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC

DEAR SIR OR MADAM:

IT HAS BEEN OUR PLEASURE TO APPROVE YOUR REQUEST TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS. WE EXTEND OUR BEST WISHES FOR SUCCESS WITH YOUR BUSINESS HERE.

PLEASE NOTE! THE LIMITED LIABILITY COMPANY MUST FILE AN ANNUAL REPORT PRIOR TO THE FIRST DAY OF THIS MONTH OF ADMISSION NEXT YEAR. FAILURE TO TIMELY FILE MAY RESULT IN A PENALTY AND REVOCATION. A PRE-PRINTED ANNUAL REPORT WILL BE MAILED TO THE REGISTERED AGENT AT THE REGISTERED OFFICE ADDRESS APPROXIMATELY 45 DAYS BEFORE THE DUE DATE.

A LIMITED LIABILITY COMPANY THAT INTENDS TO PROVIDE A PROFESSIONAL SERVICE REGULATED BY THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION MUST REGISTER WITH THAT AGENCY.

PUBLICATIONS/FORMS AND OTHER SERVICES ARE AVAILABLE ON OUR WEBSITE. VISIT WWW.CYBERDRIVEILLINOIS.COM TO VIEW THE STATUS OF THIS COMPANY, PURCHASE A CERTIFICATE OF GOOD STANDING, OR EVEN FILE THE ANNUAL REPORT REFERRED TO IN THE EARLIER PARAGRAPH.

SINCERELY YOURS,

JESSE WHITE
ILLINOIS SECRETARY OF STATE
DEPARTMENT OF BUSINESS SERVICES
LIMITED LIABILITY DIVISION
(217) 524-8008

Attachment 1

07356013

FILE #

Form **LLC-45.5**
May 2018

Secretary of State
Department of Business Services
Limited Liability Division
501 S. Second St., Rm. 351
Springfield, IL 62756
217-524-8008
www.cyberdriveillinois.com

Payment must be made by certified check, cashier's check, Illinois attorney's check, C.P.A.'s check or money order payable to Secretary of State. If check is returned for any reason this filing will be void.

Illinois Limited Liability Company Act

Application for Admission to Transact Business

SUBMIT IN DUPLICATE
Type or print clearly.

Filing Fee: $150
Penalty: $
Approved: Me

This space for use by Secretary of State.

FILED

MAY 01 2019

JESSE WHITE
SECRETARY OF STATE

1. Limited Liability Company name (see Note 1): The Rehabilitation Institute of Southern Illinois, LLC

2. Assumed name: _____
(This item is only applicable if the company name in item 1 is not available for use in Illinois, in which case form LLC 1.20 must be completed and submitted with this application.)

3. Jurisdiction of organization: Delaware

4. Date of organization: April 15, 2019

5. Period of duration: Perpetual
(Enter perpetual unless there is a date of dissolution provided in the agreement, in which case enter that date.)

6. Address of the principal place of business: (P.O. Box alone or c/o is unacceptable.)

9001 Liberty Parkway
Number Street Suite #

Birmingham, AL 35242
City State ZIP

7. Registered agent: C T Corporation System
First Name Middle Name Last Name

Registered office: (P.O. Box alone or c/o is unacceptable.) 208 South LaSalle Street, Suite 814
Number Street Suite #

Chicago, IL 60604
City ZIP

Note: The registered agent must reside in Illinois. If the agent is a business entity, it must be authorized to act as agent in this state.

8. If applicable, date on which company first conducted business in Illinois: _____

(continued on back)

LLC-45.5

9. Purpose(s) for which the company is organized and proposes to conduct business in Illinois (see Note 2):
   Rehabilitation Services

10. The Limited Liability Company: (check one)

    ☐ is managed by the manager(s) or ☒ has management vested in the member(s):

11. List names and business addresses of all managers and any member with the authority of manager:

    Encompass Health Southern Illinois Holdings, LLC
    9001 Liberty Parkway
    Birmingham, AL 35242

12. The Illinois Secretary of State is hereby appointed the agent of the Limited Liability Company for service of process under circumstances set forth in subsection (b) of Section 1-50 of the Illinois Limited Liability Company Act.

13. This application is accompanied by a Certificate of Good Standing or Existence, duly authenticated within the last 60 days, by the officer of the state or country wherein the LLC is formed.

14. The undersigned affirms, under penalties of perjury, having authority to sign hereto, that this application for admission to transact business is to the best of my knowledge and belief, true, correct and complete.

Dated: 4/30/2019
Month, Day, Year

Signature

Patrick Darby, Vice President
Name and Title (type or print)

Encompass Health Southern Illinois Holdings, LLC
If applicant is signing for a company or other entity, state name of company or entity.

Note 1: The name must contain the term Limited Liability Company, LLC or L.L.C. The name cannot contain any of the following terms: "Corporation," "Corp." "Incorporated," "Inc.," "Ltd.," "Co.," "Limited Partnership" or "L.P." However, a limited liability company that will provide services licensed by the Illinois Department of Financial and Professional Regulation must instead contain the term Professional Limited Liability Company, PLLC or P.L.L.C. in the name.

Note 2: A professional limited liability company must state the specific professional service or related professional services to be rendered by the professional limited liability company.

Attachment 1

STATE OF MISSOURI

Jason Kander
Secretary of State

CORPORATION DIVISION
CERTIFICATE OF GOOD STANDING

I, JASON KANDER, Secretary of State of the State of Missouri, do hereby certify that the records in my office and in my care and custody reveal that

BJC HEALTH SYSTEM
N00045883

was created under the laws of this State on the 11th day of May, 1992, and is in good standing, having fully complied with all requirements of this office.

IN TESTIMONY WHEREOF, I hereunto set my hand and cause to be affixed the GREAT SEAL of the State of Missouri. Done at the City of Jefferson, this 13th day of May, 2015.

Jason Kander
Secretary of State

Certification Number: CERT-05132015-0078

ATTACHMENT 2

File Number 6997-719-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

MEMORIAL REGIONAL HEALTH SERVICES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MAY 14, 2015, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* OCTOBER *A.D.* 2017 .

Authentication #: 1729902598 verifiable until 10/26/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

File Number 6775-531-6

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

METRO-EAST SERVICES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 17, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* OCTOBER *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Authentication #: 1729902624 verifiable until 10/26/2018
Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 1

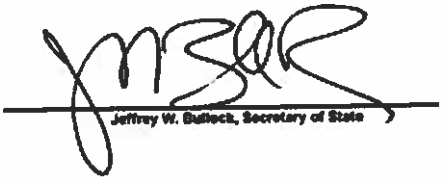
Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "ENCOMPASS HEALTH CORPORATION" IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SIXTEENTH DAY OF MAY, A.D. 2019.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.



2028917 8300

SR# 20194014269

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 202839409

Date: 05-16-19

ATTACHMENT 1

GROUND LEASE AGREEMENT

BETWEEN

[BJC]

AS LANDLORD

AND

The Rehabilitation Institute of Southern Illinois, LLC

AS TENANT

TABLE OF CONTENTS

GROUND LEASE AGREEMENT

This Ground Lease Agreement (this "Lease") is made and entered into as of the _____ day of _____, 2019 (the "Lease Date"), by and between **[BJC]**, a _____ (the "Landlord"), and The Rehabilitation Institute of Southern Illinois, LLC (the "Tenant"). In consideration of the mutual covenants herein contained, the parties agree as follows:

1. DESCRIPTION OF PREMISES.

(a) Upon and subject to the terms and conditions contained in this Lease, Landlord leases to Tenant, and Tenant leases from Landlord, a certain parcel of land containing approximately **[8.9]** acres and located at _____ Frank Scott Parkway East in Shiloh, Illinois, and any improvements now existing thereon, together with all related easements, rights, privileges, appurtenances, and the rights of ingress and egress (the "Premises"), as more particularly depicted on Exhibit A attached hereto. [The Premises are part of a _____-acre development owned by the Landlord known as "_____" (the "Development"), as more particularly depicted on Exhibit A.]

(b) Landlord and Tenant mutually agree that the drawing or description attached hereto as Exhibit A constitutes the Premises to the best of their knowledge, but that the same does not constitute a legal description of the Premises. Landlord and Tenant further agree that upon the completion of a survey and, if applicable, plan of subdivision, pursuant to this Lease, this Lease shall be amended by attaching the legal description of the Premises from said survey as Exhibit A-1 which Exhibit A-1 will be separately signed by Landlord and Tenant to indicate their agreement thereto and which description shall be deemed to be the legal description of the Premises for the purposes of this Lease and shall include the final acreage of the Premises to be used in calculating the rent hereunder.

2. TERM; COMMENCEMENT DATE.

(a) Except as otherwise provided herein, the initial term of this Lease (the "Initial Term") shall commence on the Commencement Date and shall be for a period of twenty (20) years thereafter. The "Commencement Date" shall be the first day of the calendar month after the date on which Tenant commences operations in the inpatient/outpatient rehabilitation facility to be constructed on the Premises. Promptly following the Commencement Date, Landlord and Tenant agree to execute a supplemental agreement in the form of Exhibit B attached hereto, which agreement shall set forth the Commencement Date.

(b) If Tenant does not terminate this Lease on or before the end of the Inspection Period (as hereafter defined), then this Lease shall become fully effective. The "Effective Date," as used herein, shall be the day immediately following the last day of the Inspection Period.

3. RENEWAL OPTIONS.

(a) Option Periods. As long as an Event of Default (as defined in Section 18(a)(i)) has not occurred and is continuing as of the expiration of the Initial Term or any applicable Option Period (as hereafter defined), Tenant shall have, and is hereby granted, eight (8)

successive options to extend the term of this Lease. Each such option shall be for an additional period (an "Option Period", and together with the Initial Term, the "Term") of five (5) years, with each such Option Period to begin, respectively, upon the expiration of the Initial Term of this Lease or the immediately preceding Option Period, as the case may be. The lease of the Premises during each Option Period shall be on the same terms and conditions as herein set forth (except for the amount of Basic Rent (as defined in Section (7(a)) due during such Option Period).

(b) Exercise of Option Periods. If Tenant shall elect to exercise an option for an Option Period, Tenant shall do so by giving written notice to Landlord not less than six (6) months prior to the expiration of the Term (as such term may have previously been extended). If Tenant fails to give timely written notice of its election to exercise an option for an Option Period, the Option Period and any successive Option Period(s), if applicable, shall be deemed waived.

4. INSPECTION PERIOD.

Tenant shall have one hundred twenty (120) days following the Lease Date (the "Inspection Period") as a due diligence period, during which time Tenant shall be permitted to conduct all inspections and investigations necessary in order to determine if the Premises are acceptable to Tenant. Tenant, its employees, agents and designees, shall further have the right of ingress and egress over and through the Premises during normal business hours for the purpose of inspecting, appraising, soil and environmental testing, testing for the drainage, surveying, preparing engineering or architectural drawings, and any other activities reasonably necessary to assess the Premises, including the review of the title commitment for the Premises and the commencement of the governmental permitting process (collectively, the "Inspections"). Tenant shall be liable for all damages or injury to person or property resulting from the Inspections occasioned by the acts of Tenant, its employees, agents or representatives, and Tenant shall indemnify and hold Landlord harmless from any liability arising out of the entry of Tenant, its employees, agents or representatives on the Premises in connection with the Inspections. The obligations of Tenant in the immediately preceding sentence will survive termination of this Lease for a period of one year. Within five (5) business days following the Lease Date (the "Document Delivery Date"), Landlord shall deliver to Tenant the documentation and other information related to the Development described on Exhibit C attached hereto (collectively, the "Existing Due Diligence"). Landlord acknowledges that the Existing Due Diligence is critical to Tenant's Inspections, and as a result, the Inspection Period will be extended automatically one (1) day for each day that the delivery of the Existing Due Diligence is delayed past the Document Delivery Date. The Inspection Period shall be automatically extended one (1) day for each day that Tenant's access to the Premises for its Inspections is impeded or denied by Landlord, any occupant of the Premises or the condition of the Premises. Tenant shall provide Landlord with prompt notice of any such automatic extension. In the event Tenant determines, for any reason whatsoever or no reason at all, that the Premises are not acceptable to Tenant, Tenant may terminate this Lease prior to the end of the Inspection Period by providing written notice of such termination to Landlord and the Title Company. If Tenant so terminates this Lease, all obligations of Landlord and Tenant hereunder shall immediately cease (except any obligations which by their terms expressly survive termination of this Lease).

5. CONTINGENCIES.

(a) Title Commitment and Survey.

(i) During the Inspection Period, Tenant shall obtain (A) a title insurance commitment for the Premises (the "Title Commitment") issued by First American Title Insurance Company or another title insurance company acceptable to Tenant (the "Title Company") in the amount of the leasehold interest in the Premises and the Tenant Improvements, committing to insure Tenant against loss on account of any defect or encumbrance in the title, unless herein excepted and (B) a survey of the Premises (the "Survey").

(ii) On the Effective Date, Landlord shall deliver to the Title Company, with a copy thereof to Tenant, (A) the title premium (B) an affidavit with respect to (i) mechanic's liens, certifying that as of the Effective Date there are no known unpaid bills rendered or to be rendered for services performed or materials furnished to the Premises and (ii) parties in possession, certifying that on the Effective Date, there are no parties other than Landlord in possession of the Premises and (C) any other affidavits or documents reasonably required by the Title Company and/or Tenant to enable the Title Company to record a memorandum of this Lease, delete the standard title exceptions from Tenant's title insurance policy and issue said title policy in the form reasonably required by Tenant (and as communicated by Tenant during the Inspection Period).

(iii) If the Premises are subject to a mortgage, Landlord, no later than the Effective Date, shall either cause the mortgage to be released as to the Premises or shall deliver to Tenant a subordination, non-disturbance and attornment agreement in recordable form, satisfactory to Tenant in form and substance and executed by the mortgagee, acknowledging and agreeing that the foreclosure of the mortgage shall not eliminate or affect this Lease, and recognizing, among other things, Tenant's right of first offer and right of first refusal to purchase the Premises, as provided in Sections 29 and 30 herein.

(iv) The Premises are being leased subject to any specific matters set forth in the Title Commitment and the Survey unless written objections of the same (the "Title Objections") are delivered to Landlord prior to the expiration of the Inspection Period. Landlord shall have the right to remedy or cure the Title Objections within ten (10) business days following receipt of the Title Objections; provided, however, that if the Title Objections cannot be remedied or cured within said ten (10) business day period, and if Landlord begins to diligently attempt to cure or remedy the Title Objections and continues such efforts, Tenant shall extend the cure period up to an additional thirty (30) days. Should Landlord notify Tenant that Landlord will not cure any timely made Title Objections or should Landlord fail to timely cure any timely made Title Objections, Tenant shall have the right to (i) accept said uncured Title Objections and continue with this Lease or (ii) terminate this Lease upon written notice to Landlord at any time thereafter. If Tenant so terminates this Lease, all obligations of Landlord and Tenant hereunder shall immediately cease (except any obligations which by their terms expressly survive termination of this Lease).

(b) Licenses and Permits. Tenant's obligation to lease the Premises is subject to Tenant having received, prior to the expiration of the Inspection Period, evidence that Tenant will be able to secure all permits, licenses, variances, easements, subdivision plats and approvals pertaining to the building, occupancy, signs, parking, curb cuts, driveways (including ingress and egress to public thoroughfares), zoning, environmental controls, and any other governmental permits which, in the sole judgment of Tenant, are necessary to permit it to construct the Tenant Improvements and operate its business upon the Premises, all at a cost acceptable to Tenant.

Landlord represents and warrants that Landlord has no knowledge of anything that would prohibit Tenant from obtaining all such necessary licenses, permits and other approvals.

(c) Utilities and Zoning. Tenant's obligation to lease the Premises is subject to Tenant having received, prior to the expiration of the Inspection Period, evidence of the availability of all necessary utilities or other services and a certificate of zoning or other written confirmation evidencing that the Premises are zoned so as to permit Tenant's construction of the Tenant Improvements and Tenant's intended use of the Premises. Such evidence and certificate shall be in a form and substance satisfactory to Tenant. Notwithstanding anything in this Lease to the contrary, the Inspection Period shall be automatically extended until such satisfactory evidence of zoning and utility availability has been received and approved by Tenant.

(d) Soils and Environmental Tests. At Tenant's expense, Tenant may obtain (i) borings and/or soil bearing tests and other tests to determine the suitability of the Premises for the Tenant Improvements and (ii) a Phase I environmental site assessment of the Premises. Tenant may obtain a Phase II environmental site assessment of the Premises, if necessary, with the prior written consent of Landlord (which consent will not be unreasonably withheld, conditioned or delayed).

6. CONSTRUCTION.

Landlord acknowledges that Tenant is not required to submit to Landlord detailed plans and construction drawings for the Tenant Improvements or any signage that Tenant desires to construct on the Premises; provided, however, Tenant, prior to the commencement of construction of the Tenant Improvements, shall submit to Landlord for review preliminary information depicting the exterior elevation of and the materials that will be used on the exterior of the Tenant Improvements (the "Preliminary Exterior Plans"). Landlord shall have fifteen (15) days from receipt of the Preliminary Exterior Plans to review and approve the same (which approval shall not be unreasonably withheld, conditioned or delayed), and if Landlord does not notify Tenant that the Preliminary Exterior Plans have been approved or that specified changes are requested, such plans shall be deemed approved. Following Landlord's approval of the Preliminary Exterior Plans, no material changes shall be permitted without the consent of Landlord, which consent shall not be unreasonably withheld, conditioned or delayed.

7. RENT.

(a) Basic Rent. Tenant, from and after the Commencement Date during the Term, shall pay to Landlord on the first day of every month, at the address set forth in Section 31, or to such other address designated by Landlord to Tenant in writing from time to time (as hereafter provided), and without demand therefor, an amount equal to one-twelfth ($1/12^{th}$) of the annual amount of ***[insert the product of $0.50 multiplied by the number of useable square feet of the Premises]*** ("Basic Rent"), unless abated or diminished as may be provided herein. In the case of any change by Landlord of the address or wiring instructions to which payments are to be made, Landlord shall designate in writing to Tenant such alternate address or wiring instructions at least fifteen (15) days prior to the date on which payment is due. Basic Rent shall be paid in equal monthly installments on the first day of each month, in advance, commencing upon the Commencement Date. On each Adjustment Date occurring during the Initial Term and any Option Period, the then-current Base Rent shall be increased effective at such Adjustment Date by seven

and one-half percent (7.5%) of the Base Rent in effect immediately prior to such Adjustment Date; provided, however, Base Rent for years 31-35 of the Term (if such Option Period is exercised by Tenant) shall be determined as set forth on Exhibit D attached hereto. For purposes of this Lease, the term "Adjustment Date" shall be each fifth anniversary date of the Commencement Date.

(b) Additional Rent. All amounts which Tenant is required to pay to Landlord or any other party pursuant to this Lease (other than Basic Rent), together with any penalty, interest and costs which may be added for nonpayment or late payment thereof as may be expressly provided for herein, shall constitute additional rent ("Additional Rent" and together with Basic Rent, "Rent"). If Tenant fails to pay any Additional Rent due under this Lease and such failure continues beyond any cure period applicable thereto, then Landlord shall have the right to pay the same and shall have all of the rights, powers and remedies with respect thereto as are provided herein or by law. It is the intention of Landlord and Tenant that this Lease be a so-called "triple net" Lease and that Tenant be responsible for all Taxes (as hereafter provided), all quasi taxes or fees from any governmental authority and any utilities, maintenance and repair expenses related to the use and enjoyment of the Premises and the Tenant Improvements during the Term; and all Basic Rent shall be paid absolutely "net" to Landlord except as to the express obligations of Landlord contained herein. Accordingly, all claims related to Taxes, insurance or other items or responsibilities at the Premises and the Tenant Improvements which are not Landlord's responsibility under this Lease or elsewhere are the sole responsibility of Tenant, and Tenant shall, and does hereby, release Landlord from and against all such claims not specifically assumed by Landlord.

8. TAXES; IMPOSITIONS.

(a) Landlord shall pay all real estate taxes, including penalties and interest, for tax years preceding the Commencement Date. Landlord shall also pay all special assessments that are a lien on the Premises on the Commencement Date, whether or not such assessments are past due, then due or are thereafter to become due and any assessments or charges which are for improvements then installed, or which are then known but which will be payable in whole or in part after the Commencement Date.

(b) Except as otherwise provided in Sections 8(a) and 8(d), from and after the Commencement Date, Tenant agrees to pay to the appropriate governmental agencies all real property taxes, assessments, impositions, or all other claims or charges including special assessments (collectively, the "Taxes") that may constitute or may be reduced to a lien upon the Premises and the Tenant Improvements, including but not limited to, water charges and sewer charges, before the same shall become delinquent. All such payments for the first and last year of the Term shall be prorated between Landlord and Tenant so that Tenant shall be responsible for that portion of the Taxes that is attributable to the Term. Tenant's tax obligation hereunder shall commence on the Commencement Date. In the event there is included in the Taxes any special assessment or assessment which may be paid in installments, unless otherwise directed by written notice from Tenant, Landlord shall advise the appropriate governmental agency of its intention to elect payments in installments thereof, and Tenant shall pay such installments as shall be due and payable during the Term, regardless of when such installment was assessed. Tenant shall be permitted to contact the taxing authority having jurisdiction over the Premises and request that all tax bills related to the Premises and the Tenant Improvements be delivered to Tenant for direct payment by Tenant. In the event the taxing authority is unwilling to deliver said tax bills to Tenant,

Landlord shall forward to Tenant promptly upon receipt all tax bills related to the Premises, and Tenant shall not be deemed in default hereunder unless it has failed to pay any Taxes on the Premises by the later to occur of (i) thirty (30) days after receipt of the applicable tax bill from Landlord and (ii) the date on which the Taxes become delinquent.

(c) In the event the Premises are a portion of a larger tract, Landlord agrees to use its best efforts to have the Premises designated as a separate parcel for taxing purposes so that the assessed valuation of the land and buildings shall relate only to the land constituting the Premises and the Tenant Improvements.

(d) In the event the Premises is a portion of a larger tract and Landlord is unable to have the Premises designated as a separate parcel for taxing purposes, so that taxes are assessed upon the larger tract of which the Premises is a portion, Tenant agrees to pay that portion of the Taxes that is reasonably attributable to the Premises and the Tenant Improvements, determined as follows:

(i) In the event the Taxes are identified or apportioned by the taxing authorities or are identifiable or apportionable based on valuation or other information furnished by the taxing authority so that (A) the portion of the Taxes attributable to the value of the Premises can be distinguished from the portion of the Taxes attributable to the value of the land constituting the larger tract (the "Land Taxes") and (B) the portion of the Taxes attributable to the value of the Tenant Improvements can be distinguished from the portion of the Taxes attributable to the value of the improvements on the larger tract (the "Building Taxes"), then Tenant will pay (x) the portion of the Land Taxes attributable to the value of the Premises and (y) the portion of the Building Taxes attributable to the value of the Tenant Improvements.

(ii) In the event the Taxes are identified or apportioned by the taxing authorities or are identifiable or apportionable based on valuation or other information furnished by the taxing authority so that (A) the portion of the Land Taxes attributable to the value of the Premises cannot be distinguished from the portion of the Land Taxes attributable to the value of the larger tract and (B) the portion of the Building Taxes attributable to the value of the Tenant Improvements can be distinguished from the portion of the Building Taxes attributable to the value of the other improvements on the larger tract, then Tenant will pay (x) a percentage of the Land Taxes determined by dividing the area of the Premises by the total area of the larger tract Premises and (y) the portion of the Building Taxes attributable to the value of the Tenant Improvements.

(iii) In the event the Taxes are identified or apportioned by the taxing authorities or are identifiable or apportionable based on valuation or other information furnished by the taxing authority so that (A) the portion of the Land Taxes attributable to the value of the Premises can be distinguished from the portion of the Land Taxes attributable to the value of the larger tract and (B) the portion of the Building Taxes attributable to the value of the Tenant Improvements cannot be distinguished from the portion of the Building Taxes attributable to the value of the other improvements on the larger tract, then Tenant will pay (x) the portion of the Land Taxes attributable to the value of the Premises and (y) a percentage of the Building Taxes determined by dividing the gross floor area of the Tenant Improvements by the gross floor area of all buildings located on the larger tract.

(iv) In the event the Taxes are not identified or apportioned by the taxing authority and are not identifiable or apportionable based on valuation or other information furnished by the taxing authority so that the Land Taxes cannot be distinguished from the Building Taxes, then as to all Taxes, Tenant will pay a percentage of the Taxes determined by dividing the area of the Premises by the total area of the larger tract or by some other method reasonably agreed upon by Landlord and Tenant.

(e) Landlord will notify Tenant in writing of any Taxes that Tenant is required to pay in accordance with the provisions of Section 8(d). Such notification shall be furnished to Tenant promptly following Landlord's receipt of the tax bill, but in no event less than thirty (30) days before the date on which penalties begin to accrue for nonpayment of such Taxes. Such notification shall be accompanied by a copy of the tax bill. Any Taxes that Tenant is required to pay in accordance with the provisions of Section 8(d) shall be paid by it to Landlord no later than the date on which such Taxes are due unless the notification by Landlord is received by Tenant less than thirty (30) days before the date on which such taxes are due, in which event Tenant shall pay such taxes within thirty (30) days after the date of such notification, and Landlord shall be responsible for the payment of any penalties, interest or other charges imposed upon delinquent payment of Taxes. The written notification by Landlord to Tenant of such Taxes shall set forth (i) the total Taxes on the larger tract accompanied by a copy of the tax bill; (ii) whether the total Taxes on the larger tract are identifiable or apportionable between land and buildings and if so, the amount of Taxes attributable to the land and the amount of Taxes attributable to buildings; and (iii) Tenant's portion of the total Taxes together with a statement showing how Tenant's portion was calculated in accordance with this Section.

(f) If Tenant fails to pay any Taxes that it is required to pay within the time period provided above, Landlord may, at its option, pay said Taxes, together with any and all penalties, and said amount shall become immediately due and payable as Additional Rent.

(g) Tenant shall have the right in its own name, or in Landlord's name where appropriate, but at Tenant's own cost and expense, to contest by appropriate proceedings the amount or legality of any Taxes that it is obligated to pay hereunder and make application for the reduction thereof, or any assessment upon which the same may be based, and Landlord agrees, at the request of Tenant, to execute or join in the execution of any instruments or documents necessary in connection with such contest or application. If Tenant shall contest such tax assessment, or other imposition, provided the payment of such Taxes may legally be held in abeyance, the time within which Tenant shall be required to pay the same shall be extended until such contest or application shall have been finally determined, except that Tenant shall be responsible for any penalty imposed by the taxing authority resulting from the late payment of Taxes due to said contest.

(h) In no event shall Tenant be liable for payment of any income, estate, inheritance, franchise, excise or capital gains taxes imposed upon Landlord or the estate of Landlord. Tenant shall not pay any income, franchise, excise, sales or excess profits tax levied upon, required to be collected by, or assessed against Landlord.

9. UTILITIES.

(a) Tenant shall have the right to grant easements over, upon and under the Premises for Utilities, access, and similar purposes to service the development thereof and the Tenant Improvements. Landlord agrees, from time to time upon request by Tenant, without any compensation being paid therefor, to, within five (5) business days after a request from Tenant, join in the granting of such easements, which easements shall be on terms and conditions reasonably acceptable to Landlord, and to take any other action reasonably necessary to effectuate the same.

(b) Tenant shall pay for all Utilities used or consumed at the Premises thereafter.

10. USE OF PREMISES.

(a) The Premises may be used for any and all lawful purposes and is intended to initially be used as an inpatient/outpatient rehabilitation facility and uses incidental thereto (collectively, the "Permitted Uses"). Landlord represents and warrants that the Permitted Uses are not in conflict with Landlord's agreements with third parties or any other restrictions applicable to the Premises, and Landlord shall hold Tenant harmless from any claims to the contrary by third parties.

(b) Tenant agrees to comply in all material respects with all applicable requirements of laws, ordinances, orders and regulations of the federal, state, county and municipal authorities now in force, or which hereafter may be in force in connection with Tenant's use and occupation of the Premises and in the prosecution or conduct of its business therein, and Tenant agrees to comply in all material respects with any direction or certificate of occupancy issued pursuant to any law by any public officer or officers, to the extent the same relate solely to the Tenant Improvements or operational matters.

11. SIGNS.

(a) Upon Landlord's prior written consent, which shall not be unreasonably withheld, conditioned or delayed, (i) Tenant shall be permitted to place interior and exterior signs at the Premises and the Tenant Improvements consistent with Tenant's business practices and in compliance with all applicable laws, ordinances, regulations and other applicable signage guidelines and (ii) Tenant shall be permitted to erect directional signage at the Development for the benefit of the Premises in compliance with all applicable laws, ordinances, regulations and other applicable signage guidelines. Landlord hereby grants Tenant the right, upon the termination, cancellation, or expiration of this Lease, to enter upon the Premises and remove any and all such signs, it being understood that Tenant shall repair any damage thereby caused to the Premises or the Tenant Improvements at its sole cost and expense.

(b) Tenant, at its expense, shall be permitted to place a panel (i) on any project entry signage that may be erected by Landlord at the main entrances to the Development, and (ii) on any directional signage that may be erected by Landlord at the Development.

12. REPAIRS AND MAINTENANCE.

Tenant will keep the Premises and the Tenant Improvements in good condition and repair, subject to ordinary wear and tear and Landlord's obligations under this Lease.

13. IMPROVEMENTS OR ADDITIONS BY TENANT.

During the Term, except as otherwise provided below, Tenant may make alterations, additions and improvements to the Premises and to the Tenant Improvements without the consent of Landlord, and Tenant shall have the right to erect and install the Tenant Improvements and such other or additional improvements and equipment on the Premises as Tenant may, in its sole judgment, deem desirable for conducting its business thereon or for such other business as Tenant may deem advisable.

14. INDEMNIFICATION.

(a) Tenant shall indemnify Landlord from all liability, loss or other damage claims for obligations resulting from any injuries or losses to persons or property occurring in or on the Premises or the Tenant Improvements, including reasonable attorney's fees and court costs incurred by Landlord in defending any such claims, except when caused by the negligence or willful misconduct of Landlord or its agents, servants, employees, contractors, subcontractors or invitees.

(b) Landlord shall indemnify Tenant from all liability, loss or other damage claims for obligations resulting from any injuries or losses to persons or property occurring in or on the Premises or the Tenant Improvements, including reasonable attorney's fees and court costs, if caused by the negligence or willful misconduct of Landlord or its agents, servants, employees, contractors, subcontractors or invitees.

15. INSURANCE.

(a) Tenant shall carry at its own expense throughout the Term "Special Form" property insurance for damage to the Premises and the Tenant Improvements (but not Tenant's trade fixtures or other personalty) in an amount equal to at least eighty percent (80%) of the full replacement cost thereof (exclusive of the cost of excavations, foundations and footings), with such coverage subject to policy terms, conditions and exclusions. Tenant shall be named as a loss payee on such policy. Landlord acknowledges that, except as may be specifically provided otherwise in this Lease, Landlord shall have no right to any of the proceeds of said insurance and that Landlord has no insurance coverage under any policies obtained by Tenant.

(b) Tenant agrees to carry at its own expense throughout the Term commercial general and, if applicable, excess liability insurance covering the Premises, the Tenant Improvements and Tenant's use thereof, in the amount of at least One Million and No/100 Dollars ($1,000,000.00) per occurrence and Three Million and No/100 Dollars ($3,000,000.00) in the aggregate on an annual basis on account of bodily injuries or death and property damage, with such coverage subject to policy terms, conditions and exclusions. Said policy or policies shall name Landlord as an additional insured, as its interests may appear under this Lease only.

(c) Tenant shall deliver to Landlord certificates evidencing said policy or policies of insurance prior to the date of any use or occupancy of the Premises by Tenant and thereafter upon written request from Landlord. Tenant may, at its option, bring its obligations to insure under this Section within the coverage of any so-called blanket policy or policies of insurance that it may now or hereafter carry, by appropriate amendment, rider, endorsement or otherwise.

16. DAMAGE OR DESTRUCTION OF PREMISES.

In the event of total or partial destruction of the Tenant Improvements by fire or other casualty insured under the property damage insurance maintained by Tenant, Tenant agrees to restore and repair the Premises and the Tenant Improvements at Tenant's expense; provided, however, that in the event the Tenant Improvements are so destroyed that they cannot be repaired or rebuilt within one hundred eighty (180) days after the date of the damage or destruction, then Tenant may, upon thirty (30) days written notice to Landlord following written notice to Landlord. Upon Landlord's receipt of such notice and payment, all further obligations of Landlord and Tenant hereunder shall cease and terminate.

17. CONDEMNATION.

(a) (i) If the whole of the Premises shall be taken for any public or quasi-public use under any statute or by right of eminent domain or by private purchase in lieu thereof, then this Lease shall automatically terminate as of the date that possession has been taken. In the event of a partial taking (or purchase) of the Premises pursuant to which any portion of the Premises is taken (or so purchased) which renders the remainder unsuitable for Tenant's intended use as determined in Tenant's sole discretion, then Tenant shall have the right, but not the obligation, to terminate this Lease by giving written notice of such termination to Landlord on or prior to the date ninety (90) days after the date of such taking (or purchase). If this Lease shall be so terminated, the Rent shall, if and when necessary, be adjusted to the day of the taking (or purchase) and neither party shall have any further rights, duties obligations or liabilities hereunder.

(ii) In the event of a taking (or purchase) resulting in the termination of this Lease pursuant to the provisions of subsection (a)(i) above, the parties hereto agree to apply for and prosecute separate claims for awards for such taking to the extent reasonably possible. In the event it is not reasonably possible to prosecute separate claims, the parties hereto agree to cooperate with one another in applying for and prosecuting a joint claim for awards and further agree, that the award shall be distributed to Landlord and Tenant proportionately based on the relative value of their respective interests in the Premises and Tenant's interest in the Tenant Improvements.

(b) (i) In the event of a partial taking (or purchase) which does not render the Premises unsuitable for Tenant's intended use, Tenant shall, at its own cost and expense, make all repairs to the Premises affected by such taking (or purchase) to the extent necessary to restore the same to a complete architectural unit (to the extent permitted, however, taking into consideration the amount of land remaining after any such taking or purchase); provided, however, that Tenant shall not be obligated to expend an amount in excess of the proceeds of the net award available to Tenant for such purposes.

(ii) From and after the date of such taking (or purchase), the Basic Rent shall be reduced by a fraction, the numerator of which shall be the amount of the total square footage of land of the Premises so taken (or purchased) and the denominator of which shall be the total square footage of land comprising the Premises prior to such taking (or purchase).

(c) If the whole or any part of the Premises, or of Tenant's leasehold estate under this Lease, shall be taken in condemnation proceedings or by any right of eminent domain for temporary use or occupancy, the foregoing provisions of this Section shall not apply and Tenant shall continue to pay the full amounts of the Rent payable by Tenant hereunder in the manner and at the times specified in this Lease, and, except only to the extent that Tenant may be prevented from so doing pursuant to the terms of the order of the condemning authority, Tenant shall perform and observe all of the other terms, covenants, conditions and obligations hereof upon the part of Tenant to be performed and observed, as though such taking had not occurred. Tenant shall be entitled to receive the entire amount of the condemnation proceeds made for such taking, whether paid by way of damages, rent or otherwise, unless such period of temporary use or occupancy shall extend beyond the termination of this Lease, in which case the condemnation proceeds shall be apportioned between Landlord and Tenant as of the date of termination of this Lease. Tenant covenants that, upon the expiration of any such period of temporary use or occupancy during the Term, it will, at its sole cost and expense, restore the Premises, as nearly as may be reasonably possible, to the condition that existed immediately prior to such taking; provided, however, that Tenant shall not be obligated to expend an amount in excess of the proceeds of the net award available to Tenant for such purposes, as hereinafter provided. To the extent that Landlord receives any portion of the condemnation proceeds as compensation for the cost of restoration of the Premises, Landlord shall pay such sum to Tenant in trust for restoration of the Premises.

18. DEFAULT.

(a) Tenant Default.

(i) The occurrence of any of the following shall entitle Landlord to declare an "Event of Default" hereunder:

(A) any installment of Rent, or any part thereof, shall be in arrears, and Tenant fails to pay the same within ten (10) days after receiving written notice thereof from Landlord, and, following such 10-day notice period, Tenant fails to pay the same within five (5) days after receiving a second written notice thereof from Landlord;

(B) Tenant fails to observe or perform any of the other covenants, agreements, or conditions of this Lease, and Tenant fails to cure such failure within thirty (30) days after receipt of written notice thereof from Landlord or, if such failure is not capable of being cured within thirty (30) days, Tenant shall have such additional time as is necessary to cure such failure so long as Tenant commences to cure such failure within said thirty (30)-day period and thereafter diligently pursues such cure to completion;

(C) Tenant (I) files a petition in bankruptcy; (II) is adjudicated bankrupt; (III) files a petition or answer seeking reorganization, arrangement, composition, readjustment, liquidation, dissolution or similar relief for itself under any present or future federal, state or other statute, law or regulation; or (IV) makes an assignment for the benefit of creditors;

(D) the filing against Tenant of an involuntary bankruptcy proceeding or similar proceeding under any other debtor relief law and the failure of Tenant to effect a full dismissal of such proceeding within ninety (90) days after the date of filing; or

(E) Tenant applying for, or the appointment of and the failure to effect a full dismissal within ninety (90) days thereof, a trustee, receiver, custodian or liquidator of Tenant or of all or any substantial part of its properties.

(ii) If an Event of Default shall occur, Landlord shall be entitled to bring suit for the Rent then due, or to declare the rights of Tenant under this Lease terminated, and thereafter, recover possession of said Premises through legal process. In the event of termination and re entry by Landlord in accordance with the foregoing, Tenant shall be obligated to pay all court costs, attorneys' fees and other expenses which may reasonably be incurred by Landlord in connection with said default. If Landlord elects to terminate this Lease, Landlord shall be entitled to recover from Tenant, which shall be in full satisfaction of Tenant's obligations under this Lease, (1) the Worth at the Time of Award of the unpaid Rent which had been earned at the time of termination and (2) the Worth at the Time of Award of the amount by which the unpaid Rent for the balance of the Term after the time of award exceeds the amount of fair market rental value of the Premises. The "Worth at the Time of Award" of the amount referred to in subsection (1) in the preceding sentence shall be computed by allowing interest at the prime rate as printed in the Wall Street Journal at the time of such computation plus 5%. The "Worth at the Time of Award" of the amount referred to in subsection (2) in the preceding sentence shall be computed by discounting such amount at the prime rate as printed in the Wall Street Journal at the time of such computation. In the event of any default by Tenant under this Lease, Landlord shall use reasonable efforts to mitigate its damages.

(b) Landlord Default. If Landlord fails to perform any of its obligations under this Lease following thirty (30) days' prior written notice from Tenant, Tenant shall have the right but not the obligation to (i) perform any such obligations on behalf of Landlord, and thereafter demand payment from Landlord, and Landlord shall promptly reimburse Tenant for any and all such reasonable costs, (ii) terminate this Lease and be relieved from all further obligations under this Lease and/or (iii) exercise any other remedies available to Tenant at law or in equity. If Landlord does not promptly reimburse Tenant for such costs pursuant to subsection (i) in the preceding sentence, Tenant shall have the right to deduct such amount from the Rent.

19. ASSIGNMENTS AND SUBLEASES.

(a) Tenant shall have the right to assign or sublease this Lease during the Term with Landlord's prior written consent, which consent shall not be unreasonably withheld, conditioned or delayed; provided, however, that Tenant shall have the right, without Landlord's prior written consent, to assign or sublease this Lease to (i) an assignee or sublessee of equal or greater financial strength than Tenant or (ii) an affiliate of Tenant, so long as, in either case, Tenant provides to Landlord, not more than fifteen (15) days after the effective date of the assignment or sublease, written notice of such assignment or sublease together with a an executed copy of the assignment or sublease instrument. In the event Tenant is reorganized, merged or consolidated with any other corporation or legal entity, the resulting or surviving corporation or legal entity which as the result of such reorganization, merger or consolidation succeeds to substantially all of the assets or business of Tenant, automatically and without the necessity of a further assignment

or any consent, shall become Tenant under this Lease in accordance with and subject to all of its terms, provisions and conditions.

(b) It is understood and agreed that during the Term hereof, Tenant shall have the right to sublet portions of the Premises to sublessees and/or to grant concessions in the Premises to concessionaires and/or to license departments in the Premises to licensees for uses consistent with or complementary to any of the Permitted Uses without Landlord's prior written consent; it being understood, however, that by reason of such subletting, concessions and/or licensing, Tenant shall not be relieved of liability hereunder.

20. SUBORDINATION AND NON-DISTURBANCE; ESTOPPEL CERTIFICATES.

(a) Prior to the Effective Date, Landlord shall obtain from any and all existing mortgagees, ground lessors and trustees that then hold interests in the Premises and deliver to Tenant, a non-disturbance agreement satisfactory to Tenant in form and substance (the "Initial SNDA") that provides that, so long as Tenant is not in default under this Lease, (i) said mortgagee, ground lessor or trustee shall not join Tenant as a party defendant in any action or proceeding foreclosing a mortgage (unless required to foreclose the mortgage, and then only for such purpose and not for the purpose of termination of the Lease) or in any eviction proceeding or in any action to terminate the ground lease, (ii) Tenant's possession of the Premises and Tenant's rights and privileges under this Lease, or any extensions or renewals thereof which may be exercised in accordance with this Lease, shall not be diminished or interfered with by the mortgagee, trustee or ground lessor, (iii) Tenant's occupancy of the Premises shall not be disturbed by the mortgagee, trustee or ground lessor (except in accordance with the terms of this Lease), including without limitation in the event of foreclosure of any mortgage or deed of trust. If Landlord fails to obtain the Initial SNDA from all applicable parties, Tenant may terminate this Lease upon thirty (30) days' written notice to Landlord. In the event Landlord mortgages the Premises following the Effective Date, Tenant, within thirty (30) days after a written request from Landlord, shall execute a subordination, non-disturbance and attornment agreement with such mortgagee in a form reasonably acceptable to Tenant and mortgagee.

(b) Either party, without charge, at any time and from time to time hereafter but no more than two times per calendar year, within twenty (20) days after written request of the other, will certify by written instrument duly executed and acknowledged to any mortgagee or purchaser, or proposed mortgagee or proposed purchaser, or any other person, firm or corporation specified in such request, as to: (a) whether this Lease has been supplemented or amended, and if so, the substance and manner of such supplement or amendment; (b) the validity and force and effect of this Lease; (c) the existence of any default hereunder; (d) the existence of any offsets, counterclaims or defenses thereto on the part of such other party; (e) the commencement and expiration dates of the term of this Lease; and (f) any other matters as may reasonably be so requested. Any such certificate may be relied upon by the party requesting it and any other person, firm or corporation to whom the same may be exhibited or delivered and the contents of such certificate shall be binding on the party executing same.

21. QUIET ENJOYMENT.

Landlord covenants that, so long as an Event of Default has not occurred and is continuing, Tenant shall peacefully and quietly hold and enjoy the Premises and all rights, easements, covenants, and privileges belonging or in any way appertaining thereto without unreasonable hindrance or interruption by Landlord or any persons claiming by, through, or under Landlord. At any time Tenant's quiet enjoyment of the Premises is disturbed, in addition to any other remedies available to Tenant at law or in equity, Tenant shall be entitled to an equitable abatement of Rent. In the event that ingress to or egress from the Premises is in any way blocked or partially blocked as a result of any road construction or other improvements initiated, conducted by or consented to in any way by Landlord, Tenant shall be entitled to an equitable abatement of Rent.

22. LANDLORD WARRANTY OF TITLE.

Landlord hereby warrants, represents and covenants to Tenant that: (a) as of the Lease Date, Landlord is the sole owner in fee simple absolute of the Premises; (b) as of the Lease Date, Landlord has good and marketable fee simple title to the Premises free and clear of all monetary liens and monetary encumbrances except taxes not yet due and payable; (c) Landlord will defend the title to the Premises and any easements referred to in this Lease; and (d) Landlord has full right and power to execute this Lease, to lease the Premises to Tenant and to perform its obligations hereunder. In case Landlord does not have the title and rights aforesaid, then in such event Tenant shall have all rights and remedies available at law and in equity.

23. PREMISES AS PART OF A LARGER TRACT.

(a) General Covenants. Landlord agrees that (i) access to the Premises shall not be limited or restricted in any way by Landlord; (ii) Tenant, its employees, customers and invitees shall have the nonexclusive rights of ingress and egress in, on and over all of the streets, roads and ways within the Development to and from all streets, alleys and ways adjacent to the Development; and (iii) Landlord shall not interfere with Tenant's business or the Tenant Improvements. Landlord agrees to keep (or cause to be kept) the Development (excepting the Premises and the Tenant Improvements) in good maintenance and repair and in a safe, clean and sanitary condition. The foregoing shall not be construed to obligate Landlord to provide any security, such as private guards or surveillance equipment, to the Development. The cost of maintaining and repairing the Development (excepting the Premises and the Tenant Improvements) and keeping it in a safe, clean and sanitary condition shall be without cost to Tenant.

(b) Indemnity. Landlord will indemnify Tenant and save it harmless from and against any and all claims, actions, damages, liability and expense in connection with loss of life, personal injury and/or damage to property arising from or out of the common areas of the Development, or the use thereof by Tenant or any of its servants, agents, customers or invitees, if occasioned wholly or in part by any act or omission of Landlord, its agents, contractors, subcontractors, invitees, servants or employees, and not caused, in whole or in part, by any act or omission of Tenant, its agents, contractors, subcontractors, invitees, servants or employees.

24. HAZARDOUS WASTE.

(a) To the best of Landlord's knowledge, (i) no hazardous waste or hazardous substances (as defined under federal law or by the laws of the state or municipality in which the Premises are located, and including but not limited to asbestos and petroleum related products) ("Hazardous Materials") has been generated, treated, stored, disposed of or deposited in or on the Premises; (ii) Landlord has not received a summons, directive, notice or other communication, written or oral, from any federal, state or local environmental protection or similar body or any other person concerning (A) any alleged violation of any environmental law or regulation at the Premises or (B) any investigation or request for information relating to the handling, packaging, transportation, treatment, storage or disposal of Hazardous Materials on-site or when transported off-site; (iii) the Premises, including, but not limited to, the soil and ground water, do not contain Hazardous Materials; (iv) there are no underground storage tanks on the Premises; and (v) all oil burners, incinerators and other fuel burning devices and other tanks utilized by Landlord or located anywhere on the Premises, if any, comply with all applicable federal, state and local laws, rules and regulations. No Hazardous Materials shall be incorporated into any work performed hereunder by Landlord or its contractor or subcontractors.

(b) Landlord covenants and agrees to indemnify, defend protect and save Tenant, its employees, agents, officers, directors, shareholders and partners, harmless against and from any and all damages and liabilities of any kind or of any nature whatsoever (including, without limitation, reasonable attorneys' and experts' fees and disbursements), known or unknown, foreseen or unforeseen, reported or unreported, which may at any time be imposed upon, incurred by or asserted or awarded against Tenant, its employees, agents, officers, directors, shareholders and partners, or the Premises or any portion thereof and arising from or out of any Hazardous Materials on, in, under or affecting all or any portion of the Premises, introduced by, or on behalf of, Landlord or Landlord's employees, agents, officers, directors, shareholders, partners, servants, contractors, subcontractors or invitees. This indemnity shall survive the expiration or earlier termination of this Lease.

(c) Tenant covenants and agrees to indemnify, defend, protect and save Landlord harmless against and from any and all damages and liabilities of any kind or of any nature whatsoever (including, without limitation, reasonable attorneys' and experts' fees and disbursements), known or unknown, foreseen or unforeseen, reported or unreported, which may at any time be imposed upon, incurred by or asserted or awarded against Landlord or the Premises or any portion thereof and arising from or out of any Hazardous Materials on, in, under or affecting all or any portion of the Premises, introduced by, or on behalf of, Tenant.

(d) In the event that Hazardous Materials are required to be removed from the Premises (unless such Hazardous Materials were introduced by or on behalf of Tenant), such removal will be Landlord's responsibility, at its sole cost and expense. In the event that Landlord does not remove such Hazardous Materials, Tenant may have such Hazardous Materials removed and properly disposed of at Landlord's cost and expense and deduct such cost from the Rent.

25. LEASEHOLD MORTGAGE.

(a) Tenant may, at any time, mortgage, encumber, pledge or assign as security its right, title and interest in and to the leasehold estate created hereby. Tenant may, at any time,

deliver to Landlord a notice (a "Mortgage Notice") containing the name and address of the lender (a "Mortgage Lender") to which the leasehold estate created hereby has been or will be mortgaged, encumbered, pledged or assigned as security. Upon written request from Tenant or any Mortgage Lender identified in a Mortgage Notice, Landlord will acknowledge, in writing, the receipt of any Mortgage Notice that Landlord has received.

(b) Whenever Landlord shall deliver any default notice to Tenant pursuant to the Lease, Landlord shall also deliver to any Mortgage Lender at the address of such Mortgage Lender, a duplicate copy of such notice. The address of the Mortgage Lender shall be the address specified in the Mortgage Notice unless changed by subsequent written notice delivered by the Mortgage Lender to Landlord. No default notice from Landlord to Tenant shall be effective unless it is delivered to all Mortgage Lenders. If at any time a Mortgage Lender shall deliver Landlord written notice that such Mortgage Lender has released its lien on the leasehold estate created hereby or if Landlord reasonably has determined that the lien on the leasehold estate created hereby held by the Mortgage Lender has been released, such lender shall cease to be a Mortgage Lender for purposes hereof and no further notices need be delivered to it by Landlord.

(c) If Tenant shall not cure or remedy any default or breach of covenant by Tenant under this Lease within the period provided for such cure or remedy herein, Landlord shall thereupon deliver written notice to all Mortgage Lenders of Tenant's failure to so cure or remedy such default or breach of covenant, and all such Mortgage Lenders shall thereupon be entitled to exercise any one or more of the following rights, but shall not be obligated to take any action:

(i) cure or remedy, or cause to be cured or remedied, within a period of time equal to and which shall run concurrently with the period of time allowed by Tenant, such default or breach of covenant, and Landlord shall accept such cure or remedy;

(ii) acquire by foreclosure or otherwise the leasehold estate created hereby and assume the obligations of Tenant under this Lease, including those in default, and, in such event, provided that as long as, and only as long as, all Rent that is due is paid to Landlord and continues to be paid to Landlord as and when the same becomes due, Landlord shall not exercise its right of termination with respect to such default; or

(iii) require Landlord to terminate this Lease by reason of such default and enter into a new lease with the Mortgage Lender for the balance of the Term at the same rental and upon the same terms, covenants and conditions as contained in this Lease provided that Landlord is paid all amounts due under this Lease through the date of rent commencement under the new lease.

(d) In addition to the foregoing rights, a Mortgage Lender may, at any time permitted under its loan documents, foreclose or otherwise realize upon its lien on the leasehold estate created hereby and Landlord will recognize the party acquiring the leasehold estate created hereby as the lessee hereunder with all of the rights and estate of Tenant, provided such party agrees to assume and be bound by all of the terms, covenants and conditions hereof.

(e) Landlord further agrees that any Mortgage Lender, in order to protect its interest in the leasehold estate created hereby, may exercise any right of renewal granted above to Tenant and if such right of renewal is not also exercised by Tenant, then during such renewal term

as exercised by Mortgage Lender, Landlord will recognize the Mortgage Lender as the lessee hereunder with all of the rights and obligations of Tenant.

(f) Upon the termination of this Lease, Tenant shall obtain releases of any such recorded mortgages, encumbrances, pledges or assignments existing as of such termination.

(g) Landlord agrees to execute waivers of Landlord's inchoate lien for Rent in conjunction with any financing of Tenant's fixtures, machinery, inventory and/or equipment in form reasonably satisfactory to Tenant and Tenant's Mortgage Lender(s).

26. COOPERATION.

Each party (the "Requested Party"), from time to time, at the request of the other party (the "Requesting Party") and at the Requesting Party's cost and expense, but subject to the approval of the Requested Party (which approval will not be unreasonably withheld, conditioned or delayed), will execute (i) any documents, petitions, applications, and authorizations as are appropriate or required to obtain any permits, licenses, variances, approvals, subdivision plats, rezonings or other governmental approval or authorization for the Premises, any Tenant Improvements or the Development, and (b) any easements, releases of or amendments to any then existing easements, covenants or restrictions affecting the Premises or the Development and any other instruments appropriate to confirm or effect such grants, release, dedications and transfers (to the extent of the Requested Party's interest in the property subject to such matters), but only upon delivery to the Requested Party of a certificate from the Requesting Party stating that such requested document is appropriate, required or beneficial for and not detrimental to the Premises or the Development, as applicable, and does not materially reduce the value of the Premises or the Development, as applicable. Without limiting the generality of the foregoing, Tenant agrees to cooperate with any reasonable request from Landlord for an access easement across the portion of the Premises abutting Frank Scott Parkway which may be necessary to provide for vehicular ingress and egress to other portions of the Development owned by Landlord.

27. ENCUMBRANCES.

After the Lease Date, Landlord shall in no way encumber or burden the Premises without the prior written consent of Tenant (which consent will not be unreasonably withheld or delayed)

28. USE RESTRICTION ON DEVELOPMENT.

Landlord covenants and agrees that, during the Term, no portion of the Development (other than the Premises) shall be occupied or used as (a) an inpatient rehabilitation hospital, (b) a long term acute care hospital or (c) a skilled nursing facility (collectively, the "Prohibited Uses"). Landlord further covenants that in any lease, deed or other agreement hereafter executed by Landlord or any affiliate of Landlord affecting any property within the Development, Landlord or any affiliate of Landlord will insert a restrictive clause preventing such property from being used for any of the Prohibited Uses during the period in which the prohibited use covenant is in effect. Such lease, deed or other agreement will provide, among other things, that in the event of a breach of the use restrictions described therein, Tenant's remedies at law would be inadequate and therefore, in such event, Tenant shall be entitled to all remedies available at law or in equity.

29. RIGHT OF FIRST OFFER.

(a) From and after the Lease Date and during the Term, Tenant shall have a right of first offer regarding any sale of the Premises and Landlord shall not offer to sell, transfer or otherwise dispose of or convey all or part of Landlord's interest in the Premises until and unless Landlord shall have delivered written notice to Tenant (the "Landlord Offer"), which Landlord Offer shall contain the purchase price that Landlord intends to seek for the Premises.

(b) If Tenant shall either deliver written notice of rejection of the Landlord Offer to Landlord or fail to deliver written notice of acceptance of the Landlord Offer within thirty (30) days after the date of receipt of the Landlord Offer, Landlord's interest in the Premises may, during the one (1) year period thereafter, be sold, transferred or otherwise disposed of to a purchaser at the same price that was contained in the Landlord Offer; provided, however, that if Landlord elects to lower the purchase price for the Premises that was communicated to Tenant in the Landlord Offer or accept an offer from a prospective purchaser for a purchase price that is less than what was communicated to Tenant in the Landlord Offer, Landlord will be required to deliver a revised Landlord Offer to Tenant and provide Tenant with a thirty (30)-day period during which to accept the purchase price communicated in such revised Landlord Offer before Landlord can sell, transfer or otherwise dispose of its interest in the Premises at the purchase price (or any lower purchase price) contained in the revised Landlord Offer.

(c) In the event Tenant rejects the Landlord Offer or fails to accept the Landlord Offer, this Lease and all of its terms and conditions (including this right of first refusal) shall nevertheless remain in full force and effect and Landlord and any purchaser or purchasers of the Premises shall be bound thereby.

(d) Failure of Tenant to exercise the right of first offer described herein on one or more occasions shall not affect Tenant's right to exercise it on any subsequent occasion where Landlord has agreed to market the Premises at a purchase price lower than what was communicated to Tenant in a prior Landlord Offer or accept an offer from a prospective purchaser for a purchase price that is lower than what was communicated to Tenant in a prior Landlord Offer. Any sale or transfer of the Premises, or any part thereof, other than in strict compliance with the terms of this Section shall be null and void and of no effect as to Tenant, and Tenant shall be entitled to purchase the Premises from the purchaser at the same purchase price specified in the Landlord Offer, provided Tenant notifies Landlord of its election thirty (30) days after receipt of notice that complies with the requirements hereof. Payment of rental to such purchaser or otherwise treating such purchaser as Landlord shall not be deemed to be a waiver of any right of first offer or any other right or privilege of Tenant and shall not create an estoppel with respect thereto.

(e) Any sale or transfer of Landlord's interest in the Premises, or any part thereof, shall be expressly made subject to all of the terms, covenants and conditions of this Lease. In the event the Landlord Offer provides for the sale and purchase of Landlord's interest in the Premises and other property, Tenant shall only be required to purchase the Premises on the purchase price set forth in the Landlord Offer that is allocated to the Premises in order to exercise Tenant's right of first offer hereunder; provided, however, the parties hereby agree that in the event Landlord intends to market for sale the entire Development, such a sale will not be subject to the right of first offer described in this Section 29.

(f) In the event Tenant exercises its right of first offer hereunder, then (i) Landlord shall convey title by warranty deed approved by Tenant and the title company; (ii) title to the Premises shall be free and clear of any liens and encumbrances except the lien for current taxes which are not delinquent at the time of closing and such other exceptions to title as existed on the Effective Date and/or were approved by Tenant after the Effective Date; (iii) title to the Premises shall otherwise comply with the terms of this Lease as they pertain to condition of title; and (iv) any easements or other rights benefiting the Premises at the time of closing shall be made perpetual and shall be included in the deed or in a separate recordable instrument approved by Tenant and the title insurance company insuring its interest. Upon such election by Tenant, Landlord and Tenant agree to act in good faith to consummate a purchase agreement for the Premises incorporating the purchase price set forth in the Landlord Offer and other customary terms and provisions for similar transactions of similar commercial property located in the same geographic area as the Premises.

30. RIGHT OF FIRST REFUSAL.

(a) From and after the Lease Date and during the Term, Tenant shall have the right of first refusal and Landlord shall not sell, transfer or otherwise dispose of or convey all or part of Landlord's interest in the Premises as a result of an unsolicited offer to purchase from an unsolicited prospective purchaser until and unless Landlord shall have (i) obtained a bona fide offer therefor (the "Offer"); (ii) delivered written notice to Tenant, which notice shall contain (A) the name of the offeror, (B) the address of the offeror, (C) all of the terms and conditions of the Offer, and (D) a true and accurate copy of the Offer; and (iii) offered to sell, transfer or otherwise dispose of such interest to Tenant at the same price and, except as hereafter provided, upon the same terms and conditions contained in the Offer and Tenant has not elected to exercise its right of first refusal provided herein.

(b) If Tenant shall either deliver written notice of rejection of the Offer to Landlord or fail to deliver written notice of acceptance of the Offer within thirty (30) days after the date of receipt of Landlord's notice, Landlord's interest in the Premises may, during the one hundred eighty (180) days thereafter, be sold, transferred or otherwise disposed of to the original offeror at the same price and upon the same or substantially the same terms and conditions contained in the Offer as disclosed in writing to Tenant.

(c) In the event Tenant rejects the Offer or fails to accept the Offer, this Lease and all of its terms and conditions (including this right of first refusal) shall nevertheless remain in full force and effect and Landlord and any purchaser or purchasers of the Premises shall be bound thereby.

(d) Failure of Tenant to exercise this right of first refusal on one or more occasions shall not affect Tenant's right to exercise it on any subsequent occasion. Any sale or transfer of the Premises, or any part thereof, other than in strict compliance with the terms of this Section shall be null and void and of no effect as to Tenant, and Tenant shall be entitled to purchase the Premises from the purchaser upon the same terms and conditions and at the same price specified in the Offer, provided Tenant notifies Landlord of its election thirty (30) days after receipt of notice that complies with the requirements hereof. Payment of rental to such purchaser or otherwise treating such purchaser as Landlord shall not be deemed to be a waiver of any right

of first refusal or any other right or privilege of Tenant and shall not create an estoppel with respect thereto.

(e) Any sale or transfer of Landlord's interest in the Premises, or any part thereof, shall be expressly made subject to all of the terms, covenants and conditions of this Lease. In the event the Offer provides for the sale and purchase of Landlord's interest in the Premises and other property, Tenant shall only be required to purchase the Premises on the terms set forth in the Offer (with the purchase price appropriately adjusted to be allocable solely to the Premises) in order to exercise Tenant's right of first refusal hereunder; provided, however, the parties hereby agree that in the event Landlord desires to sell its interest in the entire Development, such a sale will not be subject to the right of first refusal described in this Section 30.

(f) In the event Tenant exercises its right of first refusal then, notwithstanding the terms of the Offer (i) Landlord shall convey title by warranty deed approved by Tenant and the title company; (ii) title to the Premises shall be free and clear of any liens and encumbrances except the lien for current taxes which are not delinquent at the time of closing and such other exceptions to title as existed on the Effective Date and/or were approved by Tenant after the Effective Date; (iii) title to the Premises shall otherwise comply with the terms of this Lease as they pertain to condition of title; and (iv) any easements or other rights benefiting the Premises at the time of closing shall be made perpetual and shall be included in the deed or in a separate recordable instrument approved by Tenant and the title insurance company insuring its interest. Upon such election by Tenant, Landlord and Tenant agree to act in good faith to consummate a purchase agreement for the Premises incorporating the express terms of the Offer and other customary terms and provisions for similar transactions of similar commercial property located in the same geographic area as the Premises.

31. MISCELLANEOUS PROVISIONS.

(a) Notices, Approvals, and Consents. Any notice, demand, consent, approval or other communication required or permitted under this Lease will be in writing and deemed delivered at such time as it is actually delivered, if personally delivered, five (5) days after mailing, if mailed by registered or certified mail, or one (1) business day after mailing, if sent for next day delivery by nationally recognized overnight courier, delivered or addressed as follows:

if to Landlord: _____
_____
_____
_____

with a copy to: _____
_____
_____
_____

if to Tenant: _____
c/o Encompass Health Corporation
9001 Liberty Parkway
Birmingham, Alabama 35242

Attention: Real Estate Department

with a copy to: Encompass Health Corporation
9001 Liberty Parkway
Birmingham, Alabama 35242
Attention: Legal Services Department

The customary receipt shall be conclusive evidence of service. Either Tenant or Landlord may change its address or addresses under this Section by prior written notice to the other party.

(b) Consents. Unless otherwise expressly stated herein, whenever Landlord's or Tenant's consent is required under this Lease, such consent shall not be unreasonably withheld, conditioned or delayed.

(c) Recording. On the Effective Date, Landlord and Tenant shall execute, acknowledge and deliver to the other, a memorandum of lease for recording purposes in the form attached hereto as Exhibit E. All costs and expenses related thereto shall be borne by Tenant, and after recording, a copy of the recorded document shall be delivered to both parties. This Lease shall not be recorded in its entirety without the mutual consent of the parties.

(d) Surrender of Premises. Tenant shall surrender the Premises at the end of the Term in good condition, ordinary and reasonable wear and tear and damage from casualty or condemnation excepted.

(e) Title to Improvements. Tenant from time to time may construct, repair, remodel, remove or replace the Tenant Improvements on the Premises in accordance with applicable laws. Title to the Tenant Improvements and any repairs, alterations, additions or improvements to the Tenant Improvements shall be vested in and remain in Tenant at all times during the Term. Tenant alone shall be entitled to claim any and all depreciation in connection with its federal or state income tax returns. Upon the expiration of this Lease, any extensions or renewals hereof, or its termination in any way, title to the Tenant Improvements shall automatically pass to and become vested in Landlord, and Tenant, upon request of Landlord, shall execute such quitclaim deed, bill of sale, or assignment as may be necessary to evidence the transfer of such title to Landlord.

(f) Holding Over. If Tenant remains in possession of the Premises following the expiration of the Term, then Tenant's subsequent holding over, without consent of Landlord, shall result in the creation of a tenancy from month-to-month at a monthly Basic Rent equal to 125% of the Basic Rent payable immediately prior to the expiration of this Lease, and such rent shall be payable on the first day of each month during the month-to-month tenancy. All other terms and conditions of this Lease shall remain in full force during any month-to-month tenancy hereunder.

(g) Non-Merger. During the Term, the leasehold estate of Tenant shall not merge with the fee simple or other estate in the Premises but shall always remain separate and distinct notwithstanding the union of all or any part of said estate either in Landlord or Tenant, or in a third party by purchase or otherwise, unless and until all persons having an interest therein,

including a leasehold mortgagee, shall join in a written instrument consenting to or effecting such merger.

(h) Brokers. Each party represents and warrants to the other that there is no real estate broker or finder in any way entitled to compensation as a consequence of this Lease. Each party agrees to indemnify and hold the other party harmless with respect to any judgment, damages, legal fees, court costs, and any and all liabilities of any nature whatsoever arising from a breach of said representation. The provisions of this Section shall survive the Effective Date and any subsequent cancellation or termination of this Lease.

(i) Governing Law. This Lease and the performance hereunder shall be governed, construed and interpreted according to the laws of the state in which the Premises are located.

(j) Exhibits. All Exhibits attached hereto are incorporated herein by reference.

(k) Headings. This Lease's section headings are for quick reference and convenience only and do not alter, amend, define, limit, describe, or otherwise affect the terms, conditions, and agreements set forth herein.

(l) Waiver. No waiver by either of the parties hereto of any provision or breach hereof, shall be deemed a waiver of any other provision or of any subsequent breach by Tenant or Landlord of the same or any other provisions. Landlord's or Tenant's consent to or approval of any act shall not be deemed to render unnecessary the obtaining of Landlord's or Tenant's consent to or approval of any subsequent act. No remedy or election hereunder shall be deemed exclusive, but shall, whenever possible, be cumulative with all other remedies at law or in equity.

(m) Severability. If any provision of this Lease is found by a court of competent jurisdiction to be illegal, invalid, or unenforceable, the remainder of this Lease will not be affected, and in lieu of each provision that is found to be illegal, invalid, or unenforceable, a provision will be added as a part of this Lease that is as similar to the illegal, invalid, or unenforceable provision as may be possible and is legal, valid, and enforceable.

(n) No Construction Against Preparer of Lease. This Lease has been jointly prepared and negotiated by Tenant and Landlord. Tenant and Landlord believe that this Lease is the product of their efforts, that it expresses their agreement, and that it should not be interpreted in favor of either Tenant or Landlord or against either Tenant or Landlord merely because of their efforts in preparing it.

(o) When Lease Becomes Binding. The submission of this document for examination and negotiation does not constitute an offer to lease, or a reservation of, or option for the Premises; and this Lease shall become effective and binding only upon the execution and delivery hereof by both Landlord and Tenant.

(p) Modifications. This Lease may be modified or altered only by agreement in writing by both Landlord and Tenant.

(q) Successors and Assignees. Subject to the terms and conditions of Section 19, this Lease and the terms, conditions and covenants hereof shall be binding upon and shall inure

to the benefit of each of the parties hereto, their successors or assigns, and shall run with the land. All terms and words used in this Lease, regardless of the number and gender in which they are used, shall be deemed and construed to include any other number, singular or plural, and any other gender, masculine, feminine or neuter, as the context or sense of this Lease or any Section or clause herein may require, the same as if such words had been fully and properly written in the required number and gender.

(r) Attorneys' Fees. In the event of any action or proceeding brought for the enforcement or interpretation of this Lease, or the exercise of any rights of Landlord or Tenant hereunder, the prevailing party in such action or proceeding shall be entitled to recover reasonably attorneys' fees and costs from the non-prevailing party.

(s) Business Days. In the event any period of time provided for in this Lease ends on a day other than a business day on which banks are generally open for a full day for business, such ending date shall automatically be extended to the next business day.

[signatures on following page]

IN WITNESS WHEREOF, the parties have caused this Lease to be executed under seal by their respective duly authorized representatives as of the date first above written.

LANDLORD:

_____

By: _____
Name: _____
Title: _____

TENANT:

_____

By: _____
Name: _____
Title: _____

EXHIBIT A

DEPICTION OR DESCRIPTION OF PREMISES AND DEVELOPMENT

EXHIBIT B

LEASE COMMENCEMENT AGREEMENT

This Lease Commencement Agreement is a supplement to that certain Ground Lease Agreement (the "Lease") dated the _____ day of _____, 2019, between _____, a _____ ("Landlord"), and _____, a _____ ("Tenant"), demising the premises more particularly described therein. Pursuant to the provisions of the Lease, Landlord and Tenant intending to be legally bound hereby agree to the following:

1. The Initial Term of the Lease commenced on and the Commencement Date is _____, 201__;

2. The Initial Term of the Lease shall end on _____, 20___, unless sooner terminated or otherwise extended as therein provided.

IN WITNESS WHEREOF, the parties have caused this Lease Commencement Agreement to be executed by their respective duly authorized representatives as of the _____ day of _____, 201__.

LANDLORD:

_____

By: _____
Name: _____
Title: _____

TENANT:

_____

By: _____
Name: _____
Title: _____

EXHIBIT C

EXISTING DUE DILIGENCE

1. Any title searches, commitments or policies related to the Development that are in Landlord's possession or control

2. Any surveys, subdivision plats and environmental, soils, wetlands or property condition reports related to the Development that are in Landlord's actual possession or control

3. Any water and sewer capacity or service agreements related to the Development and in Landlord's actual possession or control

4. Any utility availability information related to the Development that is in Landlord's actual possession or control

5. Any unrecorded documents that potentially impact the use and/or development of the Premises that are in Landlord's actual possession or control

6. Any documents that address rules, regulations and guidelines imposed on occupants of the Development

EXHIBIT D

FAIR MARKET RENTAL VALUE

In the event such Option Period is exercised for years 31-35, Basic Rent for such period shall be equal to the Fair Market Rental Value as of the commencement of each such Option Period. For purposes hereof, "Fair Market Rental Value" means the fair market rental value of the Premises, stated as an annual rent that remains fixed during the Option Period, (i) assuming the same is unencumbered by this Lease, (ii) determined in accordance with the appraisal procedure described below or in such other manner as shall be mutually acceptable to Landlord and Tenant, (iii) not taking into account any reduction in value resulting from an indebtedness to which the Premises may be subject, (iv) not including the value of the Tenant Improvements and (v) without regard to the remaining Term (including unexercised Option Periods) of the Lease.

Landlord and Tenant shall use good faith efforts to agree upon the Fair Market Rental Value of the Premises hereunder in connection with the exercise of any Option Period. However, in the event that Landlord and Tenant are unable to mutually agree on the Fair Market Rental Value of the Premises hereunder, either party may invoke an appraisal process by notifying the other party in writing and including in such notice the name of a person selected to act as an appraiser on the notifying party's behalf. Within fifteen (15) business days after receipt of any such notice, Landlord (or Tenant, as the case may be) shall by notice to Tenant (or Landlord, as the case may be) appoint a second person as an appraiser on its behalf. Each of the appraisers thus appointed (each of whom must be a member of the American Institute of Real Estate Appraisers or any successor organization thereto and must have at least 5 years of appraisal expertise with real property similar to the Premises) shall, within sixty (60) days after the date of the notice appointing the second appraiser, complete and deliver its appraisal of the Premises to both Landlord and Tenant, reflecting the Fair Market Rental Value as of the relevant date (giving effect to the impact, if any, of inflation from the date of their decision to the relevant date); provided that if only one appraiser shall have been so appointed, or if two appraisers shall have been so appointed but only one such appraiser shall have made such determination within such 60-day period, then the determination of such appraiser shall be final and binding upon the parties. The determination of each appraiser shall be in the form of a written report (collectively, the "Appraisal Reports") setting forth the Fair Market Rental Value and the information relied upon, and the analysis employed, by each appraiser in determining the Fair Market Rental Value. If two appraisers shall have been appointed and shall have made their determinations within the respective requisite periods set forth above and if the difference between the amounts so determined shall not exceed 10% of the lesser of such amounts, then the Fair Market Rental Value shall be an amount equal to 50% of the sum of the amounts so determined. If the difference between the amounts so determined shall exceed 10% of the lesser of such amounts, then such two appraisers shall have fifteen (15) business days to appoint a third appraiser, but if such appraisers fail to do so, then either party may request a court of competent jurisdiction appoint an appraiser within fifteen (15) business days of such request, and both parties shall be bound by any appointment so made within such fifteen (15) business-day period. The third appraiser shall be provided with a copy of the Appraisal Reports. Any appraiser appointed by such court shall be instructed to determine the Fair Market Rental Value within thirty (30) days after appointment of such appraiser. The determination of the first two appraisers which is closest to the determination of the third appraiser shall be final and binding upon Landlord and Tenant as the Fair Market Rental Value, and in the event the determinations of the first two appraisers are equally close to the determination of the third appraiser, the

determination of the third appraiser shall be final and binding upon Landlord and Tenant as the Fair Market Rental Value. This provision for determination by appraisal shall be specifically enforceable to the extent such remedy is available under applicable law, and any determination hereunder shall be final and binding upon the parties except as otherwise provided by applicable law. Landlord and Tenant shall each pay the fees and expenses of the appraiser appointed by it and each shall pay one-half of the fees and expenses of the third appraiser.

EXHIBIT E

FORM OF MEMORANDUM OF GROUND LEASE

MEMORANDUM OF GROUND LEASE

This Memorandum of Ground Lease (this "Memorandum") is made and entered into effective the ____ day of _____, 20__, by and between _____, a _____ ("Landlord"), whose address for purposes hereof is _____, and _____, a _____ ("Tenant"), whose address for purposes hereof is 9001 Liberty Parkway, Birmingham, Alabama 35242, Attention: Real Estate Department.

Recitals

A. Landlord has leased certain real property located in _____ County, Illinois, as further described on Exhibit A attached hereto and made a part hereof (the "Premises"), to Tenant pursuant to a Ground Lease Agreement dated as of _____, 2019, which is incorporated herein by reference as if appearing in full (the "Lease"). Unless otherwise defined herein, capitalized terms shall have the meaning assigned to them in the Lease.

B. The parties wish to provide record notice of certain of the terms and conditions of the Lease.

Agreement

NOW, THEREFORE, Landlord and Tenant do hereby state the following:

1. Lease of the Premises. Landlord has leased the Premises to Tenant, and Tenant has leased the Premises from Landlord, upon the terms and conditions stipulated in the Lease.

2. Term. The initial term of this Lease commences on the date that is the earliest to occur of _____. **[CONFORM TO LEASE]**

3. Option to Extend. The terms of the Lease provide Tenant with ____ (__) options to renew the term of the Lease for ____ (__) years each.

4. Use Restriction. Section 28 of the Lease provides that no portion of the Development (other than the Premises) shall be occupied or used as (a) an inpatient rehabilitation hospital, (b) a long term acute care hospital or (c) a skilled nursing facility (collectively, the "Prohibited Uses"). Section 28 of the Lease further provides that said prohibited use covenant will only be in effect (i) while the Premises are used for one or more of the Prohibited Uses, (ii) from the Lease Date through the completion of construction of the Tenant Improvements, (iii) for any period that the Premises are not used for one or more of the Prohibited Uses due to a casualty or condemnation and (iv) for any period up to one hundred eighty (180) consecutive days that the Premises are not used for one or more of the Prohibited Uses due to renovation. Section 28 of the Lease provides that said prohibited use covenant shall cease to apply and shall be without further force or effect if, after Tenant has opened for business, the Premises are not used for at least one

of the Prohibited Uses for a continuous period of one hundred eighty (180) days unless such period of non-use is due to a casualty, condemnation or renovations.

6. Right of First Offer. Tenant has been granted a right of first offer to purchase the Premises as more particularly provided in Section 29 of the Lease.

7. Right of First Refusal. Tenant has been granted a right of first refusal to purchase the Premises as more particularly provided in Section 30 of the Lease.

8. Conflict. In the event of a conflict between the terms and provisions of this Memorandum and the Lease, the Lease shall govern and control. Copies of the Lease are held by both Landlord and Tenant at the respective addresses first set forth above.

IN WITNESS WHEREOF, Landlord and Tenant have caused this Memorandum to be executed by their duly authorized representatives as of the date and year first above written.

LANDLORD:

LANDLORD:

_____

By: _____
Name: _____
Title: _____

TENANT:

_____

By: _____
Name: _____
Title: _____

[ADD NOTARY ACKNOWLEDGMENTS]

Exhibit "A"
To the Memorandum of Ground Lease

[Description of Premises]

Exhibit "B"

To the Memorandum of Ground Lease

[Description of Development]

Note:

This draft lease reflects the intent to enter into a long-term non-capitalized land lease that will be executed in order to undertake the project. However, in accordance with 77 Ill. Admin. Code 1120.110(b)(1), this draft lease, which reflects acquisition of control over the land, is not included as part of the total estimated project costs, as that term is defined within 77 Ill. Admin. Code 1130.140.

FEJ, STZ Title

This document prepared by:

Armstrong Teasdale LLP
7700 Forsyth Blvd., Suite 1800
St. Louis, Missouri 63105
Attn: Daniel J. Burke Jr.

A02516652 5
A02516652
MICHAEL T. COSTELLO
RECORDER OF DEEDS
ST. CLAIR COUNTY
BELLEVILLE, IL
11/09/2016 02:10:09PM
RHSP FEE: 9.00
STATE FEE: 1975.00
COUNTY FEE: 987.50
TOTAL FEE: $3,002.75
PAGES: 5

KM 11-9-16

STATE OF ILLINOIS
STATE & COUNTY TAX
NOV.-9.16
ST. CLAIR COUNTY

0000007363
REAL ESTATE TRANSFER TAX
0296.50
FP351003

This space reserved for Recorder's use only

4035

SPECIAL WARRANTY DEED

THIS SPECIAL WARRANTY DEED, made this 4th day of November, 2016, between **Havenhills Investment Company, LLC**, a Missouri limited liability company, with a mailing address of 1001 Boardwalk Springs Place, Suite 10, O'Fallon, Missouri 63368 ("**Grantor**"), and **Progress East Healthcare Center**, an Illinois not-for-profit corporation, with a mailing address of 8300 Eager Road, Suite 600B, St. Louis, Missouri 63144, c/o Bryan Reichley, Director of Real Estate ("**Grantee**");

WITNESSETH, that Grantor, for and in consideration of the sum of Ten and NO/100 Dollars ($10.00), and other good and valuable consideration, in hand paid by the Grantee, the receipt of which is hereby acknowledged, by these presents does hereby **GRANT, BARGAIN, SELL AND CONVEY** unto said Grantee the real estate located in St. Clair County, Illinois, which is legally described as follows (the "**Real Estate**"):

See **Exhibit A** attached hereto and incorporated herein by this reference;

TO HAVE AND TO HOLD the same, together with all rights and appurtenances to the same belonging unto the Grantee, and to its successors and assigns forever. The said Grantor hereby covenanting that Grantor and its successors and assigns, shall and will **WARRANT AND DEFEND** the title to the Real Estate unto the said Grantee, and to its successors and assigns forever, against the lawful claims of all persons claiming by, through or under Grantor but none other, excepting, however those permitted exceptions ("**Permitted Exceptions**") listed on **Exhibit B** attached hereto and incorporated herein by this reference.

Attachment 2

APPROVED MAPPING & PLATTING
Director
SUBJECT TO ZONING REGULATIONS

41
3840 + 0800

5

Hereby releasing and waiving all rights under and by virtue of the Homestead Exemption Laws of the State of Illinois.

Permanent Parcel Number: 09-05.0-102-002

(Remainder of page intentionally left blank, signature page follows)

Attachment 2

IN WITNESS WHEREOF, the undersigned has executed this Special Warranty Deed as of the day and year first written above.

GRANTOR:

HAVENHILLS INVESTMENT COMPANY, LLC,
a Missouri limited liability company

By: Shiloh Land Acquisitions, LLC, a Missouri limited liability company, its Manager ("Shiloh")

By: _____
Paul J. McKee, Jr., Chief Manager of Shiloh

STATE OF MISSOURI)
) ss.
COUNTY OF St. Louis)

On this 4th day of November in the year 2016, before me, a Notary Public in and for said state, personally appeared Paul J. McKee, Jr., the Chief Manager of Shiloh Land Acquisitions, LLC, a Missouri limited liability company, which is the Manager of Havenhills Investment Company, LLC, a Missouri limited liability company, known to me to be the person who executed the foregoing instrument and acknowledged to me that he executed the same on behalf of said limited liability companies for the purposes therein stated as his free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County and State aforesaid, the day and year first above written.

_____
Notary Public Michelle A Sholar

My Commission Expires: 01/08/19

MICHELLE A. SHOLAR
My Commission Expires
January 8, 2019
St. Louis County
Commission #15511680

Send subsequent tax bills to and after recording return to:

Progress East Healthcare Center
c/o Bryan Reichley, Director of Real Estate
8300 Eager Road, Suite 600B
St. Louis, Missouri 63144

Attachment 2

EXHIBIT A

Legal Description of Real Estate

Part of the NW 1/4 of Section 5, T1N, R7W of the 3rd P.M., County of St. Clair, State of Illinois and being more particularly described as follows:

Commencing at the Northwest corner of said Section 5; thence South 00° 48' 36" East, on the West line of said Section 5, a distance of 15.01 feet to the point of beginning of the tract herein described; thence from said point of beginning South 89° 06' 29" East, 15 feet South of and parallel to the North line of said Section 5, a distance of 1,702.09 feet; thence South 04° 38' 16" East, a distance of 10.05 feet; thence South 89° 06' 29" East, 25 feet South of and parallel to the North line of said Section 5, a distance of 316.63 feet to the Southwesterly right of way line of Cross Street; thence South 43° 36' 16" East, on said Southwesterly right-of-way line of Cross Street, a distance of 296.48 feet to the Northerly right of way line of Frank Scott Parkway; thence the following 11 courses and distances on said Northerly right of way line of Frank Scott Parkway; 1) South 20° 41' 41" West 54.97 feet; 2) South 64° 24' 20" West, 157.48 feet; 3) South 62° 05' 34" West, 228.56 feet; 4) South 72° 04' 57" West, a distance of 366.31 feet; 5) South 86° 31' 49" West 207.13 feet; 6) North 87° 28' 35" West, a distance of 380.25 feet; 7) North 77° 14' 17" West, a distance of 255.29 feet; 8) North 66° 24' 47" West, a distance of 159.91 feet; 9) North 61° 26' 10" West, a distance of 325.71 feet; 10) North 54° 21' 37" West, a distance of 182.18 feet; and 11) North 69° 20' 25" West, a distance of 99.44 feet to the West line of said Section 5; thence North 00° 48' 36" West, on said West line of Section 5, a distance of 173.70 feet to the point of beginning.

Excluding the following parcel which was conveyed to Ameren Illinois Company, described as follows:

Part of the NW 1/4 of Section 5, T1N, R7W of the 3rd P.M., County of St. Clair, State of Illinois and being more particularly described as follows:

Commencing at the Northwest corner of said Section 5; thence South 00° 48' 36" East, on the West line of said Section 5, a distance of 15.01 feet; thence South 89° 06' 29" East, on a line 15 feet South of and parallel to the North line of said Section 5, a distance of 1,403.06 feet to the Point of Beginning of said described tract; thence continuing on said parallel line South 89° 06' 29" East, a distance of 299.03 feet; thence South 04° 38' 16" East, a distance of 10.05 feet; thence South 89° 06' 29" East, on a line 25 feet South of and parallel with the North line of said Section 5 a distance of 50.00 feet; thence South 00° 53' 31" West a distance of 220.00 feet; thence North 89° 06' 29" West, on a line being parallel to the North line of said Section 5, a distance of 350.00 feet; thence North 00° 53' 31" East, a distance of 230.00 feet to the Point of Beginning.

The real estate described above which was conveyed to Ameren is shown as Lot Q-1 on the Plat of Survey recorded in St. Clair County Illinois on July 9, 2013, as Document No. A02375938.

Prior Deed: Document No. A02270149

EXHIBIT B

Permitted Exceptions

1. Building lines as set by Supervisors Resolution adopted June 6, 1966, and recorded in Book 2017, Page 13.

2. Rights of the public, the State of Illinois, and the municipality in and to that part of the land, if any, taken or used for road purposes.

3. Easement in favor of Ameren Illinois Company d/b/a Ameren Illinois recorded July 18, 2013, as Doc. No. A02377186.

4. Terms and conditions of a Declaration of Restrictive Covenant recorded July 18, 2013, as Doc. No. A02377184.

5. Easement in favor of Kinloch Long Distance Telephone Company of Missouri recorded March 24, 1903, in Book 292, Page 456.

6. Watermain Easement in favor of the Village of Shiloh recorded February 22, 1995, in Book 3017, Page 998, as Doc. No. A01266215.

7. Easement in favor of American Telephone and Telegraph Company recorded May 22, 1953, in Book 1282, Page 516, as Doc. No. 713566.

8. Rights of the County of St. Clair, State of Illinois, as contained in deed for right of way recorded January 29, 1953, in Book 969, Page 594, as Doc. No. 701743.

9. Easement for right of way in favor of the Town of Shiloh recorded June 26, 1917, in Book 455, Page 623, as Doc. No. 28490.

10. Real estate taxes for the years 2015 and 2016.

11. Matters that would be shown on a current and accurate survey.

12. All rights and easement in favor of the holder of any interest in the mineral estate or of any party claiming by, through, or under said holder, if any.

13. That certain Illinois Farm Lease dated March 31, 2016, between Havenhills Investment Company, LLC, Shiloh Land Acquisitions, LLC, and McEagle Land Acquisitions, LLC, collectively, as lessor, and Dietz Family Farms, LLC, as lessee.

Persons with 5% or Greater Interest in the Licensee
The Rehabilitation Institute of Southern Illinois, LLC

The Rehabilitation Institute of Southern Illinois, LLC will be a joint venture between BJC and Encompass. The corporate entity is a Delaware corporation.

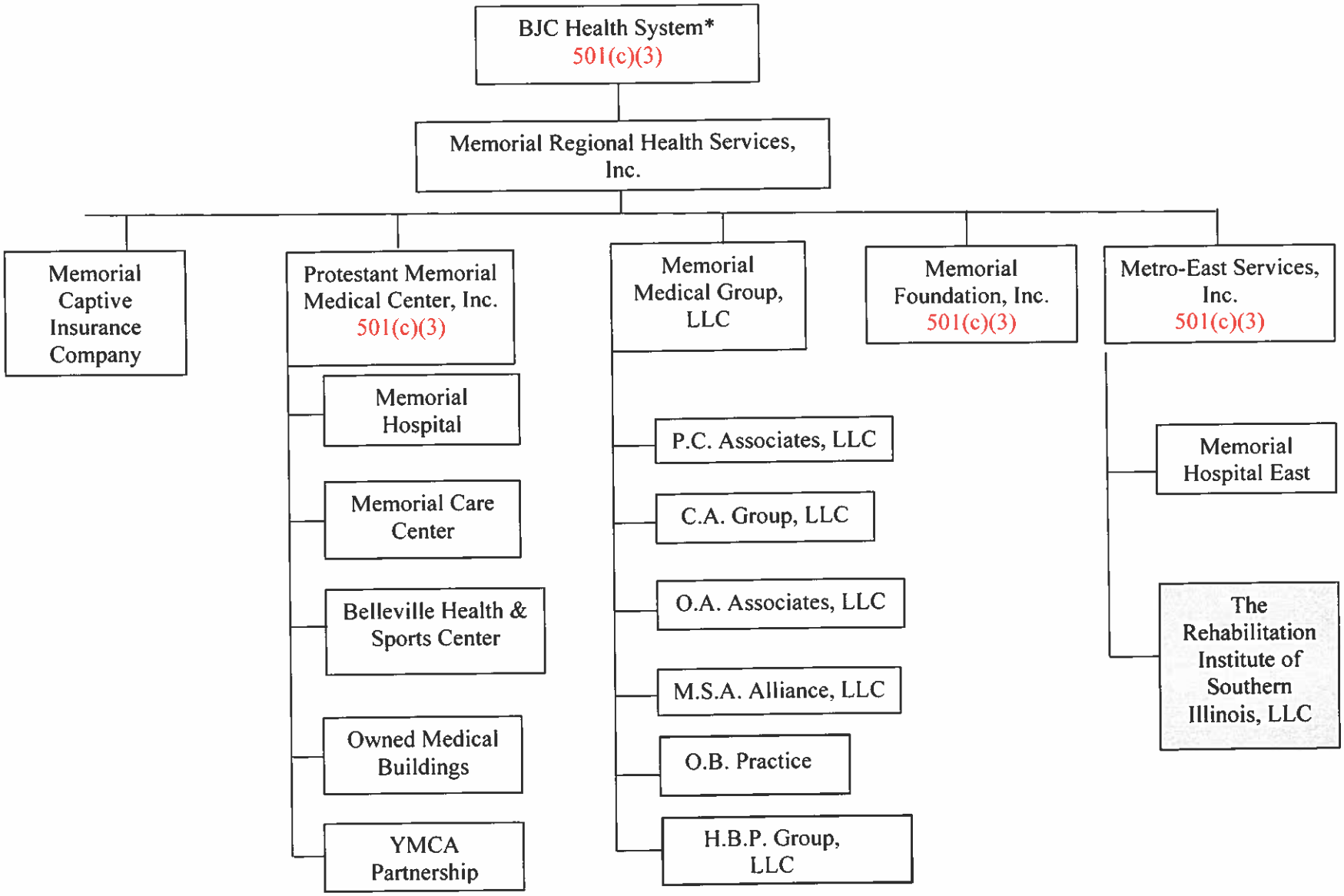
The Rehab Institute of Southern Illinois, the Licensee, will be a 50-50 joint venture between BJC HealthCare ("BJC") through its subsidiary Metro East Services, Inc. and Encompass Health Corporation ("Encompass"). BJC is a Missouri nonprofit corporation. Encompass is a Delaware corporation.

Two wholly-owned subsidiaries of BJC HealthCare, Memorial Regional Health Services, Inc. and Metro-East Services, Inc. have been identified as Co-Applicants for the proposed project.

Progress East Healthcare Center, a wholly-owned subsidiary of BJC HealthCare, owns the land on which The Rehab Institute will be constructed. A ground lease between BJC, who as the ultimate parent of Progress East Healthcare Center ultimately controls the land, and the Applicant entity is provided in Attachment 2.

Organizational Relationships to Licensee

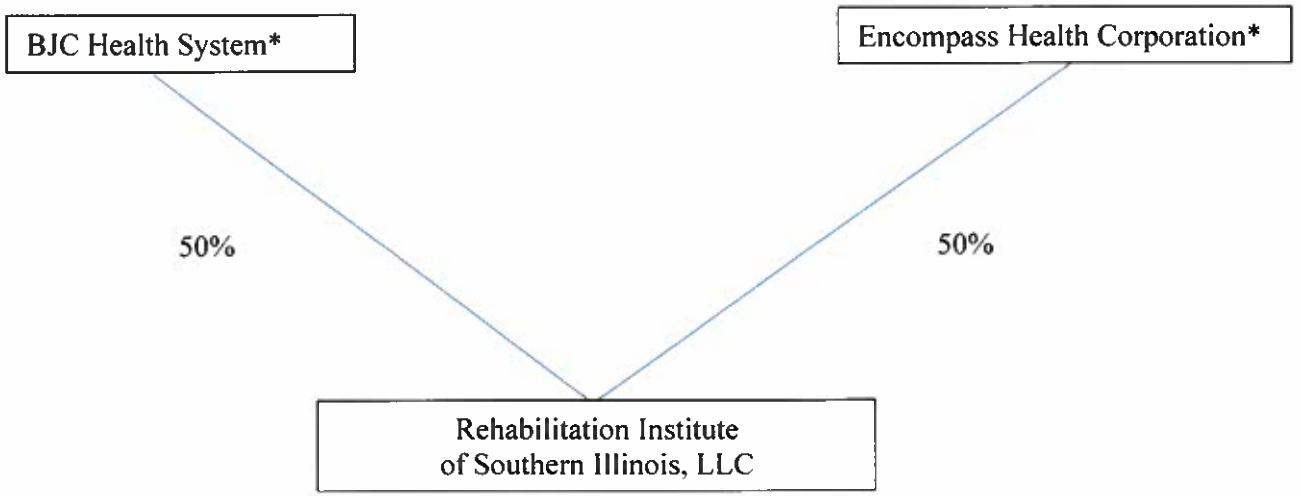
The Rehabilitation Institute of Southern Illinois, LLC



*Progress East Healthcare Center (Site Owner-a wholly-owned subsidiary of BJC Health System)

Attachment 4
Page 1

Organizational Relationships to Licensee
The Rehabilitation Institute of Southern Illinois, LLC



*There are various wholly owned corporate entities in between, but control rests with the ultimate parent and co-applicants, as identified.

CONSULTING ENGINEERING
GEOSPATIAL SERVICES

THOUVENOT, WADE & MOERCHEN, INC.
CORPORATE OFFICE
4940 OLD COLLINSVILLE ROAD
SWANSEA, IL 62226
618.624.4488
TWM-INC.COM

April 30, 2019

Mr. Rodney Gilchrist
Senior Manager, Design & Construction
Encompass Health
9001 Liberty Parkway
Birmingham, Alabama 25243

RE: The Rehabilitation Institute of Southern Illinois – Shiloh, Illinois
Encompass Health
TWM – 180855

Dear Mr. Gilchrist:

As requested, our office has reviewed the FEMA Flood Insurance Rate Map 17163C0210D to evaluate the classification of the 8.9 acres of property located in the NW Quarter of Section 5, T1N, R7W of the Third Principal Meridian, St. Clair County, Illinois that is to be the site of the proposed Rehabilitation Institute of Southern Illinois.

Our review has determined that the subject property is classified as Zone X, meaning that the property is outside the 500-year flood plain. I am attaching a portion of the FEMA Map for inclusion with this letter.

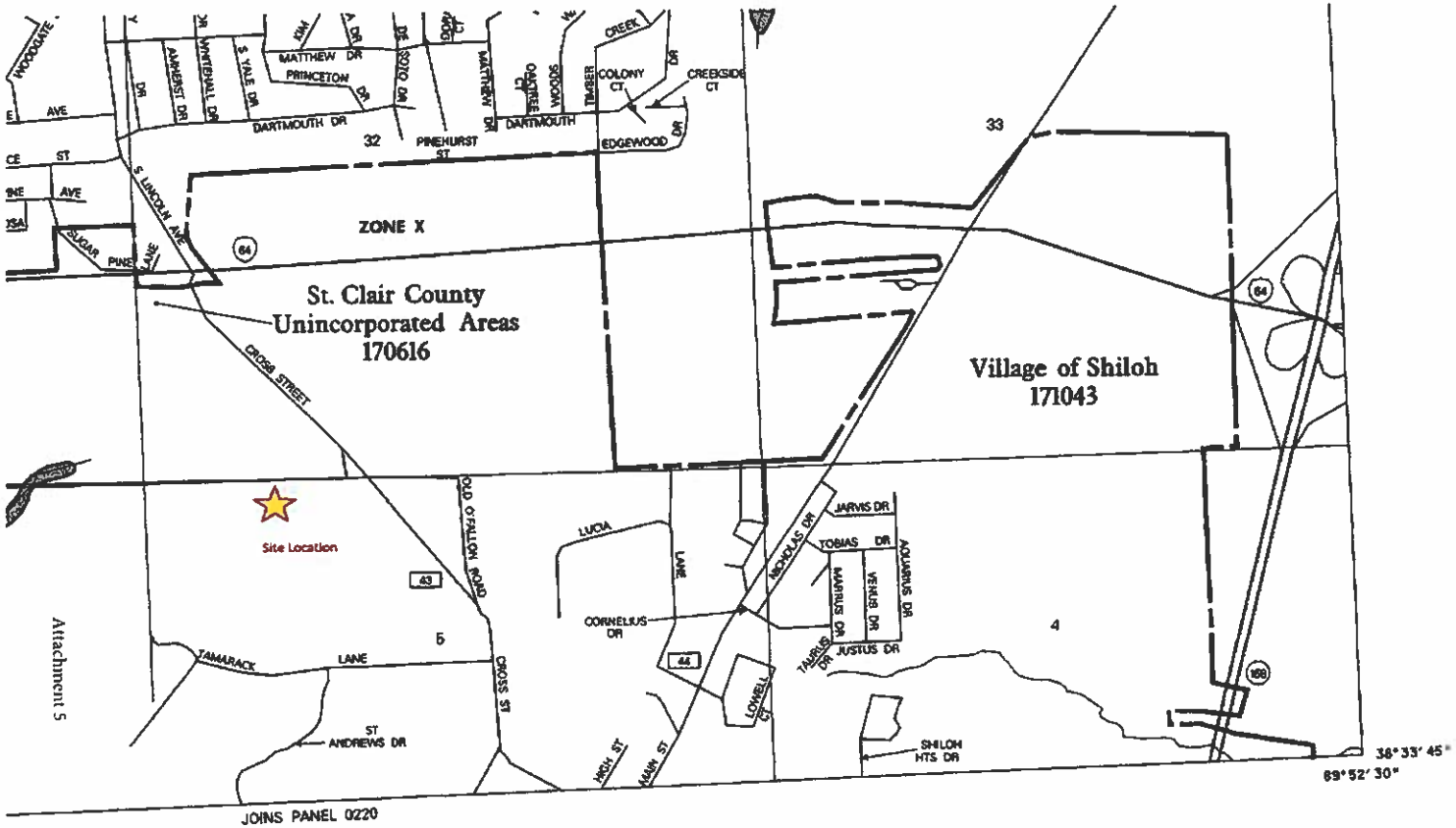
If you need anything else, please feel free to contact me.

Respectfully,

Thouvenot, Wade & Moerchen, Inc.

Paul K. Homann, P.E.
Senior Vice President

CC: None
Encl: FEMA Flood Map



Attachment 5

NATIONAL FLOOD INSURANCE PROGRAM

FIRM
FLOOD INSURANCE RATE MAP
ST. CLAIR COUNTY,
ILLINOIS
AND INCORPORATED AREAS

PANEL 210 OF 555

(SEE MAP INDEX FOR PANELS NOT PRINTED)

CONTAINS:

COMMUNITY	NUMBER	PANEL	SUFFIX
O'FALLON, CITY OF	170693	0210	D
SHILOH, VILLAGE OF	171043	0210	D
ST. CLAIR COUNTY	170676	0210	D

Notice to User: The MAP NUMBER shown below should be used when placing map orders; the COMMUNITY NUMBER shown above should be used on insurance applications for the subject community.

MAP NUMBER
17163C0210D

EFFECTIVE DATE:
NOVEMBER 5, 2003

Federal Emergency Management Agency

Illinois Department of Natural Resources

JB Pritzker, Governor
Colleen Callahan, Director

www.dnr.illinois.gov

Mailing address: State Historic Preservation Office, 1 Old State Capitol Plaza, Springfield, IL 62701

St. Clair County
Shiloh
Frank Scott Parkway East, west of Cross Street
Section:5-Township:1N-Range:7W
IEPA, TWM-180855
New construction, BJC Rehabilitation Hospital - Encompass Health

PLEASE REFER TO: SHPO LOG #011021919

March 15, 2019

Paul Homann
Thouvenot, Wade & Moerchen, Inc.
4940 Old Collinsville Road
Swansea, IL 62226

Dear Mr. Homann:

The Illinois State Historic Preservation Office is required by the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420, as amended, 17 IAC 4180) to review all state funded, permitted or licensed undertakings for their effect on cultural resources. Pursuant to this, we have received information regarding the referenced project for our comment.

Our staff has reviewed the specifications under the state law and assessed the impact of the project as submitted by your office. We have determined, based on the available information, that no significant historic, architectural or archaeological resources are located within the proposed project area.

According to the information you have provided concerning your proposed project, apparently there is no federal involvement in your project. However, please note that the state law is less restrictive than the federal cultural resource laws concerning archaeology. If your project will use federal loans or grants, need federal agency permits, use federal property, or involve assistance from a federal agency, then your project must be reviewed under the National Historic Preservation Act of 1966, as amended. Please notify us immediately if such is the case.

This clearance remains in effect for two (2) years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the IL Human Skeletal Remains Protection Act (20 ILCS 3440).

Please retain this letter in your files as evidence of compliance with the Illinois State Agency Historic Resources Preservation Act.

If further assistance is needed please contact Jeff Kruchten, Chief Archaeologist at 217/785-1279 or jeffery.kruchten@illinois.gov.

Sincerely,

Robert F. Appleman
Deputy State Historic
Preservation Officer

Attachment 6
Page 1

Project and Sources of Funds Itemization
The Rehabilitation Institute of Southern Illinois, LLC

Summary of Project and Related Cost Data Assumptions

Project Costs and Sources of Funds			
Component	**Clinical**	**Non-Clinical**	**Total**
Site Preparation	$ 790,524	$ 263,508	$ 1,054,032
New Construction Contracts	$ 14,462,059	$ 4,820,687	$ 19,282,746
Contingencies	$ 1,505,207	$ 423,068	$ 1,928,275
Architectural/Engineering Fees	$ 1,100,291	$ 366,764	$ 1,467,055
Consulting and Other Fees	$ 933,708	$ 311,236	$ 1,244,944
Movable/Other Equipment (not in contracts)	$ 3,648,489	$ 1,216,163	$ 4,864,652
Other Costs To Be Capitalized	$ 808,409	$ 348,137	$ 1,156,546
Total Project Cost	**$ 23,248,687**	**$ 7,749,563**	**$ 30,998,250**

Site Preparation
Project site preparation costs are based upon the proposed site location in Shiloh, IL and Encompass Health and BJC experience.

New Construction
The new construction will be a single-story 47,749 square foot building. Project building costs are comprised of all costs and expenses covered under the construction contract, including major medical and other fixed equipment and contractor's overhead and profit. Costs are estimated based on national architectural/construction standards adjusted for St. Clair County building code compliance and Encompass and BJC experience. These costs are projected to be $19,282,746, or $403.84 per square foot.

Contingencies
Project contingencies costs are an allowance for unforeseeable events related to construction and are estimated to be $1,928,275, which is 10% of estimated new construction costs.

Architectural/Engineering fees
Project architectural/engineering fees are projected to be $1,467,055, or approximately 7% of new construction and contingencies costs. These costs are consistent with Encompass Health and BJC experience.

Project and Sources of Funds Itemization
The Rehabilitation Institute of Southern Illinois, LLC

Consulting and Other fees
Project consulting and other fees are comprised of the following fees:

Consulting and Other Fees	Costs
CON Development Fees	$ 575,000
ACE-IT Installation	$ 221,950
Permits and Local/State Fees	$ 447,994
Total	$ 1,244,944

Moveable Equipment Costs not in Building Contract
Project moveable equipment costs are estimated costs commensurate for a 40-bed facility and are based on Encompass Health and BJC experience.

Net Interest Expense during Construction
Project costs will be funded by cash transfers from the JV Partners.

Other Costs that are to be Capitalized
Project other costs to be capitalized are primarily comprised of pre-opening salaries expenses.

Cost Space Requirements
The Rehabilitation Institute of Southern Illinois, LLC

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. 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**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	$ 23,248,687		35,812 BGSF	35,812 BGSF			
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical	$ 7,749,563		11,937 BGSF	11,937 BGSF			
TOTAL	**$ 30,998,250**		**47,749 BGSF**	**47,749 BGSF**			

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 9
Page 1

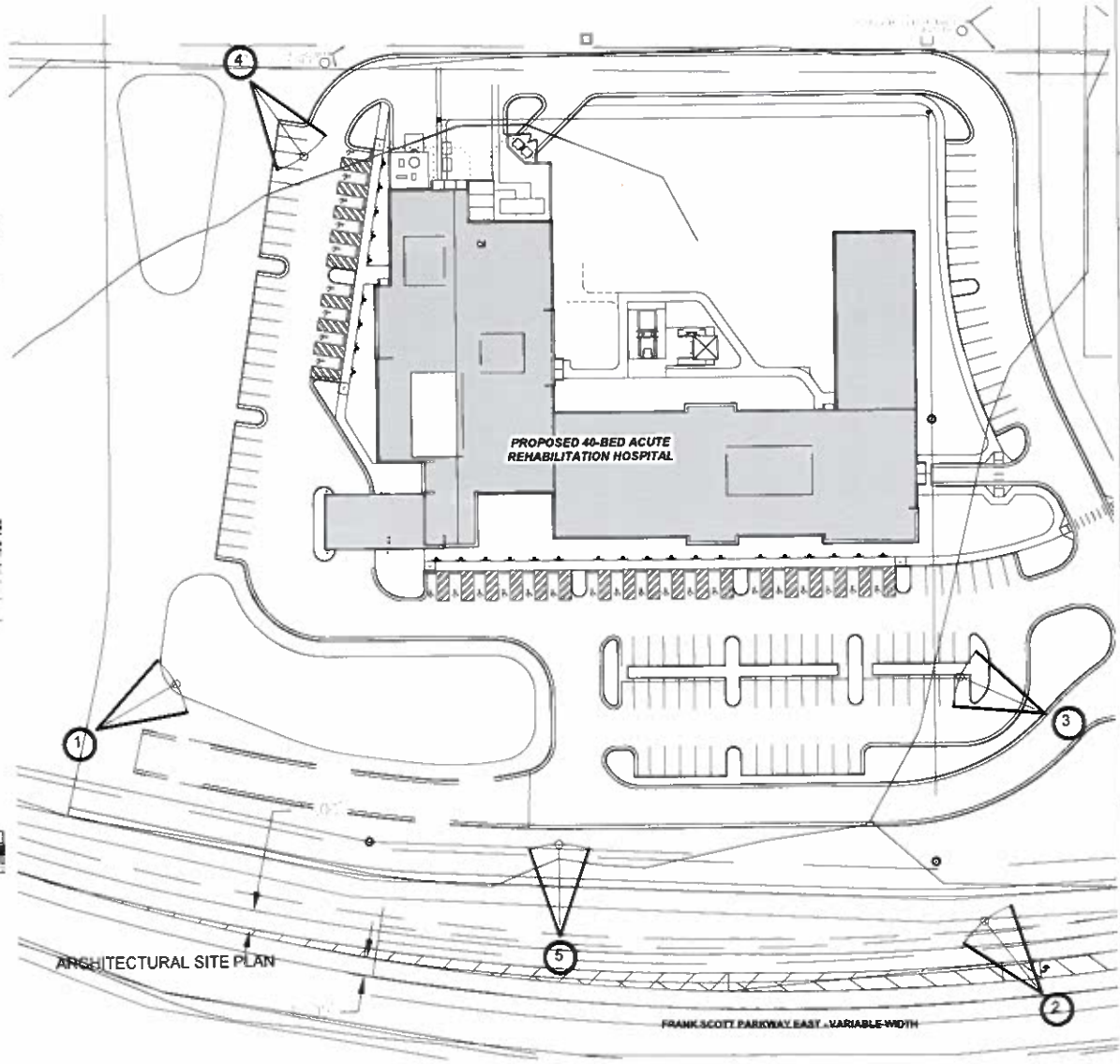
PERSPECTIVE VIEW 1

PERSPECTIVE VIEW 2

PERSPECTIVE VIEW 3

PERSPECTIVE VIEW 4

PERSPECTIVE VIEW 5



ARCHITECTURAL SITE PLAN

Attachment 9

Gresham Smith

greshamsmith.com

3595 Grandview Parkway
Suite 100
Birmingham, AL 35243
205.298.9000

Encompass Health

THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC.

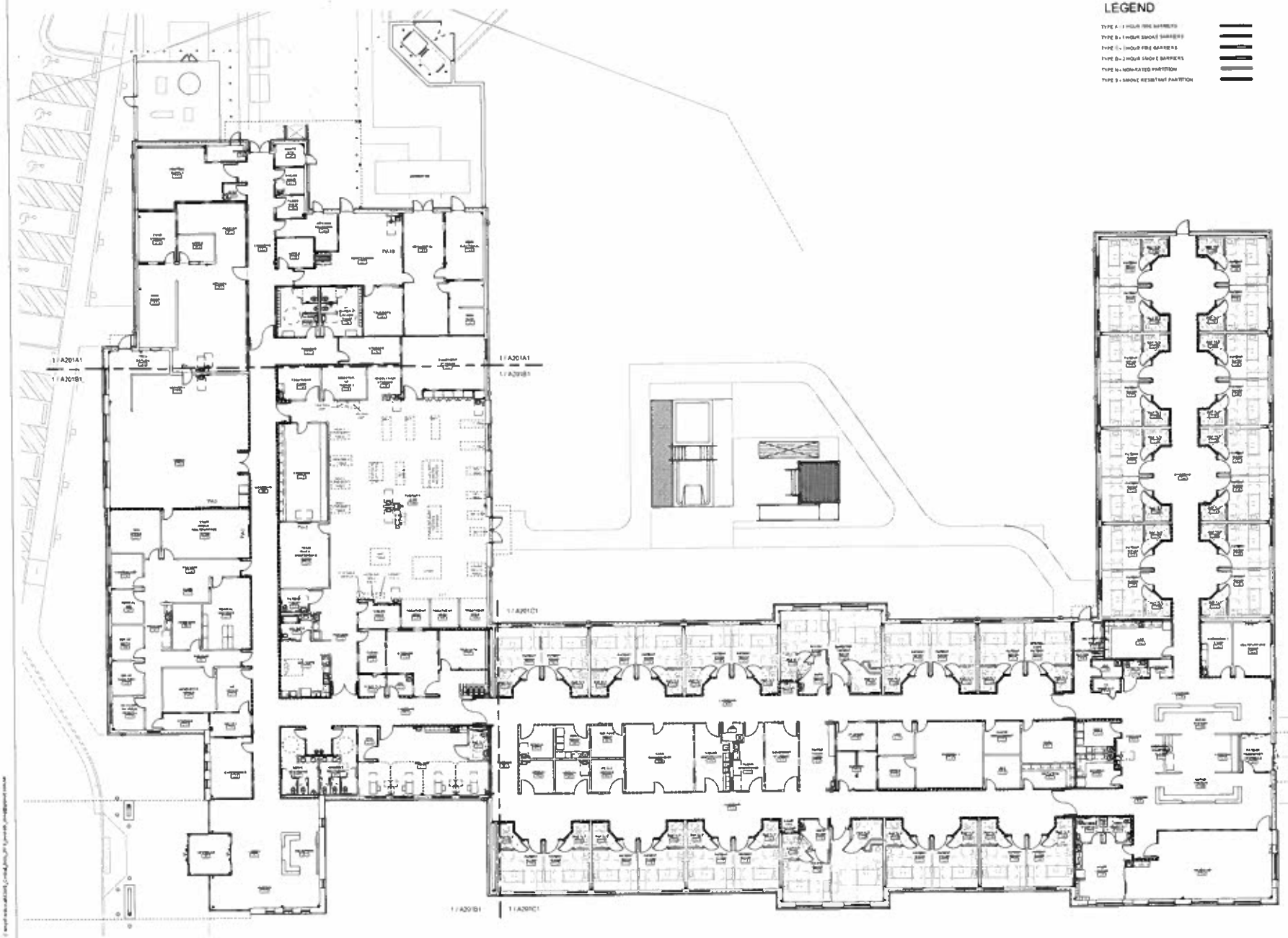
Revision

No.	Date	Description

ARCHITECTURAL SITE PLAN

A100

PROJECT 43645.00
DATE 03/01/2013



1 LEVEL 1 OVERALL - FLOOR PLAN

Attachment 9

Gresham Smith

GreshamSmith.com

3985 Grandview Parkway
Suite 300
Birmingham, AL 35243
205.298.9200

Encompass Health

THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC.

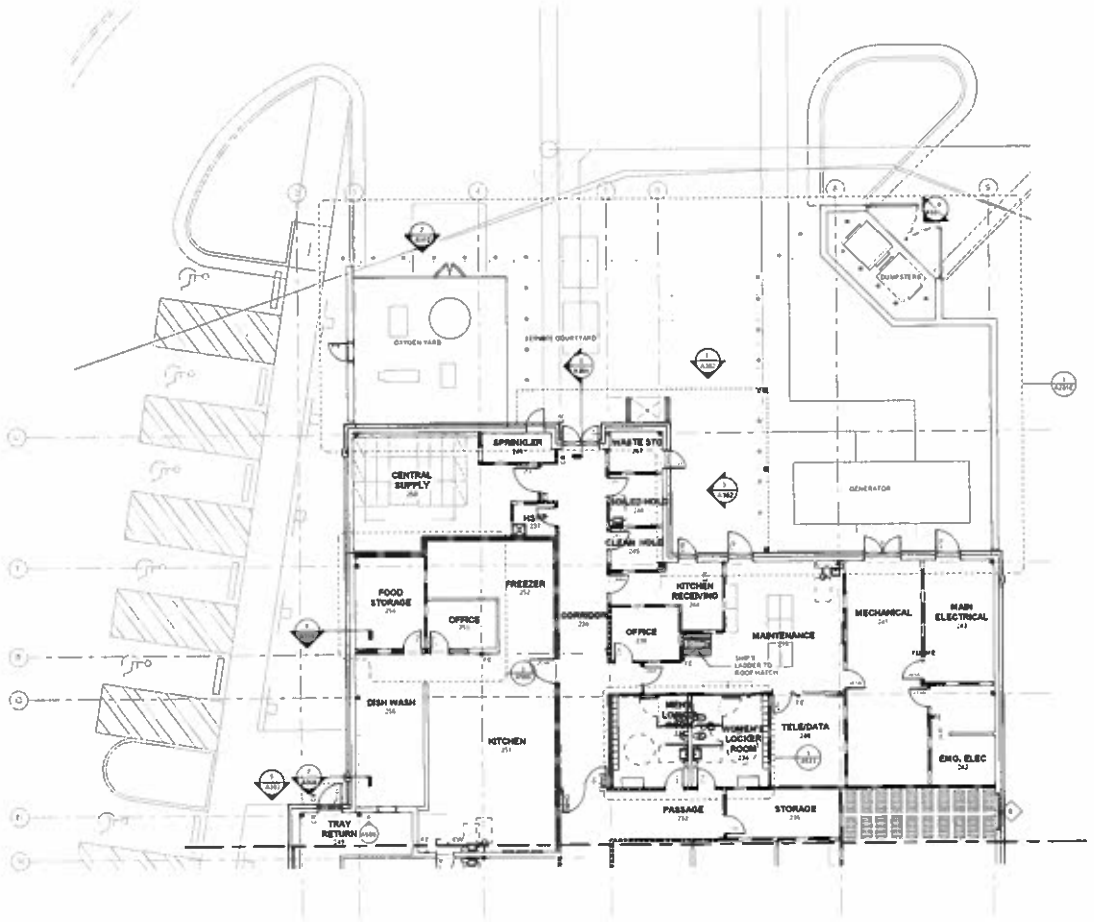
Revision

No.	Date	Description

OVERALL FLOOR PLAN

A200

PROJECT 43645.00
DATE 03/01/2019



1 LEVEL 1 PART A - NEW CONSTRUCTION PLAN

LEGEND

TYPE A - 1 HOUR FIRE BARRIERS

TYPE B - 1 HOUR SMOKE BARRIER

TYPE C - 2 HOUR FIRE BARRIER

TYPE D - 2 HOUR SMOKE BARRIERS

TYPE N - NON-RATED PARTITION

TYPE S - SMOKE RESISTANT PARTITION

SEE PROJECT INFORMATION SHEET G001 FOR COMPONENTS OF WALL PARTITION BARRIERS

ACCESSIBLE	ADC	ISOLATION PANEL	IP
AUTOMATIC DOOR (INTEGRAL HOLD-OPEN IS NOT ALLOWED)	AUTO	KEY PAD	KP
AUTOMATIC DOOR OPERATOR WITH INTEGRAL HOLD-OPEN	AUTO W/HO	MEDICAL GAS ALARM PANEL	MGAP
CARD READER	CR	MEDICAL GAS OUTLET	MGO
CUBICLE CURTAIN TRACK (SEE DETAIL 2/A601)	CCT	MEDICAL GAS ZONE VALVE	MGZV
DISCONNECT PANEL	DP	MOTION DETECTOR	MD
ELECTRIC WATER COOLER	EWC	PATIENT CORD SOLE	PCOR
ELECTRICAL PANEL	EP	REMOTE RELEASE BUTTON	RB
ELECTROMAGNETIC HOLD OPEN	EMHO	PUSH BUTTON FOR AUTOMATIC DOOR	PB
EMERGENCY EYE WASH	EW	ACCESSIBLE DRESSING BENCH	BENCH
EXPANSION JOINT	EJ	OWNER FURNISHED EQUIPMENT (SHOWN LIKE SO)	OFE
FIRE EXTINGUISHER CABINET	FEC		

COMPLY WITH ALL REQUIREMENTS INCLUDED IN THE "GENERAL NOTES FOR NEW CONSTRUCTION FLOOR PLANS" ON SHEET A201A1

SEE "GENERAL NOTES" ON SHEET A201A1 — N1

SEE "NEW CONSTRUCTION KEYNOTES" ON THIS SHEET — 2/1

DOOR DESIGNATION (SEE SHEET A601 AND PROJECT MANUAL FOR DOOR FRAME AND HARDWARE SCHEDULE)

EXTERIOR WINDOW DESIGNATION (SEE SHEET A601 FOR EXTERIOR WINDOW SCHEDULE) — ◇

INTERIOR WINDOW DESIGNATION (SEE SHEET A601 FOR INTERIOR WINDOW SCHEDULE) — ◇W1

TOILET ACCESSORY SET (SEE SHEET A605 FOR TOILET ACCESSORY SCHEDULE)

WALL DESIGNATION (SEE SHEET G001 FOR TYPES OF WALLS/ PARTITION/BARRIERS) — A60

GENERAL NOTES FOR NEW CONSTRUCTION FLOOR PLANS

201. COMPLY WITH THE REQUIREMENTS OF THE FOLLOWING NOTES IN THIS SET OF DRAWINGS WHICH ALSO APPLY TO THE NEW CONSTRUCTION FLOOR PLANS:
A. "GENERAL NOTES FOR PROJECT" ON PROJECT INFORMATION SHEET G001
B. "GENERAL NOTES FOR DIMENSION FLOOR PLANS" ON SHEET A201A2
C. "GENERAL NOTES FOR REFLECTED CEILING PLANS" ON SHEET A602A1
D. "GENERAL NOTES FOR CABINETWORK/CASEWORK" ON SHEET A605

202. SEE DIMENSION FLOOR PLANS, ENLARGED PLANS, INTERIOR ELEVATIONS, DETAILS, ETC. FOR DIMENSIONS AND KEYNOTES WHICH APPLY TO THE NEW CONSTRUCTION FLOOR PLANS.

203. NOT USED

204. ITEMS DENOTED ON THE NEW CONSTRUCTION FLOOR PLANS WITH A DASHED LINE ARE BEING FURNISHED BY THE OWNER. COMPLY WITH THE REQUIREMENTS OF "GENERAL NOTES FOR PROJECT" ON PROJECT INFORMATION SHEET G001.

205. REFER TO ARCHITECTURAL SCHEDULES AND LEGENDS LOCATED AS FOLLOWS:
A. TOILET ACCESSORY SET SCHEDULE: SEE SPECIFICATION SECTION 10 2800 IN THE PROJECT MANUAL.
B. DOOR FRAME AND HARDWARE SCHEDULE: NOTES AND ABBREVIATIONS SEE SHEET A000 AND PROJECT MANUAL.
C. DOOR FRAME AND HARDWARE LEGENDS AND DETAILS: SEE SHEET A601.
D. INTERIOR WINDOW SCHEDULE: NOTES AND ABBREVIATIONS SEE SHEET A601 PROJECT MANUAL.
E. INTERIOR WINDOW LEGENDS AND DETAILS: SEE SHEET A601.
F. EXTERIOR WINDOW DESIGNATIONS AND LEGEND: SEE EXTERIOR ELEVATIONS FOR DESIGNATIONS AND SEE SHEET A201A1 FOR EXTERIOR WINDOW LEGEND.

206. SEE REFLECTED CEILING PLANS ON SHEETS A602A1-A602A2 FOR LOCATIONS OF GYPSUM BOARD OR CEMENT PLASTER FURR-DOWNS AND SOFFITS AS SHOWN IN DETAILS 1/A601 AND 2/A601.

207. REFER TO SHEET G6 ABBREVIATIONS AND SYMBOLS FOR TYPICAL DETAILS WHICH APPLY TO THE NEW CONSTRUCTION FLOOR PLANS, BUT WHICH MAY NOT BE SPECIFICALLY REFERENCED ON THE FLOOR PLANS.

208. SEE INTERIOR DESIGN DRAWINGS FOR INTERIOR FINISHES AND FOR LOCATIONS OF ACCENT WALLS AND WALL PROTECTION.

209. SEE SHEETS A201A1 AND "GENERAL NOTES FOR DIMENSION FLOOR PLANS" ON SHEET A201A2 FOR CRITICAL ACCESSIBILITY CODE REQUIREMENTS REGARDING MANEUVERING CLEARANCES AT DOORS, TOILET ROOMS, TOILET STALLS, PLUMBING FIXTURES, WATER CLOSETS, URINALS, SINKS, LAVATORIES, ELECTRIC WATER COOLERS, FUEL SHOWERS, ETC., DRESSING ROOMS, MOUNTING OF TOILET ACCESSORIES, ETC.

210. AT ALL EXTERIOR WALLS CONSTRUCTED OF METAL STUDS: THE 5/8 INCH TYPE "X" GLASS MAT PAPERLESS INTERIOR GYPSUM BOARD ON THE INTERIOR SIDE OF THE METAL STUDS SHALL BE EXTENDED UP TO THE STRUCTURE ABOVE AND SHALL BE SEALED FOR "AIR-TIGHT" SEPARATION OF THE EXTERIOR WALL CAVITY FROM ALL INTERIOR SPACES. (SEE NOTE 214 @ BLOCKOUTS.) NOTE: IT IS CRITICAL THAT THE CAVITY OF ALL EXTERIOR WALLS BE SEALED "AIR-TIGHT" AND "SOUND-TIGHT" FROM THE CAVITIES OF ALL INTERIOR WALLS.

212. NOTE: ONLY SOME OF THE REQUIRED GRAB BARS ARE SHOWN ON THE FLOOR PLANS. SEE ENLARGED PLANS, INTERIOR ELEVATIONS, SPECIFICATION SECTION 10 2800, TOILET ACCESSORY SCHEDULE, ETC. FOR ADDITIONAL LOCATIONS WHERE GRAB BARS ARE ALSO REQUIRED.

213. REGARDING ACCESS PANELS:
A. THE CONTRACTOR SHALL VERIFY THAT ACCESS PANELS OF TYPE SPECIFIED ARE INSTALLED IN WALLS AND IN "NON-ACCESSIBLE TYPE" CEILINGS AND SOFFITS WHERE ACCESS, REPAIR OR ADJUSTMENT TO MECHANICAL, PLUMBING, FIRE PROTECTION, SECURITY, ELECTRICAL AND COMMUNICATION ITEMS MAY BE REQUIRED.
B. ACCESS PANELS SHALL BE THE FIRE RATED TYPE EQUAL TO THE RATING OF THE WALL, BARRIER, PARTITION, SOFFIT OR CEILING IN WHICH THEY OCCUR.
C. WALL MOUNTED ACCESS PANELS LOCATED IN RATED FIRE WALLS, RATED FIRE BARRIERS, RATED SMOKE BARRIERS AND/OR NON-RATED SMOKE PARTITIONS SHALL BE SELF-CLOSING AND "KEY LOCKED".
D. CEILING MOUNTED ACCESS PANELS IN ALL TOILET ROOMS SHALL BE "KEY LOCKED".
E. WALL MOUNTED ACCESS PANELS SHALL BE "KEY LOCKED" IN SPACES THAT ARE ACCESSIBLE TO THE PUBLIC, PATIENTS AND GENERAL STAFF.
F. ACCESS PANELS SHALL BE GASKETED TO BE "AIR-TIGHT" IN THE FOLLOWING SPACES: ALL SPACES UNDER NEGATIVE PRESSURE (WHICH DO NOT HAVE A SUPPLY DIFFUSER SUCH AS SMALL TOILET ROOMS), ISOLATION ROOMS, ISOLATION ANTE ROOMS AND ALL TOILET ROOMS THAT OPEN INTO ANY OF THE AFOREMENTIONED SPACES.

214. SEE SPECIFICATION SECTION 09 2900 AND THE SB DRAWINGS FOR REQUIRED LOCATIONS OF 5/8 INCH TYPE "X" GLASS MAT PAPERLESS INTERIOR GYPSUM BOARD. (NOTE: THE USE OF WATER RESISTANT GYPSUM BOARD (GREEN BOARD) IS NOT ACCEPTABLE IN WET LOCATIONS. INSTEAD USE 5/8 INCH TYPE "X" GLASS MAT PAPERLESS INTERIOR GYPSUM BOARD.)

215. BEHIND TILE WALLS AT TUB/SHOWERS: PROVIDE 5/8 INCH TYPE "X" TILE BACKER BOARD TO COMPLY WITH THE SPECIFICATIONS. (PROVIDE TWO LAYERS OF THIS MATERIAL AT THOSE ONE HOUR RATED BARRIERS AND ELSEWHERE AS NOTED.) BEHIND ALL OTHER TUB/SHOWERS: PROVIDE 5/8 INCH TYPE "X" GLASS MAT PAPERLESS INTERIOR GYPSUM BOARD TO COMPLY WITH THE SPECIFICATIONS. (PROVIDE TWO LAYERS OF THIS MATERIAL AT THOSE ONE HOUR RATED BARRIERS AND ELSEWHERE AS NOTED.)

216. THE CONTRACTOR SHALL BE RESPONSIBLE FOR COORDINATING WITH THE OWNER'S EQUIPMENT VENDORS TO ENSURE THAT THERE WILL BE NO OWNER FURNISHED ITEMS WITH A SURFACE AREA GREATER THAN 16 SQUARE INCHES, RECESSED INTO A RATED FIRE BARRIER OR RATED SMOKE BARRIER. SEE DETAILS FOR HOW TO PROVIDE FOR RECESSED ITEMS IN A RATED FIRE AND/OR SMOKE BARRIER. ITEMS RECESSED IN NON-RATED SMOKE PARTITIONS OR ALL OTHER FULL HEIGHT PARTITIONS SHALL BE SEALED "AIR-TIGHT" AT ALL PENETRATIONS.

217. SEE A603B and A603J FOR DETAIL OF A SURFACE MOUNTED ACCESSIBLE ELECTRIC WATER COOLER (EWC) ALCOVE.

218. NOT USED

219. AT ALL EXTERIOR WALLS CONSTRUCTED OF CONCRETE MASONRY UNITS (CMU), THE CMU SHALL BE EXTENDED UP TO THE STRUCTURE ABOVE AND BE SEALED "AIR-TIGHT" AND "SOUND-TIGHT".

220. THE ENCLOSURE WALL/PARTITION/BARRIERS SHALL BE EXTENDED UP TO THE DECK ABOVE AND BE SEALED "AIR-TIGHT" IN SPACES WHERE SOUND TRANSMISSION (IRRITATIONS) ARE EITHER REQUIRED BY THE CODE OR NECESSARY TO COMPLY WITH GOOD DESIGN PRACTICE. THESE SPACES INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: TOILET ROOMS, CONFERENCE ROOMS, HUDDLE, STAFF LOUNGES, STAFF LOCKER ROOMS, CONSULTATION ROOMS, PATIENT ROOMS, EXAM ROOMS, TREATMENT ROOMS, ISOLATION ROOMS, ISOLATION ANTE ROOMS, AND ROOMS WITHOUT FINISHED CEILINGS.

221. NOT USED

222. FOR THE INSTALLATION OF OWNER FURNISHED CEILING MOUNTED EXAM LIGHTS, THE CONTRACTOR SHALL REFER BOTH TO THE OWNER FURNISHED MANUFACTURER'S INSTRUCTIONS AND TO THE STRUCTURAL DRAWINGS FOR SUPPORT AND INSTALLATION DETAILS.

223. ALL RATED SMOKE BARRIERS AND RATED EXIT PASSAGEWAY BARRIER WALLS SHALL BE CONSTRUCTED FROM TOP OF CONSTRUCTION OF INTERVENING WALLS.

224. NOT USED

225. NOT USED

226. THE FLOORS, WALL/PARTITIONS AND CEILINGS (INCLUDING THEIR PERIMETERS & ALL PENETRATIONS THROUGH THEM) IN ALL OF THE FOLLOWING SPACES SHALL BE SEALED "AIR-TIGHT": PATIENT ROOMS (WHICH ARE DESIGNATED AS "NEGATIVE PRESSURE"), "NEGATIVE PRESSURE" ISOLATION" ROOMS WITH THEIR ADJACENT TOILET ROOMS & ANTE ROOMS.

Attachment 9

Gresham Smith
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Birmingham, AL 35243
205.298.9200

Encompass Health
Headquarters
9001 Liberty Parkway Birmingham AL 35242

THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC.

Revision		
No.	Date	Description

LEVEL 1 PART A - NEW CONSTRUCTION PLAN

A201A1

PROJECT #3641.00
DATE 03/01/2019

LEGEND

TYPE A - 1 HOUR FIRE BARRIERS

TYPE B - 1 HOUR SMOKE BARRIERS

TYPE C - 2 HOUR FIRE BARRIERS

TYPE D - 2 HOUR SMOKE BARRIERS

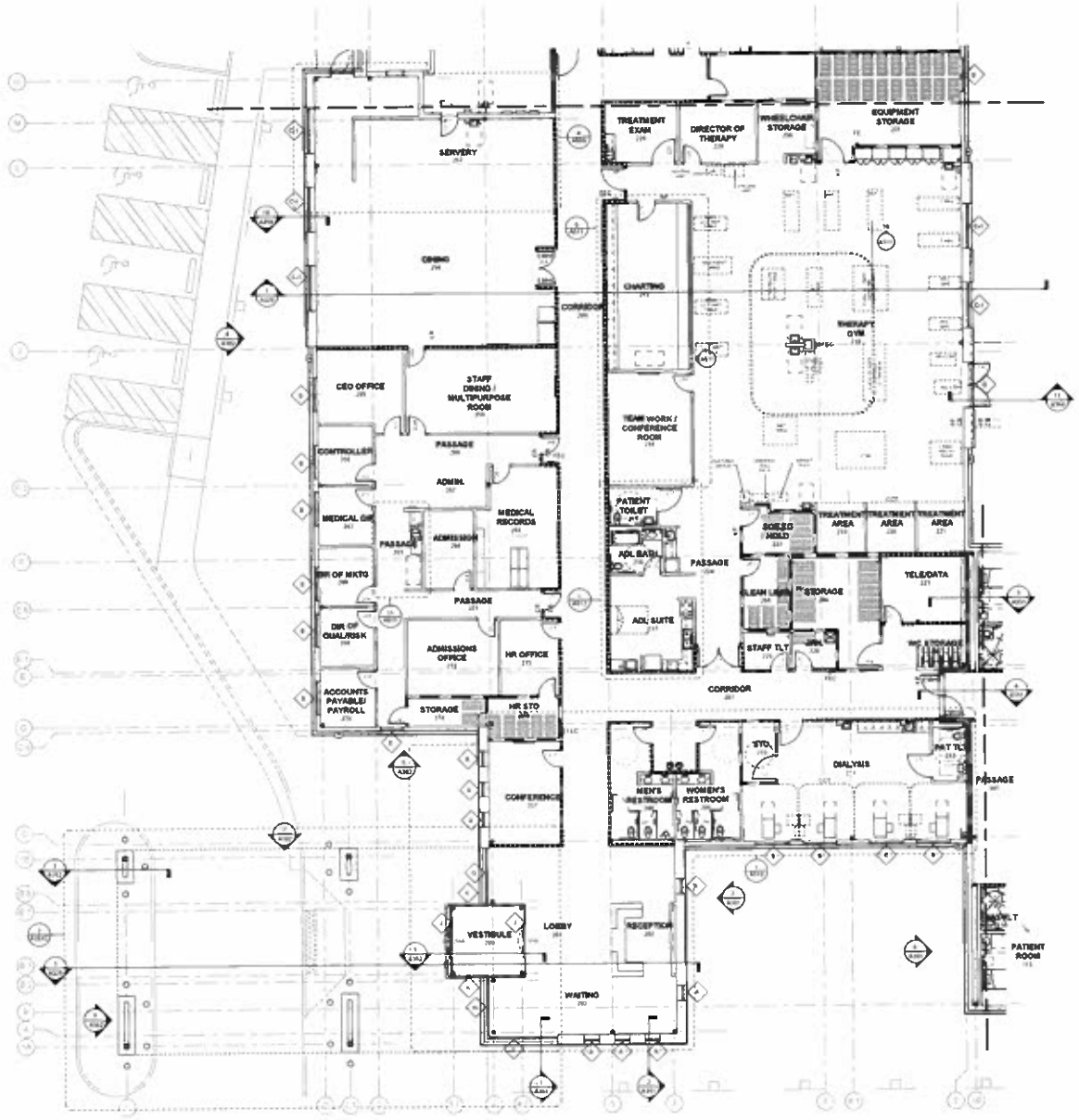
TYPE N - NON-RATED PARTITION

TYPE S - SMOKE RESISTANT PARTITION

SEE PROJECT INFORMATION SHEET G001 FOR COMPONENTS OF WALLS/PARTITIONS/ BARRIERS

ACCESSIBLE	ACC
AUTOMATIC DOOR (INTEGRAL HOLD-OPEN IS NOT ALLOWED)	AUTO
AUTOMATIC DOOR OPERATOR WITH INTEGRAL HOLD-OPEN	AUTO W/ HO
CARD READER	CR
CURTAIN TRACK (SEE DETAIL 2/A802)	CUT
DISCONNECT PANEL	DP
ELECTRIC WATER COOLER	EWC
ELECTRICAL PANEL	EP
ELECTROMAGNETIC HOLD-OPEN	EHHO
EYE WASH / EYE WASH	EW
EXPANSION JOINT	EJ
FIRE EXTINGUISHER EQUIPMENT	FEC
ISOLATION PANEL	IP
KEYING	KP
MEDICAL GAS ALARM PANEL	MGAP
MEDICAL GAS OUTLET	MGO
MEDICAL GAS ZONE VALVE	MGZV
MOTION DETECTOR	MD
PATIENT CURBSIDE	PCON
RE-NOTE RELEASE BUTTON	RB
PUSH BUTTON FOR AUTOMATIC DOOR	PB
RETRACTABLE DRESSING BENCH	BENCH
OWNER FURNISHED EQUIPMENT (DASHED LINES)	
SEE "GENERAL NOTES" ON SHEET A201A1	N1
SEE "NEW CONSTRUCTION KEYNOTES" ON THIS SHEET	751
DOOR DESIGNATION (SEE SHEET A601 AND PROJECT MANUAL FOR DOOR FRAME AND HARDWARE SCHEDULE)	
EXTERIOR WINDOW DESIGNATION (SEE SHEET A601 FOR EXTERIOR WINDOW SCHEDULE)	
INTERIOR WINDOW DESIGNATION (SEE SHEET A601 FOR INTERIOR WINDOW SCHEDULE)	
TOILET ACCESSORY SET (SEE SHEET A500 FOR TOILET ACCESSORY SCHEDULE)	
WALL DESIGNATION (SEE SHEET G002 FOR TYPES OF WALLS/ PARTITIONS/ BARRIERS)	A60

COMPLY WITH ALL REQUIREMENTS INCLUDED IN THE "GENERAL NOTES FOR NEW CONSTRUCTION FLOOR PLANS" ON SHEET A201A1



1 LEVEL 1 PART B - NEW CONSTRUCTION PLAN

Attachment 9

Gresham Smith

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Encompass Health

THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC.

Revision

No.	Date	Description

LEVEL 1 PART B - NEW CONSTRUCTION PLAN

A201B1

PROJECT 43645.00
DATE 03/01/2019

LEGEND

BEE PROJECT INFORMATION SHEET G011 FOR COMPONENTS OF WALL SEPARATIONS/ BARRIER S

COMPLY WITH ALL REQUIREMENTS INCLUDED IN THE "GENERAL NOTES FOR NEW CONSTRUCTION FLOOR PLANS" ON SHEET A201A1

1 LEVEL 1 PART C - NEW CONSTRUCTION PLAN

Attachment 9

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THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC.

Revision

No.	Date	Description

LEVEL 1 PART C - NEW CONSTRUCTION PLAN

A201C1

PROJECT: 43645.00
DATE: 03/01/2019

Background of the Applicant
The Rehabilitation Institute of Southern Illinois, LLC

The following information is provided to illustrate the qualifications, background and character of the ultimate parent entities of the Applicant/Licensee and to assure the Review Board that the rehab hospital will provide a proper standard of health care service for the community.

The Rehabilitation Institute of Southern Illinois, LLC, ("RISI")

1. RISI, the Licensee, will be a 50-50 joint venture between BJC HealthCare ("BJC") through its subsidiary Metro East Services, Inc. and Encompass Health Corporation ("Encompass"). BJC is a Missouri nonprofit corporation. Two wholly-owned subsidiaries of BJC HealthCare, Memorial Regional Health Services, Inc. and Metro-East Services, Inc. have been identified as Co-Applicants for the proposed project. Encompass is a Delaware corporation. RISI is also a Delaware corporation.

2. RISI does not own nor operate any healthcare facilities, thus can certify that there have been no adverse actions during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at Attachment 11.

3. We have included a letter authorizing access to the HFSRB and IDPH to verify information about RISI at Attachment 11.

BJC HealthCare

1. BJC HealthCare is a nonprofit health care organization with 15 hospitals, five service organizations and hundreds of outreach services for residents in the greater St. Louis, southern Illinois and mid-Missouri areas. BJC is the largest provider of charity care, unreimbursed care and community benefit in Missouri, providing $904 million in free or reduced medical care, education of health professionals, medical research funding and community outreach programs. Many of its programs and services benefit the residents of Southern Illinois who travel to St. Louis for health care services provided by BJC and its affiliates.

BJC hospitals range in size from 35 beds at Missouri Baptist Sullivan Hospital to more than 1,200 beds at Barnes-Jewish Hospital. All of BJC hospitals are accredited.

BJC operates three licensed health care facilities in Illinois:

- Memorial Hospital Belleville, IDPH License #0001461. (We need copies of the licenses for these entities to include in the application)
- Memorial Hospital East, IDPH License #0006049.
- Alton Memorial Hospital, IDPH License #0000026.

In addition, BJC operates Memorial Care Center, an 82-bed skilled nursing facility in Belleville.

2. There have been no adverse action taken against any facility owned or operated by BJC during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at Attachment 11.

3. We have included a letter authorizing access to the HFSRB and IDPH to verify information about BJC Healthcare at Attachment 11.

Encompass Health

1. ***Encompass Health*** owns and operates a single facility in Illinois through a joint venture arrangement with Mercyhealth:

- Van Matre Encompass Health Rehabilitation Hospital in Rockford. (We need to include a copy of the IDPH license)

Encompass Health (f/k/a HealthSouth Rehabilitation Corporation) is a national leader in inpatient rehabilitation services with 130 inpatient rehab hospitals in 32 states and Puerto Rico, representing over 20% of the licensed acute rehabilitation beds nationally. One hundred and fourteen (114) of Encompass' inpatient rehab hospitals hold one or more disease-specific certifications from The Joint Commission's Disease-Specific Care Certification Program in areas such as stroke, brain injury, or hip fracture rehabilitation.

Encompass brings to the local market the resources and experience of a national company that has proven high quality, cost-effective programs and services along with the financial strength to ensure that its patients and specialized staff members have access to an extensive array of rehab-specific clinical equipment and technology.

The Rehabilitation Institute of Southern Illinois brings to the local market the strength of two parent organizations so that HSA11 patients and families can be assured the new hospital will have the combined resources and experience of a national company specializing in rehabilitation services and a regional non-profit health system with a proven track record of caring for all patients in need. The two parent entities have proven high quality, cost-effective programs and services along with the financial strength to ensure that The Rehab Institute's patients and specialized staff members have access to an extensive array of rehab-specific clinical equipment and technology to ensure high quality, cost-effective care is provided to patients.

2. There have been no adverse action taken against any facility owned or operated by Encompass during the three (3) years prior to the filing of this Application. A letter certifying the above information is attached at Attachment 11.

3. We have included a letter authorizing access to the HFSRB and IDPH to verify information about Encompass Health at Attachment 11.

May 6, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

As representative of The Rehabilitation Institute of Southern Illinois, LLC, I, Walter Smith, give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) to access 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, and the records of nationally recognized accreditation organizations.

I further verify that, The Rehabilitation Institute of Southern Illinois, LLC owns no other healthcare facilities and has had no adverse action in the past three (3) years.

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Walter Smith
Director, State Regulatory Affairs
Encompass Health Corporation
Authorized Representative

Subscribed and Sworn to before this 6th day of May, 2019.

Notary Public

LISA CORNETT GOLDEN
MY COMMISSION EXPIRES
OCTOBER 31, 2022
NOTARY PUBLIC
STATE OF ALABAMA

Attachment 11

Encompass Health

9001 Liberty Parkway
Birmingham, AL 35242

encompasshealth.com

May 6, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

As representative of Encompass Health, I, Walter Smith, give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) to access 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, and the records of nationally recognized accreditation organizations.

I further verify that, Encompass Health is a part of joint venture arrangement and has an ownership interest in Van Matre Encompass Health Rehabilitation Hospital and has had no adverse action in the past three (3) years.

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Walter Smith
Director, State Regulatory Affairs
Encompass Health Corporation

Subscribed and Sworn to before me this 6th day of May, 2019.

Notary Public

LISA CORNETT GOLDEN
MY COMMISSION EXPIRES
OCTOBER 31, 2022
NOTARY PUBLIC
STATE OF ALABAMA

Attachment 11

BJC HealthCare

May 14, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

As representative of BJC HealthCare, I, Gregory K. Bratcher, give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) to access 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, and the records of nationally recognized accreditation organizations for the following Illinois hospitals:

- Alton Memorial Hospital
- Memorial Hospital of Belleville
- Memorial Hospital East in Shiloh

I further verify that, BJC HealthCare owns Memorial Hospital of Belleville, Memorial Hospital East, and Alton Memorial Hospital. No facility owned by BJC HealthCare has had an adverse action in the past three years.

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Respectfully,

Gregory K. Bratcher
Director

Sworn and subscribed to before me this 14th day of May, 2019

Daphne L. Wilcut
Signature of Notary

NOTARY PUBLIC NOTARY SEAL STATE OF MISSOURI

DAPHNE L. WILCUT
My Commission Expires
February 21, 2023
St. Louis City
Commission #15146250

Attachment 11

HF117219

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Nirav D. Shah, M.D.,J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
10/26/2019		0005215

Rehabilitation Hospital

Effective: 10/27/2018

Van Matre Encompass Health Rehabilitation Hospital LLC
dba Van Matre Encompass Health Rehabilitation Hospital
950 S Mulford Road

Rockford, IL 61108

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #48240 5M 5/16

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

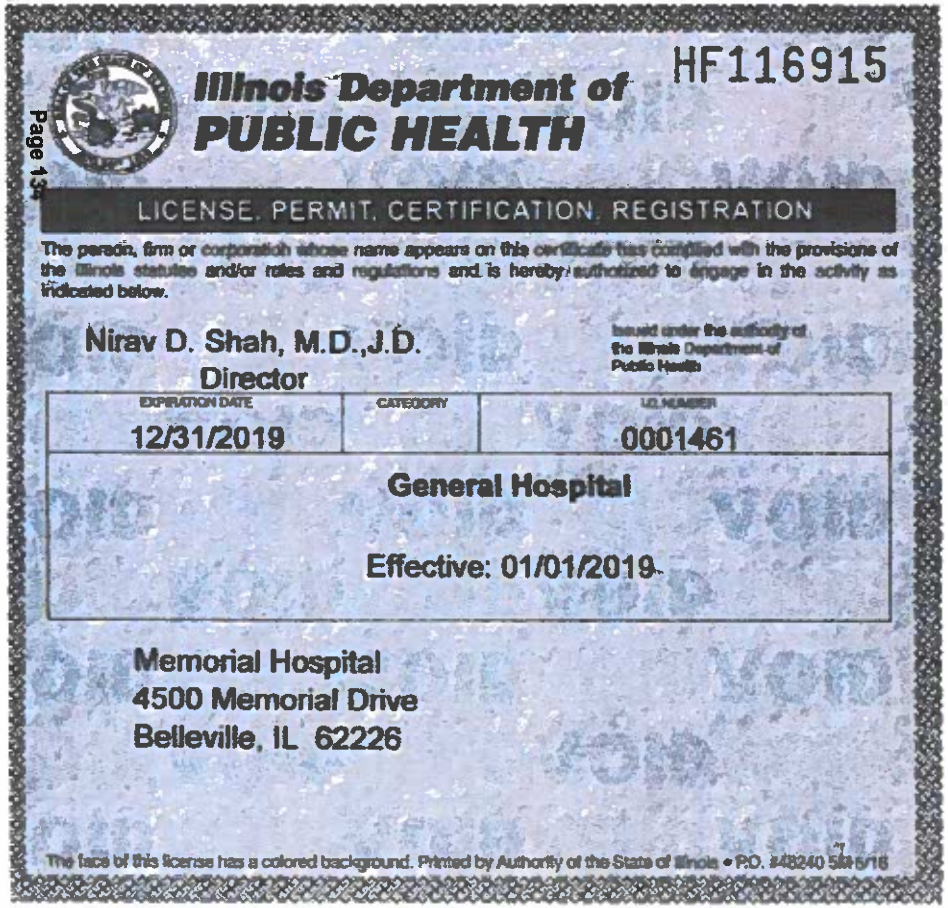
Exp. Date 10/26/2019

Lic Number 0005215

Date Printed 12/19/2018

Van Matre Encompass Health Rehabili
dba Van Matre Encompass Health Re
950 S Mulford Road
Rockford, IL 61108

FEE RECEIPT NO.



Illinois Department of PUBLIC HEALTH

HF116915

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Nirav D. Shah, M.D.,J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	LIC NUMBER
12/31/2019		0001461

General Hospital

Effective: 01/01/2019

Memorial Hospital
4500 Memorial Drive
Belleville, IL 62226

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Exp. Date 12/31/2019

Lic Number 0001461

Date Printed 11/14/2018

Memorial Hospital

4500 Memorial Drive
Belleville, IL 62226

FEE RECEIPT NO.

Attachment 11

Illinois Department of PUBLIC HEALTH

HF 117776

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

Ngozi O. Ezike, M.D.
Director

Expiration Date	Category	Location
4/11/2020		0006049

General Hospital

Effective: 04/12/2019

Metro-East Services Inc
dba Memorial Hospital East
1404 Cross Street

Shiloh, IL 62269

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp Date 4/11/2020

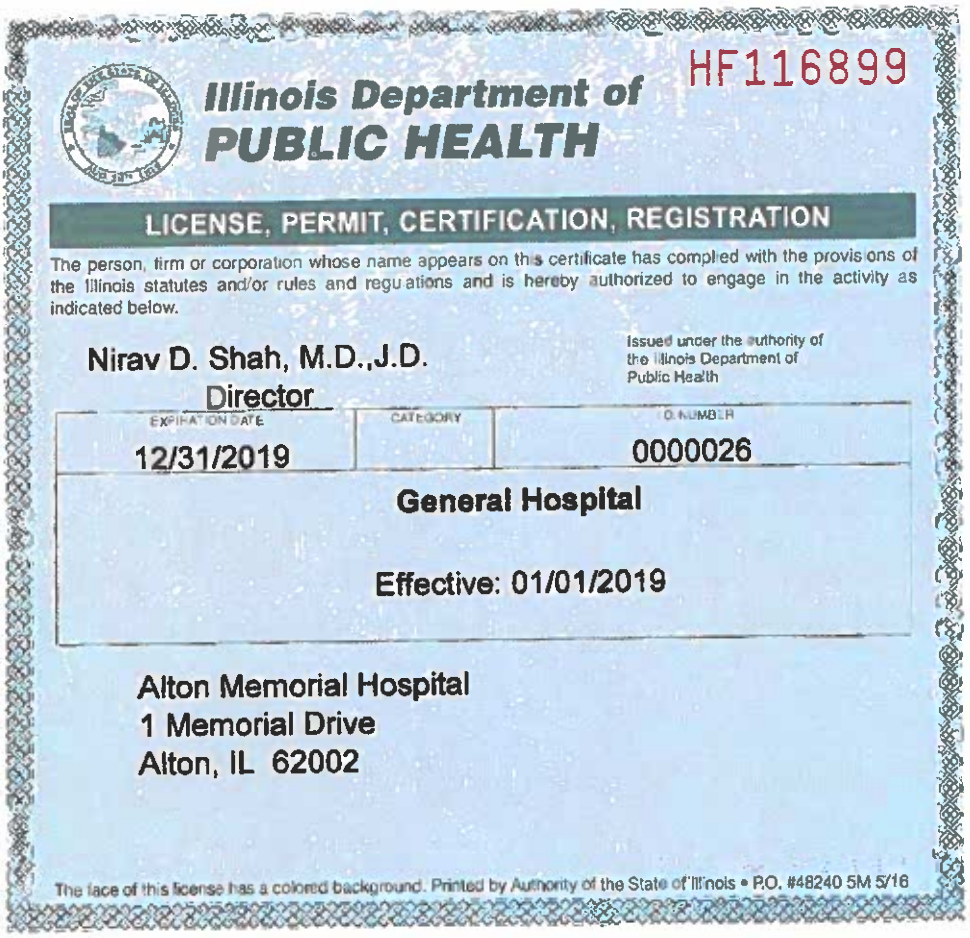
Lic Number 0006049

Date Printed 3/12/2019

Metro-East Services Inc
dba Memorial Hospital East
1404 Cross Street
Shiloh, IL 62269

FEE RECEIPT NO

Attachment 11



Illinois Department of
PUBLIC HEALTH

HF116899

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Nirav D. Shah, M.D.,J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	D NUMBER
12/31/2019		0000026

General Hospital

Effective: 01/01/2019

Alton Memorial Hospital
1 Memorial Drive
Alton, IL 62002

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← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/31/2019

Lic Number 0000026

Date Printed 11/14/2018

Alton Memorial Hospital

1 Memorial Drive
Alton, IL 62002

FEE RECEIPT NO.

Attachment 11

The Joint Commission

March 14, 2017

Re: # 352409
CCN: #143028
Program: Hospital
Accreditation Expiration Date: January 07, 2020

Kenneth Bowman
Chief Executive Officer
Van Matre Rehabilitation Center, LLC
950 South Mulford Road
Rockford, Illinois 61108

Dear Mr. Bowman:

This letter confirms that your January 05, 2017 - January 06, 2017 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on March 13, 2017, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of January 07, 2017.

The Joint Commission is also recommending your organization for continued Medicare certification effective January 07, 2017. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location:

Van Matre Rehabilitation Center, LLC
d/b/a Van Matre HealthSouth Rehabilitation Hospital
950 South Mulford Road, Rockford, IL, 61108

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

The Joint Commission

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 5 /Survey and Certification Staff

The Joint Commission

May 6, 2019

Jeffrey Reese, MBA
CEO
Van Matre Rehabilitation Center, LLC
950 South Mulford Road
Rockford , IL 61108

Joint Commission ID #: 352409
Program: Brain Injury Rehabilitation
Certification Activity: 60-day Evidence of Standards Compliance
Certification Activity Completed Date : 5/6/2019

Dear Mr. Reese:

The Joint Commission is pleased to grant your organization a Passed Certification decision for all services reviewed under the applicable manual(s) noted below:

- **Disease Specific Care Certification Manual**

This certification cycle is effective beginning February 27, 2019 and is customarily valid for up to 24 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your certification decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your certification decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

Attachment 11

AMERICAN OSTEOPATHIC ASSOCIATION

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM

142 E. Ontario Street, Chicago, IL 60611-2864 ph 312 202 8258 | 800- 621 -1773 X 8258

July 20, 2016

Mark Turner
Chief Executive Officer
Memorial Hospital
4500 Memorial Dr
Belleville, IL 62226

Dear Mr. Turner:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation (BHFA) reviewed the triennial Deficiency Assessment Report for your Acute Care Hospital and granted Full Accreditation with resurvey within 3 years and does recommend that the Centers for Medicare and Medicaid Services Regional Office (CMS, RO) approve continued deemed status for:

Memorial Hospital
4500 Memorial Dr
Belleville, IL 62226

Memorial Physical Therapy & Sports Rehab - O'Fallon
800 East Highway 50
O'Fallon, IL 62269

Memorial Healthcare Diagnostics
310 North Seven Hills Road
O'Fallon, IL 62269

Memorial Physical Therapy & Sports Rehab - East Belleville
1634 Carlyle Ave.
Belleville, IL 62221

Memorial Hand and Shoulder Therapy Center
4700 Memorial Drive, Suite 330
Belleville, IL 62226

Memorial Pain Center
4700 Memorial Drive, Suite 230
Belleville, IL 62226

Memorial Physical Rehabilitation Services
4700 Memorial Drive, Suite 150
Belleville, IL 62226

Memorial Radiology Testing CT/MRI
4700 Memorial Drive, Suite 100

Program: Acute Care Hospital
CCN # 140185
HFAP ID: 156825
Triennial Survey Dates: 03/14/2016 – 03/17/2016
Focused Resurvey Dates: 05/23/2016 – 05/23/2016
Plan(s) of Correction Received: 05/03/2016
Effective Date of Accreditation: 05/27/2016 – 05/27/2019

Attachment 11

Belleville, IL 62226

Sleep Disorders Center
310 North Seven Hills Road
O'Fallon, IL 62269

Memorial Transitional Care Clinic
4500 Memorial Drive, Suite 100
Belleville, IL 62226

Memorial Senior Care
4500 Memorial Drive
Belleville, IL 62226

Wound Clinic (Memorial Hospital)
4600 Memorial Drive
Belleville, IL 62226

Condition Level Deficiencies: ☐ None
(Use crosswalk and CFR citiations, if applicable):
482.41

Any Condition Level Deficiency that was cited during the triennial survey was found to be in compliance at the focused resurvey.

Memorial Hospital does not have Swing Beds, a DPU Rehab Unit or a DPU Psych Unit and was not surveyed under those standards.

This accreditation decision was reached on July 13, 2016 by the BHFA's Executive Committee.

Sincerely,

Lawrence U. Haspel

Lawrence U. Haspel, D.O.
Chairman, Bureau of Healthcare Facilities Accreditation
The Healthcare Facilities Accreditation Program
LUH/CDC

c: Sherri Morgan-Johnson, RN, BSN, MHSA, Nurse Consultant
Region V, CMS

Attachment 11

AMERICAN OSTEOPATHIC ASSOCIATION

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM

142 E. Ontario Street, Chicago, IL 60611-2864 ph 312 202 8258 | 800- 621 -1773 X 8258

May 27, 2016

Mark Turner
Chief Executive Officer
Memorial Hospital East
1404 Cross Street
Shiloh, IL 62269

Dear Mr. Turner:

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation (BHFA) reviewed the initial Deficiency Assessment Report for your Acute Care Hospital and granted Full Accreditation with resurvey within 3 years and does recommend that the Centers for Medicare and Medicaid Services Regional Office (CMS, RO) approve deemed status for:

Memorial Hospital East
1404 Cross Street
Shiloh, IL 62269

Program: Acute Care Hospital
CCN # Pending
HFAP ID: 378735
Initial Survey Dates: 05/09/2016 – 05/11/2016
Plan(s) of Correction Received: 05/16/2016
Effective Date of Accreditation: 05/16/2016 – 05/16/2019

Condition Level Deficiencies: ☒ None
(Use crosswalk and CFR citiations, if applicable):

Memorial Hospital East does not have Swing Beds, a DPU Rehab Unit or a DPU Psych Unit and was not surveyed under those standards.

This accreditation decision was reached on May 26, 2016 by the BHFA's Executive Committee.

Since you are seeking initial accreditation, the CMS Regional Office will be reviewing the survey findings as part of the Medicare certification process. Once all CMS requirements have been met, the CCN (CMS Certification Number) will be issued by the Regional Office.

Sincerely,

Stephen A. Martin, Jr., PhD, MPH
AAHHS/HFAP President and CEO

SAM/CDC
c: Sherri Morgan-Johnson, RN, BSN, MHSA, Nurse Consultant
Region V, CMS

Attachment 11

Alton Memorial Hospital

Alton, IL

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

June 4, 2016

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #4286
Print/Reprint Date: 08/10/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Attachment 11

Purpose of the Project
The Rehabilitation Institute of Southern Illinois, LLC

Executive Summary

Too much of Illinois' healthcare delivery system operates without sufficient access to the comprehensive post-acute care rehabilitation services that can be provided in a hospital dedicated to providing comprehensive physical rehabilitation. This is best illustrated by Illinois' residents that are ***leaving Illinois to obtain this care*** in St. Louis, Missouri.

A fundamental aspect of the CON program is to ensure sufficient access to care so that Illinois residents need not travel too far to access necessary care, and certainly not have to leave the State of Illinois. This project is designed to address that.

BJC and Encompass, the same two world-class providers from which Illinois' residents are traveling to St. Louis to obtain care, are proposing to establish a 40-bed hospital dedicated to comprehensive inpatient rehab care in Illinois. This project is needed.

- It addresses the Board's projected need for 7 Rehab beds, but looks beyond that;
- The projected need for 7 beds is rooted in the historical utilization in Illinois. Considering the patients ***leaving Illinois*** to obtain these services, the need increases to 29 beds;
- Once you consider the national standards at which this service ***should be available***, the justifiable need is 46 beds.

This project is designed to meet the rehabilitation needs of this community both for today, and for tomorrow. More importantly, it is designed to allow Illinois residents to receive world-class care in Illinois.

The detailed explanation of need is fully outlined below.

Purpose of the Project
The Rehabilitation Institute of Southern Illinois, LLC

1. The Rehab Institute will provide services to improve the health care of HSA11 residents.

A) <u>The Proposed Project will meet the Documented Need for Additional Rehab Beds</u>.

There is a documented need for seven (7) additional comprehensive physical rehabilitation beds in HSA11, according to the most recent Revised Bed Need Determinations as shown below.

Table 1
HFSRB Rehab Bed Need

STATE SUMMARY
REVISED BED NEED DETERMINATIONS
3/11/2019

REHABILITATION BEDS

REHAB SERVICE AREA	APPROVED EXISTING BEDS	CALCULATED BED NEED	ADDITIONAL BEDS NEEDED	EXCESS REHAB BEDS
HSA 1	65	65	0	0
HSA 2	66	49	0	17
HSA 3	48	34	0	14
HSA 4	80	53	0	27
HSA 5	39	36	0	3
HSA 6	588	419	0	169
HSA 7	442	372	0	70
HSA 8	80	100	20	0
HSA 9	96	98	2	0
HSA 10	22	12	0	10
HSA 11	36	43	7	0
ILLINOIS TOTAL	1,562	1,281	29	310

Source: HFSRB, Department of Public Health.

This defined numeric need is the result of the reduced number of available Rehab beds in HSA11 at the same time the service area population is increasing (and aging), resulting in high aggregate utilization of the two existing Rehab providers in the HSA11. Details supporting the HFSRB calculated need for 43 Rehab beds in the HSA11 service area are shown below.

Table 2 **HSA11 Comprehensive Physical Rehabilitation Providers' Utilization Drives Bed Need Calculations**		
HSA11 Rehab Providers	**Hospital County**	**2015 Patient Days**
Anderson Hospital	Madison	4,428
Gateway Regional Medical Center	Madison	1,194
OSF Saint Anthony's Health Center	Madison	3,389
St. Elizabeth's Hospital (Belleville)	St. Clair	4,130
St. Elizabeth's Hospital - O'Fallon	St. Clair	-0-
Total HSA11 Hospitals' Rehab Patient Days		**13,141**
2015 Area Rehab Use Rate		.0219
Multiplied by Projected 2020 Area Total Population		614,100
***Equals* Projected Rehab Patient Days in HSA11 Hospitals**		**13,466**
Average Daily Census		36.8
Projected Gross Rehab Bed Need		**43**
Sources: Inventory of Health Care Facilities and Services and Need Determinations, HFSRB 9/1/2017.		

The current gap results in less than optimal care for many service area (HSA11) patients, who are either discharged to a less intensive setting such as skilled nursing facility ("SNF") or home with home health care services, rather than the more appropriate inpatient rehab setting; are foregoing needed rehab care altogether; or, are having to travel out-of-state for Rehab services. The proposed 40-bed new freestanding Rehab facility will address the current gap in care and meet the HFSRB-identified need.

As shown below, HSA11 Rehab beds have decreased dramatically since 2017, with a loss of 60 licensed beds in Southern Illinois. The result is an unacceptably low number of Rehab beds per population in HSA11 for all ages, and particularly for ages 65+ since that population is the primary user of inpatient rehabilitation services. The overall statewide beds per population is provided for comparison purposes, further supporting the HFSRB-defined need for additional beds in HSA11.

Table 3 HSA11 Comprehensive Physical Rehab Beds per 1,000 Person				
		Licensed Rehab Beds		
HSA11 Rehab Providers	**Hospital County**	**2017**	**2019**	**2024**
Anderson Hospital	Madison	20	20	20
Gateway Regional Medical Center	Madison	14	-0-	-0-
OSF Saint Anthony's Health Center	Madison	28	-0-	-0-
St. Elizabeth's Hospital (Belleville)	St. Clair	34	-0-	-0-
St. Elizabeth's Hospital - O'Fallon	St. Clair	-0-	16	16
Total Licensed HSA11 Rehab Beds		**96**	**36**	**36**
Service Area (HSA11) Total Population (July estimate)		612,310	613,457	616,255
Rehab Beds/1,000 Population		**0.157**	**0.059**	**0.058**
Service Area (HSA11) Population Ages 65+		95,374	100,581	115,776
Rehab Beds/1,000 Population Ages 65+		**1.007**	**0.358**	**0.311**
Illinois Rehab Beds/1,000 Population Ages 65+ (2019 data)		0.856	0.753	0.651
Ratio of Illinois Beds/1,000 Pop Ages 65+ to HSA11		0.9	2.1	2.1
Sources: Inventory of Health Care Facilities and Services and Need Determinations, HFSRB 9/1/2017 and 3/11/2019 Update; MUR Report, 2018 Hospital Industry Data Institute; and Illinois Department of Public Health Certificate of Need Population Projections, 2014.				

Notably, without the proposed project to meet the need for additional beds in HSA11, the disparity between the statewide beds per person and HSA11 beds per person will increase as the HSA11 population ages.

Table 4 HSA11 Comprehensive Physical Rehab Beds per Person are Declining Despite an Increasing and Aging Population					
Indicator	**2017**	**2019**	**2024**	**Change, 2017-19**	**% Change, 2017-19**
Total Licensed HSA11 Rehab Beds	96	36	36	-60	**-62.5%**
Service Area (HSA11) Total Population	612,310	613,457	616,255	3,945	0.6%
Rehab Beds/1,000 Population	0.157	0.059	0.058	-0.10	-62.7%
Service Area (HSA11) Population Ages 65+	95,374	100,581	115,776	20,402	**21.4%**
Rehab Beds/1,000 Population Ages 65+	1.007	0.358	0.311	-0.70	-69.1%
Sources: Inventory of Health Care Facilities and Services and Need Determinations, HFSRB 9/1/2017 and MUR Report, 2018 Hospital Industry Data Institute.					

B) <u>The Proposed Project will Stem Out-migration to Missouri for Rehab Services</u>.

There are currently almost as many HSA11 patients traveling outside of HSA11 into Missouri for inpatient rehab services as there are remaining in Illinois for care. This project will solve that problem because a primary reason people are leaving Illinois is to seek care at the facility in St. Louis operated by BJC and Encompass. The relevance of this information is the impact on numeric bed need since the HFSRB bed need calculations are population and provider-based, with current utilization of the HSA11 hospitals driving the need for Rehab beds in the service area. Thus, patients who must currently travel across the river to Missouri for inpatient rehab services are not able to be quantified in the HFSRB calculations, which understates need for locally available and accessible services. This is a part of the reason we predict a need for Rehab services that exceeds the Board's projections, which are based on historical utilization. This project will provide Illinois residents access to the first-class care they seek within the borders of Illinois. Illinois residents should not have to leave the state to obtain this care.

Notably, the percentage of residents traveling outside HSA11 for Rehab services is large and increasing, likely due to the simultaneous decrease in beds. Thus, the impact of outmigration on HSA11 is material, driven by the service area's contiguous location to St. Louis, Missouri where numerous Rehab providers are located.

Table 5
HSA11 Residents' Discharges to Comprehensive Inpatient Rehab Services
An Increasing Proportion of HSA11 Residents are Leaving Illinois for Inpatient Rehab Care

HSA11 Residents' Rehab Discharges from General Acute Care Hospitals	**Rehab Discharges by Calendar Year**			
	2016	**2017**	**YTD2018**	**2018 Ann.**
Total, including Missouri	1,468	1,344	677	1,354
Minus Discharges to Illinois Hospital Rehab Bed	829	728	358	716
***Equals* HSA11 Rehab Discharges Leaving Illinois**	**639**	**616**	**319**	**638**
% HSA11 Residents Leaving Illinois for Care	43.5%	45.8%	47.1%	47.1%

Source: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database.
Notes: YTD18 is 6 months January 1 through June 30, 2018.

To put the number of patients out-migrating to Missouri for post-acute inpatient rehab care into perspective, The Rehab Institute projects to serve 662 patients in its first full year of operation, approximating the historical number of patients annually traveling out-of-state for care. The bed need for the historical outmigration <u>alone</u> is 29 beds (based on Illinois' Rehab average length of stay of 14.1 days), *without consideration* of patients who should be receiving Rehab services but are foregoing those services for a variety of reasons.

The following analysis attempts to quantify the number of HSA11 patients who should have received Rehab services but were unable to receive that optimal level of care, regardless of the reason.

Purpose of the Project
The Rehabilitation Institute of Southern Illinois, LLC

First, the number of relevant or rehab-appropriate discharges for HSA11 residents must be estimated. For the most recent 12 month period (July 2017-June 2018), HSA11 residents had a total 21,799 rehab-appropriate discharges from any hospital, regardless of hospital location (*i.e.*, includes Missouri hospitals and those outside of HSA11 in Illinois). As shown in the following table, less than 5 percent (4.7%) of the total general acute care hospital rehab-appropriate discharges were discharged to a Rehab while at the same time, 14.1% of those discharges were discharged to SNF.

For those residents choosing to travel to Missouri for general acute care services, they have a significantly greater likelihood of being discharged to a Rehab (8.0% of discharges) compared to the HSA11 patients who remain in an Illinois hospital for care, *i.e.*, only 2.2% discharged to Rehab. Thus, currently patients who travel to Missouri have greater access to Rehab services than those patients remaining in-state. The proposed 40-bed Rehab hospital will level the playing field, ensuring that residents can receive appropriate post-acute care services without having to leave the state.

Table 6
The Majority of HSA11 Residents who Receive Rehab Services Must Travel to Missouri for Care:
HSA11 Residents' Inpatient Discharges for Rehab-Appropriate MS-DRGs by Hospital of Discharge in Illinois and Contiguous States, July 2017 – June 2018

	Rehab-Appropriate General Acute Care Discharges			Hospital-Specific Discharge Rates	
Hospital	**Total**	**to SNF**	**to Rehab**	**% to SNF**	**% to Rehab**
Alton Memorial Hospital	1,510	278	33	18.4%	2.2%
Anderson Hospital	2,043	321	99	15.7%	4.8%
Gateway Regional Medical Center	955	137	2	14.3%	0.2%
HSHS ST Elizabeth's Hospital - O'Fallon	2,256	296	107	13.1%	4.7%
Memorial Hospital - Belleville	3,472	675	21	19.4%	0.6%
Memorial Hospital East	750	92	5	12.3%	0.7%
Missouri Hospitals (Aggregate)	**9,216**	**979**	**736**	**10.6%**	**8.0%**
OSF Saint Anthony's Health Ctr - Alton	693	165	8	23.8%	1.2%
Touchette Regional Hospital	198	18	0	9.1%	0.0%
All Other Hospitals	706	114	8	16.1%	1.1%
Total	**21,799**	**3,075**	**1,019**	**14.1%**	**4.7%**
Missouri Hospitals as a % of Discharges	42.3%	31.8%	72.2%	--	--
Illinois Hospitals Only (excl. Missouri)	**12,583**	**2,096**	**283**	**16.7%**	**2.2%**

Source: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database.
Note: Rehab-appropriate discharges are select MS-DRGs across services lines and excluding all newborns, obstetrics, psychiatric, and substance abuse patients.

Because only 2.2% of patients in an Illinois hospital are discharged to Rehab services, the vast majority (72.2%) of HSA11 residents who are able to obtain Rehab services are those who are willing and able to travel out-of-state.

Next, the expected percentage of rehab-appropriate general acute care hospital discharges who would benefit from inpatient rehab services is applied to the total rehab-appropriate discharges for HSA11 residents, regardless of where those residents received general acute care inpatient services. The following analyses shows that there are significantly more HSA11 residents who need, and thus would benefit from, Rehab services than currently receiving them. Thus, as documented, there is a projected net need for an **additional 42 Rehab beds** to be located in and serve the residents in HSA11. Calculations follow.

Table 7
Projected Rehab Bed Need Based on Current HSA11 Discharges (July 2017-June 2018) from All Hospitals, including Missouri Hospitals

Calculations	**Current Need**
General Acute Care Hospital Discharges Appropriate for Inpatient Rehab Care	21,799
Multiplied by Actual Rehab Discharge Rate for HSA11 Patients Traveling to Missouri	8%
Equals Estimated Total HSA11 Discharges in Need of Rehab Bed	1,744
Minus Current Total HSA11 Discharges to Rehab, including Out-of-State	1,019
Equals Incremental HSA11 Discharges in Need of Rehab Care	725
Plus Redirected Rehab Discharges from Southern IL Counties, exclusive of HSA11*	157
Equals Total Projected Rehab Discharges	882
Multiplied by CY17 Illinois Statewide Rehab Average Length of Stay	14.1
Equals Projected Rehab Patient Days in Need	12,439
Divided by Calendar Days	365
Equals Incremental Bed Need @ 100% Occupancy	35
Divided by Target Occupancy Factor	0.85
***Equals* Incremental Bed Need @ 85% Target Occupancy**	**42**

Sources: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database; and Encompass Health.
*Note: This is based on the current proportion of patients (22%) from Southern Illinois counties to HSA11 residents who are currently traveling to The Rehabilitation Institute of St. Louis (Missouri) for care.

The proposed project meets the community need for additional Rehab beds to be located in and serve HSA11 patients, as demonstrated above. The analysis is based on the following assumptions:

- Rehab-appropriate discharges exclude obstetrical, neonatal, psychiatric, and substance abuse patients.
- The actual current 8% Rehab discharge rate for HSA11 patients discharged from general acute care hospitals in Missouri.

Purpose of the Project
The Rehabilitation Institute of Southern Illinois, LLC

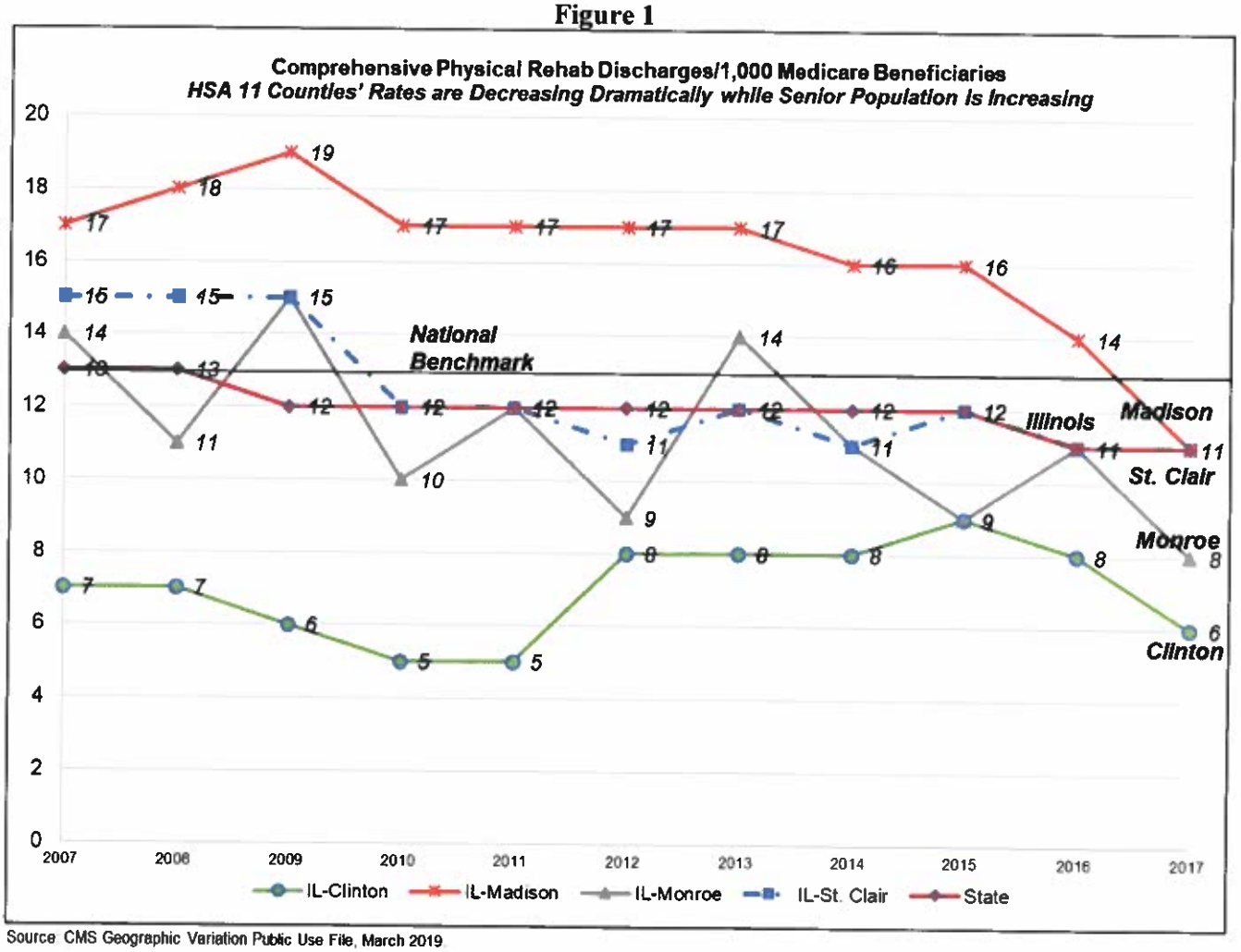
- The vast majority of discharges (approximately 82%) driving the need for the new facility are from the HSA11 service area, with approximately 18% from surrounding southern IL counties.
- Some redirection of patients from southern Illinois counties (outside the HSA11 counties) who currently travel to St. Louis for Rehab care is expected.
- The bed need is based on current discharges, thus conservatively excludes expected growth in rehab-appropriate discharges due to the aging of patient population.

CMS Inpatient Rehab Use Rates Applied to HSA11 Population

Another way to quantify the bed need for the residents in HSA11 when all patients are considered, including those who travel out-of-state for care, is to apply national Centers for Medicare and Medicaid Services ("CMS") data to the service area population. That analysis follows.

The following graph documents that the limited availability of Rehab beds for residents in HSA11 has adversely impacted residents' access to Rehab services for many years.

Figure 1



Source: CMS Geographic Variation Public Use File, March 2019

Attachment 12
Page 8

Notably, Madison County residents had greater access to Rehab services than residents in the other HSA11 counties; however, as beds were decommissioned there, Madison County residents' access declined to levels similar to other counties. Madison County's level currently matches that of St. Clair, which is notable since those are the two most populated counties in the service area, and rank in the Top 10 statewide in terms of total population. Clinton County residents have consistently had lower Rehab discharges than the other service area counties and the nation for 11 years.

Absent the addition of beds, HSA11 residents will continue to either forego needed Rehab services altogether or, alternatively, travel outside the state for care, neither of which are viable options for patients in a community with an increasing population ages 65+.

In order to estimate the number of additional beds needed in HSA11 for the Planning Year Horizon (2024), the following methodology and assumptions were used:

- National actual Rehab Medicare utilization (13 discharges per 1,000 Medicare beneficiaries, which is the 75th percentile nationally) was the baseline or target discharge rate used to project HSA11 Medicare FFS Rehab admissions.

- Total admissions (all payors) were projected by applying the statewide distribution of patients (*i.e.*, Medicare FFS as a percent of total admissions) to HSA11 Medicare FFS Rehab admissions.

- Actual statewide average length of stay ("ALOS") for Rehab patients (all payors) was used to project HSA11 Rehab days.

- Inventory of existing Rehab beds based on HFSRB reported 36 beds, which reflects the most recent bed closures.

As shown below, based on the national Medicare Rehab use rates, there is a projected net need for an **additional 46 Rehab beds in 2024** to meet the needs of the residents in HSA11 at that time. Calculations follow.

Table 8 **HSA11 Projected Rehab Bed Need in Planning Year Horizon (2024)** **Based on National CMS 75th Percentile Discharge Rate**	
Calculations for HSA11 Bed Need	**2024 Projections**
Projected HSA11 Medicare Beneficiaries, 2024	123,076
Multiplied by HSA11 CY17 Percent of Medicare FFS Beneficiaries	65.0%
Equals Total Projected Medicare FFS Beneficiaries, HSA11	79,999
Multiplied by National CY17 Rehab Admit Rate per FFS Beneficiaries	13
Equals Projected HSA11 Rehab Admits – Medicare FFS	1,040
Divided by Statewide % Rehab YTD18 Admits that are Medicare FFS	57.8%
Equals Projected HSA11 Rehab Admits – All Payers, 2024	1,800
Multiplied by Current (CY17) Illinois Rehab Patient Length of Stay	14.1
Equals Projected 2024 Rehab Days, HSA11	25,380
Total HSA11 Rehab Beds Needed at 100% Occupancy	70
Target Rehab *Occupancy Rate*	85.0%
Projected Gross Need for HSA11 Rehab Beds	82
Minus Existing Rehab Beds in HSA11	36
***Equals* Projected Net Rehab Bed Need, HSA11**	**46**
Sources: CMS Geographic Variation Public Use Files; Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database; Inventory of Health Care Facilities and Services and Need Determinations, HFSRB 9/1/2017; and, Illinois Department of Public Health Certificate of Need Population Projections, 2014.	

In summary, regardless of the methodology utilized, there is a need for at least 40 additional beds to be located in and serve the residents of HSA11. The additional beds will ensure that residents have available and accessible options for Rehab inpatient care without the need to travel out-of-state, forego services altogether, or utilize less intensive services in lieu of Rehab, when needed.

C) <u>The Proposed Project will Provide High Quality, Cost-Effective Care</u>.

It is important for patients and families to have a choice of Rehab providers close to home. As noted previously, the ability of the patient's family to actively participate in the patient's care plan and provide support to the patient ultimately enhances quality of care for patients. For elderly family members particularly, the ability to participate in the care without having to travel across the river on a daily basis means more participation and involvement in the patient's care.

Purpose of the Project
The Rehabilitation Institute of Southern Illinois, LLC

The mere addition of beds is not sufficient, however, to ensure that the proposed project will provide health services that improve the health care of the service area population. It is proven programs, services, staff, and facility design that are integral to the delivery of high quality care. BJC and Encompass have proven programs and services in place in Missouri that are illustrative of the high quality, cost-effective care that will be provided in the new 40-bed Rehab hospital in Shiloh.

The Rehabilitation Institute of St. Louis ("TRISL"), which is a joint venture of BJC and Encompass, is Joint Commission-accredited and has the following Disease-Specific Care Certifications from The Joint Commission:

- Stroke Rehabilitation
- Brain Injury Rehabilitation
- Amputee Rehabilitation
- Wound Care
- Spinal Cord Rehabilitation.

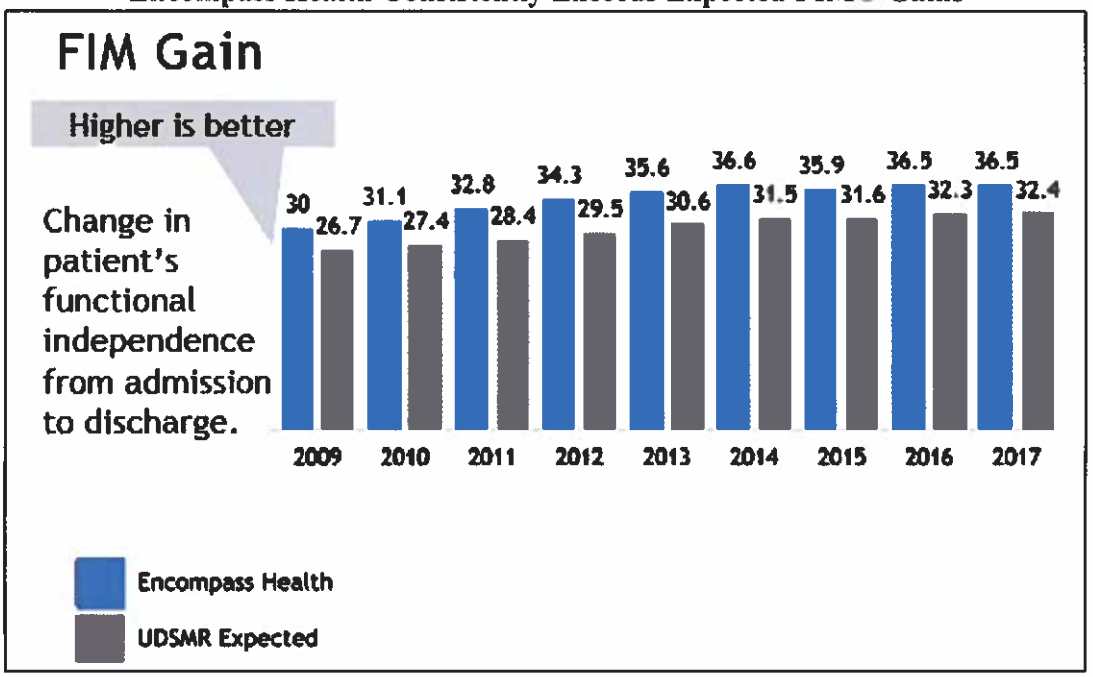
The high quality care at TRISL epitomizes the proven programs and services of Encompass, regardless of how quality is defined. For example and consistent with the Disease-Specific Care Certifications of TRISL, 114 of Encompass Health's inpatient rehab hospitals hold one or more disease-specific certifications from The Joint Commission's Disease-Specific Care Certification Program in areas such as stroke, brain injury, or hip fracture rehabilitation.

Encompass Health consistently exceeds expectations in terms of its hospitals' FIM® Gain scores, which measures a patient's gain in functional improvement from admission to discharge and indicates the degree of practical improvement toward the patient's rehab goals. The FIM® (functional independence measure) score is based on 18 cognitive and functional measures including walking, climbing stairs, transfers, bowel and bladder function, and dressing.

As indicated by the chart below, Encompass Health's FIM® Gain exceeded the UDSMR® expected FIM® Gain for each of the last nine years. [1]

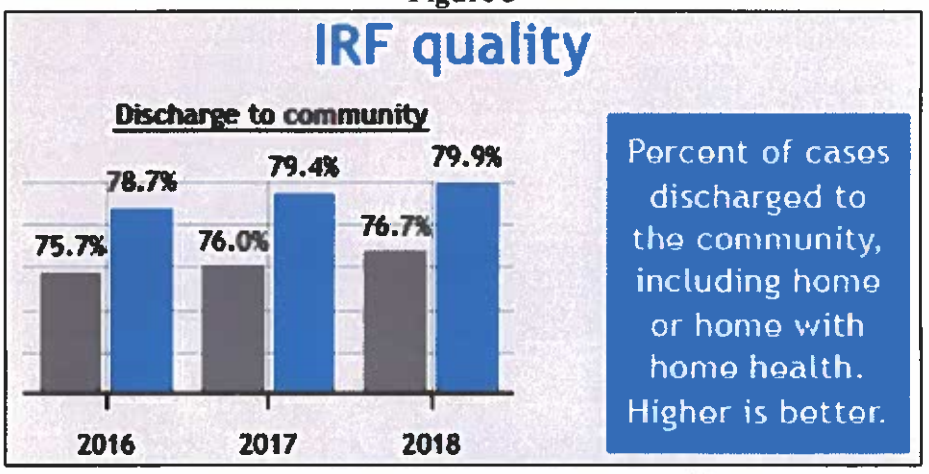
[1] This is the most recent data available for FIM scores because CMS is replacing the FIM functional assessment measures with the CARE Tool measures effective October 1, 2019.

Figure 2
Encompass Health Consistently Exceeds Expected FIM® Gains



Further evidence of Encompass Health's provision of quality care is the percentage of patients discharged to the community versus to a SNF or acute care hospital. As shown on the following page, Encompass has a proven track record of returning approximately 80% of its patients back to the community, outperforming other providers nationally. The Rehab Institute of Southern Illinois will utilize Encompass Health's proven programs to ensure high quality care is provided to its patients.

Figure 3



Source: Investor Reference Book, Post Q4 2018 Earnings Release Updated March 5, 2019, Encompass Health.

Finally, as shown below, Encompass hospitals across the nation continually engage in primary research to determine the best practices and protocols for a variety of diagnoses so that patients will always have the highest level of outcomes and quality care.

A listing of select current research at Encompass hospitals nationally follows.

- Western PA Patient Registry
- Audiology & Speech Language Registry
- Psych and Neuro of Spatial Cognition
- SDM-Stroke
- SDMM-Geriatric
- Incontinence Study
- Project Steady
- Speed and Distance
- Stroke Studies (several separate studies are underway at various facilities)
- Review of Stroke Patients that Return to Acute
- Stroke Rehabilitation Disparities
- C. Diff EIP
- Flexor Tendon Repair
- Fitness to Drive in Older Adults
- Home Modifications
- AO Spine
- Prolonging Safe Driving - Stroke
- Prism Adaptation Therapy
- Step-Hi
- Tele-rehab vs in-clinic therapy
- The Impact of Falls Prevention Education on Fall Rates
- Is The Ability To Detect A Foreign Accent Located In The Right Hemisphere?
- Bleeding in tracheotomy patients
- Dynamic Body-weight Support (DBWS) on Inpatient Rehabilitation
- Predicting D/C Destination in Hip Fractures
- IM Impact on Falls
- Acuity rating project
- MMJ Study
- Amputee Rehab Outcome Research

Thus, as documented here, the proposed new Rehab hospital will implement Encompass' proven programs and services to improve the health care of the market area population to be served. (Details on how the project will improve the population's health status and well-being are provided below in response to #5.)

D) <u>The Proposed Project will Complement Existing Rehab Services Offered in HSA11</u>.

Currently, HSA11 is served by two Rehab providers: Anderson Hospital and St. Elizabeth's Hospital – O'Fallon ("St. Elizabeth's"). Both programs offer services in a unit within their respective general acute care hospital. Thus, the proposed Rehab Institute will be the only standalone, freestanding rehab-only hospital in HSA11. Moreover, as stated previously, the proposed new hospital will include all private rooms.

The advantages of the proposed freestanding rehab-only hospital compared to the existing HSA11 in-hospital units are many, including for example:

- The ability of The Rehab Institute to focus solely on the needs of rehab patients and bring national programs and services (including for example, electronic medical records) specifically designed for rehab patients to the local market, whereas existing general acute care hospitals simply cannot. Instead, general acute care hospitals must prioritize and distribute limited resources across many service lines and programs, with inpatient rehab units representing only a small portion of their portfolio of health care services.
- A facility design that makes clear some of the many advantages of a freestanding facility compared to typical in-hospital units, including significantly larger rehab therapy areas with more equipment and technology, an extensive outdoor therapy area, dedicated bariatric rehab rooms, dedicated isolation rooms, and a dedicated dialysis unit.
- The ability of a dedicated rehab hospital to recruit highly-specialized and specially-trained rehab-specific clinical staff members.

As documented below, the St. Elizabeth's – O'Fallon has high and increasing occupancy, currently operating above the target 85% occupancy level. Anderson Hospital consistently operates at a relatively low occupancy rate. Anderson Hospital's use of all semi-private rooms may be a factor in its consistently low occupancy.

Table 9
Existing Providers are Unwilling and/or Unable to Meet HSA11 Residents' Needs

Inpatient Rehab Providers	Licensed Rehab Beds	Rehab Occupancy	
		March 2018 – Feb 2019	Most Recent Quarter*
St. Elizabeth's Hospital – O'Fallon	16	79.1%	86.8%
Anderson Hospital	20	57.3%	57.5%

Source: MUR Report, 2018 Hospital Industry Data Institute.
*Note: most recent quarter is December 2018 – February 2019.

In addition to offering a limited number of beds at their respective facilities, the HSA11 Rehab providers appear to offer limited services as well, as indicated by the distribution of Medicare patients.

Purpose of the Project
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The following table shows the distribution of Rehab patients at St. Elizabeth's – O'Fallon and Anderson Hospital, documenting that the existing Rehab providers appear to each serve a limited array of patients compared to providers nationally. For example, nearly half (47.5%) of St. Elizabeth's Rehab discharges are for stroke or spinal cord patients while nearly half (46.0%) of Anderson Memorial Rehab discharges are stroke or hip or femur fracture patients. While it is laudable that the existing IRF providers are caring for stroke patients in addition to spinal cord and hip or femur facture patients, it appears that patients with other diagnoses are not able to access inpatient rehab services comparable to national levels.

Thus, while existing Rehab providers in HSA11 appear to be actively admitting stroke, spinal cord, or hip or femur fracture patients for intensive acute rehab, patients with other types of diagnoses who would also benefit from intensive inpatient rehab appear to be underserved, receiving less intensive, lower level of care (such as SNF) in lieu of IRF services.

Table 10
Comparison of Medical Conditions Treated by HSA11 Rehab Providers to National Averages for Medicare Patients (April 2017 - March 2018)

		The Rehabilitation Center Anderson Hospital		*HSHS St. Elizabeth Hospital -O'Fallon Rehabilitation Unit*	
Conditions	**National**	**Discharges**	**% of Total**	**Discharges**	**% of Total**
Stroke	**22.6%**	**90**	**31.1%**	**111**	**37.4%**
Nervous System Disorder (Excluding Stroke)	13.9%	19	6.6%	13	4.4%
Brain Disease or Condition (Non-Traumatic)	7.4%	17	5.9%	10	3.4%
Brain Injury (Traumatic)	4.6%	10	3.5%	13	4.4%
Spinal Cord Disease or Condition (Non-Traumatic)	4.7%	10	3.5%	30	10.1%
Spinal Cord Injury (Traumatic)	1.9%	10	3.5%	10	3.4%
Hip or Femur Fracture	9.6%	43	14.9%	22	7.4%
Hip or Knee Replacement, Amputation or Other Bone or Joint Condition	16.4%	40	13.8%	50	16.8%
All Other Conditions	19.0%	50	17.3%	38	12.8%
Estimated Total	**100.0%**	**289**	**100.0%**	**297**	**100.0%**

Note: To protect patient privacy, CMS does not provide discharge totals by facility for conditions with less than 11 total discharges. Therefore, a discharge total of 10 patients was applied to estimate volumes for those conditions.
Source: Data.Medicare.gov, Inpatient Rehabilitation Facility (IRF) Compare datasets, IRF-Conditions dataset, Updated March 6, 2019.

Purpose of the Project
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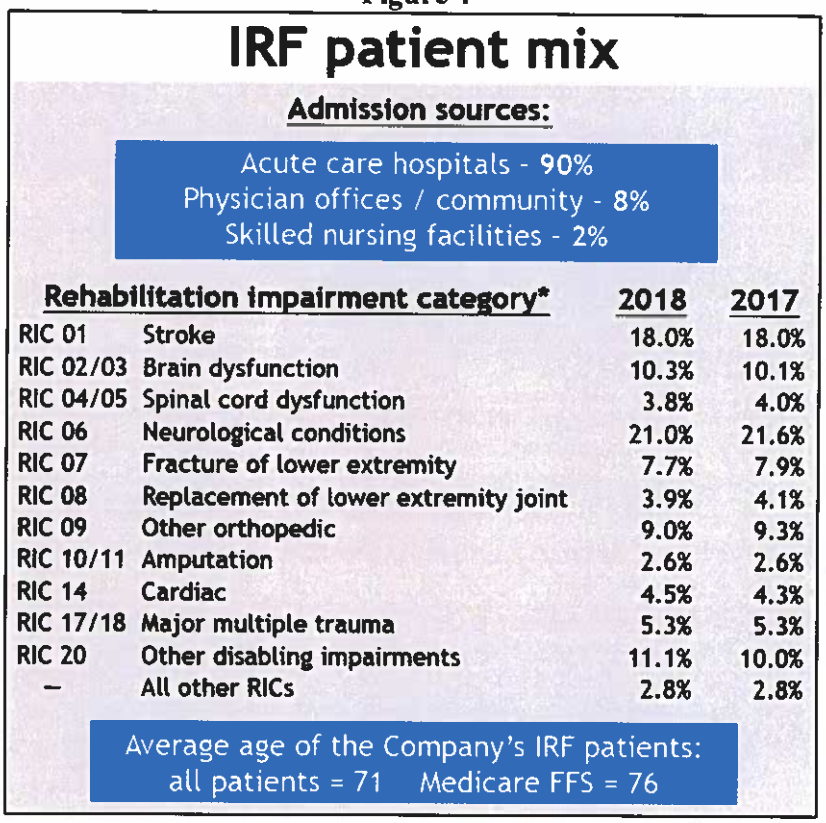
The Rehab Institute of Southern Illinois will offer proven programs and services to patients recovering from a wide array of injuries and illnesses, including not only stroke, spinal cord injury, and hip or femur fracture, but also amputations, cardiac episodes, and pulmonary conditions, to name a few. Thus, the proposed project will complement the existing Rehab providers, ensuring that patients with a wide array of diagnoses in need of inpatient rehabilitation have available and accessible services close to home.

For reference, the overall mix of patients nationally (average for all Encompass hospitals) follows. The Rehab Institute expects to serve a similarly wide array of patient types.

Figure 4



Rehabilitation impairment category*		2018	2017
RIC 01	Stroke	18.0%	18.0%
RIC 02/03	Brain dysfunction	10.3%	10.1%
RIC 04/05	Spinal cord dysfunction	3.8%	4.0%
RIC 06	Neurological conditions	21.0%	21.6%
RIC 07	Fracture of lower extremity	7.7%	7.9%
RIC 08	Replacement of lower extremity joint	3.9%	4.1%
RIC 09	Other orthopedic	9.0%	9.3%
RIC 10/11	Amputation	2.6%	2.6%
RIC 14	Cardiac	4.5%	4.3%
RIC 17/18	Major multiple trauma	5.3%	5.3%
RIC 20	Other disabling impairments	11.1%	10.0%
–	All other RICs	2.8%	2.8%

Source: Investor Reference Book, Post Q4 2018 Earnings Release Updated March 5, 2019, Encompass Health.

Notably, an integral component in the provision of services to a wide array of patient diagnoses (or Rehabilitation Impairment Categories) is BJC's and Encompass' open medical staff model which ensures that community-based physicians are available to care for patients' medical needs alongside the PMR physician caring for their physical rehabilitative needs. For example, TRISL (the joint venture between BJC and Encompass in St. Louis) works with community-based Internal Medicine physicians, Hospitalists, and other specialties (*e.g.*, Neurology) to ensure that their inpatients have access to medical specialists as needed during their inpatient stay.

Thus, the proposed project will enhance accessibility and availability of needed Rehab beds for residents in the four-county service area by:

- Addressing the HFSRB-identified need for 7 beds with a 40-bed freestanding Rehab hospital centrally located and easily accessible to patients throughout HSA11.
- Ensuring sufficient beds are available and accessible to meet residents' needs so that they no longer must be admitted to a Missouri hospital or forego needed inpatient rehab services completely.
- Providing the most appropriate and intensive inpatient rehabilitative care so that residents do not have to settle for less-intensive rehab services such as skilled nursing (or home health care) when intensive inpatient rehab is needed, which appears to be the case presently.

E) <u>The Proposed Project will have a Positive Economic Impact Short & Long Term</u>.

The proposed project will have a positive economic impact on the health system and its patients by returning the majority of patients back to the community with the ability to live as independently as possible. In addition to positively impacting the health system and its patients, the new 40-bed hospital will have a positive economic impact on the community during construction and ongoing operations of the facility, as follows:

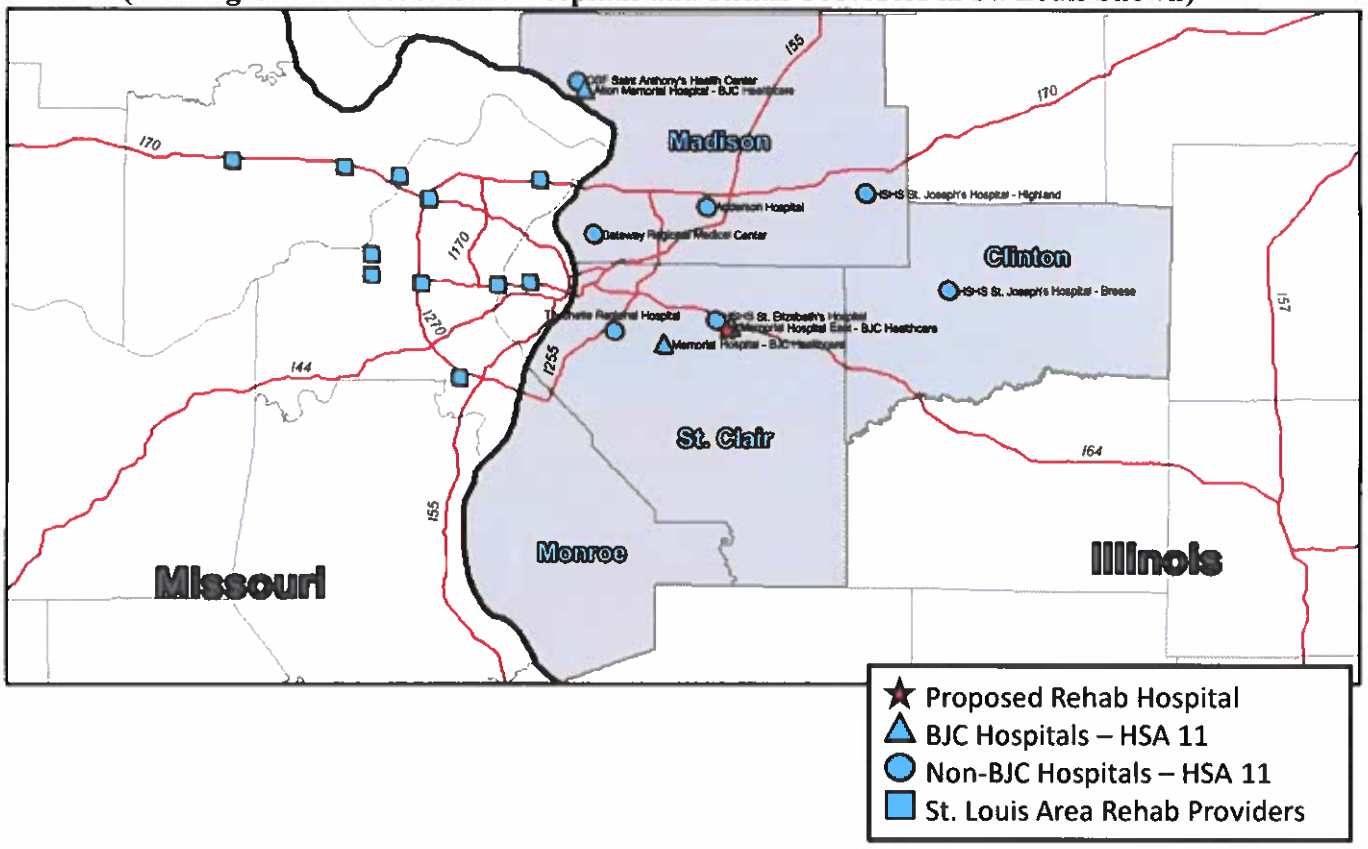
- New hospital will be a major source of jobs for professional workers.
- Economic downstream impact and employer-multiplier effect translates to an annual economic impact in the millions of dollars.
- Annual tax-paying entity (sales and property taxes).

2. The Planning area to be served is the 4-county HSA11.

The proposed project is being developed to address the need for additional inpatient rehab beds to be located in and serve the residents of HSA11. As documented above, the vast majority (72.2%) of HSA11 residents who are admitted for Rehab services are residents willing and able to travel to Missouri for their inpatient care. (*See* Table 6 previously provided.)

The following map shows The Rehab Institute's easily accessible location in the four-county planning area. Also shown on the map are general acute care hospitals in HSA11, the two existing Rehab providers in HSA11, and some of the Missouri-based Rehab providers located across the river who are serving the vast majority of HSA11 patients.

Figure 5
Service Area Map
(Existing General Acute Care Hospitals and Rehab Providers in St. Louis Shown)



Purpose of the Project
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The need for additional beds in HSA11 is based on the total population and the aging in place of that population. To put the declining number of an already-limited and undersupply of Rehab beds into perspective, consider the following:

- HSA11 total population is forecasted to exceed 616,000 persons in 2024.
- Two of the four service area counties rank in the Top 10 statewide in terms of total population:
  - Madison County ranks as the state's 8th largest county in terms of total population, both now (2019) and in the Planning Year Horizon (2024).
  - St. Clair County ranks as the state's 9th largest county in terms of total population, both now (2019) and in the Planning Year Horizon (2024).

Details regarding HSA11 population follows.

Table 11
HSA11 Total Population, 2019-2024

County	2019	2024	Numerical Change	% Change
Clinton	38,599	39,043	444	1.2%
Madison	271,374	272,727	1,353	0.5%
Monroe	36,041	37,714	1,673	4.6%
St. Clair	267,444	266,771	-673	-0.3%
TOTAL	**613,457**	**616,255**	**2,798**	**0.5%**

Sources: Illinois Department of Public Health, Illinois Health Facilities and Services Review Board, Certificate of Need Population Projections Project, 2014.
Note: Population projections as of July 1 for the specified years.

Moreover, HSA11's large total population is aging, which is relevant to the proposed Rehab project because the majority (nearly 70%) of rehab discharges are typically Medicare patients, the vast majority of whom are ages 65 and over.

Table 12
HSA11 Elderly Population, 2019 and 2024

County	Total Population		Pop 65+		65+ Pop, % Change	65 + Pop as a % of Total Pop	
	2019	2024	2019	2024		2019	2024
Clinton	38,599	39,043	6,802	7,972	17.2%	17.6%	20.4%
Madison	271,374	272,727	46,621	52,963	13.6%	17.2%	19.4%
Monroe	36,041	37,714	6,385	7,916	24.0%	17.7%	21.0%
St. Clair	267,444	266,771	40,773	46,926	15.1%	15.2%	17.6%
Total Area	**613,457**	**616,255**	**100,581**	**115,776**	**15.1%**	**16.4%**	**18.8%**

Sources: Illinois Department of Public Health, Illinois Health Facilities and Services Review Board, Certificate of Need Population Projections Project, 2014.
Note: Population projections as of July 1 for the specified years.

3. The project will address existing problems facing HSA11 residents due to the lack of beds.

As documented previously, there are two primary existing problems facing HSA11 residents that will be addressed by the proposed project:

(1) Lack of sufficient number of available and accessible Rehab beds in HSA11 to meet the need for patients based on historical (2015) patients days for HSA11 patients who were cared for in an HSA11 hospital.

(2) Lack of sufficient number of available and accessible Rehab beds in HSA11 to meet the needs of patients who are currently traveling out-of-state for Rehab care; are receiving less intensive services (such as SNF) in lieu of Rehab care; or foregoing post-acute rehab care altogether.

The proposed bed addition will address the current gap in utilization, offering local Rehab services to the HSA11 patients in need.

4. Sources used in the analyses.

As documented in the various tables previously presented, the following sources were used in the analyses:

- Illinois HFSRB State Summary Revised Bed Need Projection, 3/11/2019.
- Illinois HFSRB Inventory of Health Care Facilities and Services and Need Determinations, 9/1/2017.
- Illinois Department of Public Health, Illinois Health Facilities and Services Review Board, Certificate of Need Population Projections Project, 2014.
- Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database.
- MUR Report, 2018 Hospital Industry Data Institute
- CMS Geographic Variation Public Use File, March 2019.
- Medicare data obtained from Data.Medicare.gov, Inpatient Rehabilitation Facility (IRF) Compare datasets, IRF-Conditions dataset, Updated March 6, 2019.
- Healthcare Cost Utilization Project (H-CUP) Statistical Brief #205, An All-Payer View of Hospital Discharge to Post-acute Care, 2013, Agency for Healthcare Research and Quality (AHRQ), Published May 2016, Author Wen Tian, PhD, MD.

5. The Rehab Institute will improve the health care and well-being of HSA11 residents.

The results of the proven programs and services that BJC and Encompass will implement at The Rehabilitation Institute of Southern Illinois were previously presented, documenting that the project will in fact improve the health care and well-being of HSA11 residents by offering locally accessible and available intensive inpatient rehabilitation services.

The following describes *how* the project will address or improve the previously-referenced issues, as well as the population's health status and well-being.

First, the proposed project will ensure that HSA11 residents have access to local health care services through the establishment of a 40-bed rehab-only freestanding hospital that is accessible to service area residents when needed.

Second, the proposed project will implement the following programs, services, and facility amenities specific to Encompass Health hospitals throughout the nation, and in place at the current joint venture facility owned and operated by BJC and Encompass, *i.e.*, The Rehabilitation Institute of St. Louis.

Purpose of the Project
The Rehabilitation Institute of Southern Illinois, LLC

The success of the following programs and services is due in large part to the synergy of Encompass Health's comprehensive team approach to rehabilitation services and use of the latest technology and treatments available. The facility design specifically allows for and supports the use of extensive equipment and technology by specially-trained staff in a patient-centered environment. Notably, the proposed new 40-bed hospital will be the only freestanding Rehab hospital in HSA11.

Specific ***programs and services*** to be offered at The Rehab Institute address a wide range of diagnosis including, but not limited to, the following.

- Stroke
- Brain injury
- Neurological conditions
- Joint replacement
- Orthopedic
- Hip fracture
- Spinal cord injury
- Amputee
- Parkinson's Disease
- Multiple sclerosis
- Burns
- Pulmonary/respiratory
- Pain management

The success of these programs and services is due in large part to the highly-qualified and specially-trained ***physicians and staff members*** who comprise a **comprehensive, multidisciplinary team** including:

- **Medical Director:** A Physical Medicine and Rehabilitation ("PMR") physician who frequently meets with the patient during the patient's inpatient stay, and is ultimately responsible for implementing the patient's care plan as the multidisciplinary team leader.

- **Rehabilitation nursing:** Implements each patient's medical care program as directed by his or her physician.

- **Occupational therapy:** Designs and delivers activity-based therapy to promote independence in the areas of self-care, home management and community reintegration.

- **Physical therapy:** Evaluates and designs a treatment program to address limitations in physical function, mobility and safety.

- **Respiratory therapy:** Ensures proper respiratory function through services such as oxygen supplements and aerosol treatments.

- **Speech-language pathology:** Assesses and treats individuals with communication and comprehension disorders, cognitive difficulties and swallowing disorders.

- **Dietary and nutritional counseling:** Supervises all meals to ensure patients meet their required nutritional needs.

- **Case management:** Coordinates with the physician to ensure the patient's needs are met and involves the family and other caregivers in the patient's rehabilitation. The Case Manager is also responsible for:
  - Working with the family prior to the patient's discharge to provide training to help family members care for patients after discharge.
  - Visiting the patient's home prior discharge to identify and then address any special needs (such as equipment) the patient will have upon returning home.
  - Coordination and collaboration of services between the patient and community service providers who will be responsible for providing care to the patient post-discharge.

Patients benefit not only from the extensive array and number of staff members in place at Encompass Health hospitals, such as that proposed for the new Shiloh facility, but also from the unique patient-centric programs staff members institute at their facilities to ensure patients receive high quality care.

A few ***employee-driven patient-centric programs*** that are expected to be implemented at The Rehab Institute, as they are at existing Encompass facilities, include the following.

- **No Pass Policy** which ensures that any and all staff members must never pass by a patient's room when the nurse call light is on or when it is clear that, even without the call light on, the patient would benefit from assistance. Notably, this operational mandate applies to all staff members, not just nursing staff, so that any and all staff members ensure that patients and families' needs are the highest priority at all times.

- **Welcome Announcement** is one small way in which the staff members can make a new patient feel welcome and know that his/her admission to the hospital is recognized by all staff members as a new beginning. While the patient's name isn't announced so that the patient's privacy is protected, the announcement makes clear that a new patient in a specific room number has arrived, and will join the other patients in his/her journey along the road to rehabilitation and recovery.

- **Patient's in-room information board** is an often overlooked ubiquitous aspect of an inpatient's room at virtually every acute care hospital in the U.S. However, the staff members at Encompass recognized the full potential and importance of the in-room board to the patient, family, and staff members and so have focused on this tool as a means to enhance patient involvement, and thus ultimately quality of care.
  - For example, each patient can refer to the board for that day's rehabilitation schedule, any special daily activities in the Day Room, and a photograph of the physician who is responsible for his/her care during the inpatient stay, among other items. The patient and staff will also see reminders of any special precautions or needs, *e.g.*, indication that an alarm will sound when the patient gets out of bed. In this way, the patient and staff have a visible reminder of the patient's activities and specific needs that goes beyond

the typical in-room information board of general acute care hospitals, improving it to specifically meet the needs of inpatient rehab patients.

- **Victory Bell** that is in place at the entrance to the Therapy Gym is another way that the staff recognize individual patients and their success in rehabilitation. The Victory Bell is used by patients when they are being discharged from the hospital, signaling to other patients and all staff members that the patient has passed a significant milestone in his/her life, and that the other patients can too. (The Encompass Health hospital's Victory Bell is similar to the "Survivor Bell" that many oncology programs have in place for their patients to ring to announce the successful end of their treatment.)

The ***facility design*** supports and promotes the programs and services offered by Encompass hospitals, ensuring that staff members can provide high quality, intensive rehabilitation and restorative services in a cost-effective manner.

The approximate 47,749 square foot project has been designed specifically and solely for inpatient rehabilitation services, including the use of extensive rehabilitative equipment and technology by specially-trained staff in a patient-centered environment. Notably, the proposed rehab hospital will be comprised of all private rooms.

The ***facility design*** supports and promotes the programs and services offered by Encompass hospitals, ensuring that staff members can provide high quality, intensive rehabilitation and restorative services in a cost-effective manner. As illustrated below, the facility design is patient-centered, with an emphasis on clinical outcomes, patient safety, and the use of technology and innovation in caring for patients.

The proposed facility includes the following amenities.

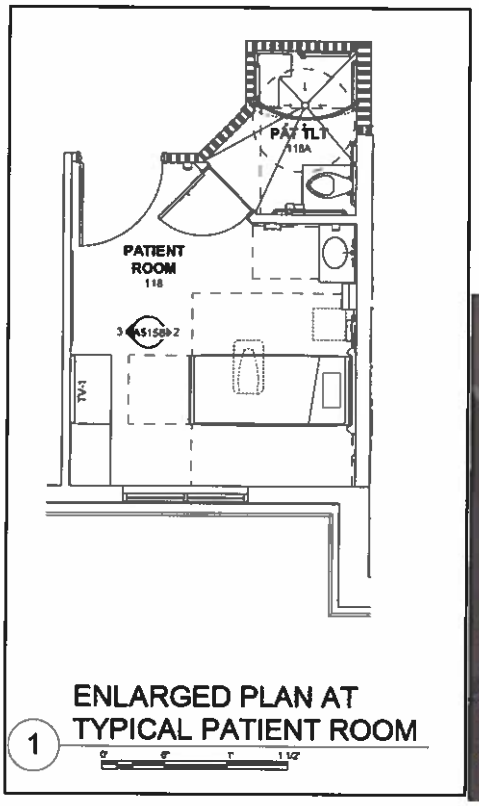
- Forty (40) private wheelchair accessible patient rooms with wheelchair accessible private bathrooms, and sufficient space bedside for caregivers and family members to interact with the patient comfortably. Notably, all patient rooms are designed with full capability of acute care inpatient rooms, *e.g.*, head walls and gases are incorporated into the design, reflecting the medical complexity of patients served.

- Two (2) private bariatric rooms, providing larger and specially-designed rooms to care for bariatric patients who require additional space in both the patient room and bathroom in addition to specialized equipment, *e.g.*, overhead track system with lift capability.

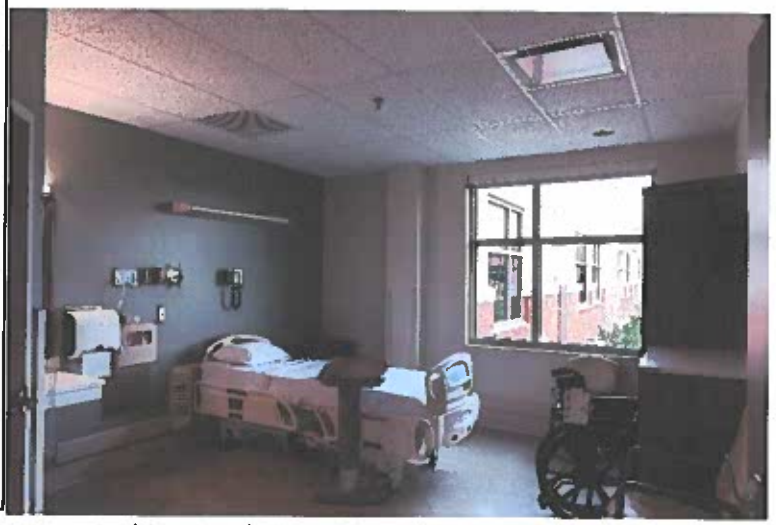
- Two (2) isolation rooms with negative air pressure flow to meet the special needs of patients with communicable diseases.

- A dialysis treatment area with four patient bays for patients requiring dialysis care during their inpatient stay.

Purpose of the Project
The Rehabilitation Institute of Southern Illinois, LLC



Architectural Figure A



Architectural Figure B

- A Therapy Gym with specialized equipment and of sufficient size ensures that patients and staff members have appropriate space to work for the patient to complete his/her daily rehabilitation, and affords family members and caregivers the opportunity to attend the patient's therapy session. (*See* Architectural Figure C below.)

  - For comparison purposes, proposed rehab hospital's Therapy Gym is nearly double the size of the typical therapy gym/inpatient rehab area offered in general acute care hospitals that have dedicated inpatient rehabilitation beds.

  - A listing and brief description of the hospital's planned clinical rehab equipment and technology that will be included in the Therapy Gym is provided later in this Attachment.

Architectural Figure C

- A dedicated and separate Activities of Daily Living ("ADL") Suite within the Therapy Gym provides patients and their families a home-like setting where the patient can relearn ADL activities in order to live as independently as possible when returning home. The ADL Suite includes a kitchen with a stove, sink, refrigerator, dishwasher, cabinets, and tables and chairs; a laundry room with a washer and dryer; and a homelike bathroom intentionally designed with a small, non-compliant American with Disabilities Act ("ADA") doorway since that is what most patients will face when they return to the community.

- A dedicated Outdoor Therapy Area, adjacent to the large indoor Therapy Gym, with specialized ramps, surfaces, curbs, and seating for rehab patients to use in order to practice navigating the various settings a patient will face when s/he returns to the community.

- A large Dining Area where patients engage in communal dining as part of their ongoing rehabilitation and restoration. (*See* Architectural Figure D below.)

Architectural Figure D

- A Dayroom Activity Area that is used for socialization and rehabilitation of patients, including special activities involving family and/or community members.

- Sufficiently-sized and appropriately-designed support functions such as the nursing unit area, in-house pharmacy, dietary services, medical records, environmental services, and central supply to ensure that the specialized needs of the rehabilitation patients are met. (*See* Architectural Figure E below showing a nursing unit area with clear sight lines to patient rooms.)

Architectural Figure E

- Overall facility design that includes sufficiently-wide corridors for easy navigation of patients, families, and staff members and designated spaces along those hallways to store equipment out of the way of patients and families but in close proximity to staff members.

- Additional features specific to the local community include the use of interior design themes, colors, and photographs consistent with and reflective of the area, *e.g.*, local landmarks, landscapes, and events, to provide a sense of community to the patients and also to enhance the mental acuity of patients through recognition of familiar sites and images throughout the hallways.

Architectural Figure F (lobby)

Patients will also benefit from ***patient-centric facility design features*** that are in place at all Encompass facilities and will be included in the Rehab Institute of Southern Illinois.

- **Color-coded hallways** at Encompass rehabilitation hospitals does not simply mean that there is a color-coded stripe painted down the hallway or a doorway is painted a certain color, as is sometimes the case in other facilities. Rather, the entire inpatient unit, including all walls and hallways, is painted a consistent and distinct color from those used in other inpatient hallways so that patients can easily find their way to and from their rooms and the therapy gym, dining room, and/or day room during their inpatient stay. Staff members' experience is that all patients, not just those suffering from a neurological episode, benefit from this patient-centric facility design feature that will be implemented at the proposed new hospital.

- **Electronic patient status/nurse call boards throughout the inpatient hallways** ensures that all staff members can at all times see when a patient in his/her inpatient room has requested assistance, and thus timely respond to the patient's needs. This facility design feature goes hand-in-hand with the No Pass Policy implemented at all Encompass hospitals, ensuring that patients' needs are immediately known and responded to by staff members.

- **Patient-centered inpatient units** are intentionally-sized based upon best-practices to promote high quality care and staff efficiency and effectiveness. Specific design features include:
  - *All private rooms*, with each room standardized in design and support space allocation. Patient rooms are designed to improve quality of care and support patient healing, provide family support, and enhance clinical efficiency and effectiveness. Patient rooms are acuity-adaptable and standardized to allow care of all diagnosis groups and to facilitate efficient processes, from patient care to cleaning and maintenance.
  - *Clear sight lines of nursing units to inpatient rooms* to ensure patient safety and high quality care. The clear sight lines from staff to patient and staff to staff enhance staff interaction with patients, increase responsiveness of staff to patients, and mitigate falls and other injuries, thus ultimately enhancing quality of care.

Patients will benefit from the Strength of the Joint Venture Partners

The proposed project will be owned and operated as a 50/50 joint venture project. Consistent with the HFSRB rules regarding joint ventures we are confident that the patients in the community will benefit from the combined strength of the organizations.

BJC HealthCare is a nonprofit health care organization with 14 hospitals, five service organizations and hundreds of outreach services for residents in the greater St. Louis, southern Illinois and mid-Missouri areas. BJC is the largest provider of charity care, unreimbursed care and community benefit in Missouri, providing $904 million in free or reduced medical care, education of health professionals, medical research funding and community outreach programs. Many of its programs and services benefit the residents of Southern Illinois who travel to St. Louis for health care services provided by BJC and its affiliates.

BJC hospitals range in size from 35 beds at Missouri Baptist Sullivan Hospital to more than 1,200 beds at Barnes-Jewish Hospital. All of BJC hospitals are accredited.

Purpose of the Project
The Rehabilitation Institute of Southern Illinois, LLC

As one of the largest nonprofit health care integrated delivery organizations in the country, BJC has the clinical excellence, community outreach and education, research and education component through its relationship with Washington University School of Medicine, and financial strength to ensure the success of the proposed project. BJC brings its commitment of improving the health and well-being of the people and communities it serves through leadership, education, innovation, and excellence in medicine to the proposed project. Moreover, the financial strength of BJC (illustrated by BJC's $5 billion in net revenues for FY17) will ensure the short and long-term success of the new 40-bed hospital by, for example, building a state-of-the-art rehab hospital now and investing in technology, equipment, and facility improvements as needed in the future.

Encompass Health is the nation's leading owner and operator of inpatient rehab hospitals, representing over 20% of the licensed acute rehabilitation beds nationally. HSA11 residents will benefit from Encompass' proven high quality, cost-effective programs that extensively utilize specialized staff and technology to deliver higher than expected clinical outcomes. A listing of select corporate programs and services that will benefit the patients and families of the proposed new hospital follows.

- **TeamWorks** is a corporate-wide clinical initiative to continually improve quality of care through the identification, standardization, and implementation of best-practices across all of Encompass' hospitals. Just two of the many ways this program has benefitted patients include (1) a quicker admission process and (2) greater coordination pre-admission and post-discharge between community health care providers and Encompass hospitals.

- **Patient Safety Task Force** is comprised of employees across all regions and disciplines who are primarily responsible for identifying changes and/or improvements in processes, policies, or programs to increase patient and staff safety in Encompass hospitals.

- **Post-Acute Innovation Center** is an example of Encompass' ongoing efforts to continually enhance quality of care. The Center was established in 2017 as a partnership with Cerner Corporation to develop clinical decision support tools that can more effectively and efficiently manage patients across multiple care settings, thus enhancing care coordination between a patient's providers, regardless of the provider's location.

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

- **Participation in The Joint Commission's Disease-Specific Care Certification Programs** has resulted in 114 of Encompass Health's inpatient rehab hospitals holding one or more disease-specific certifications from The Joint Commission's Disease-Specific Care Certification Program in areas such as stroke, brain injury, or hip fracture rehabilitation.

- **Advanced Technology** includes rehab-specific clinical equipment and technologies such as the standard equipment included in all new hospitals (presented at the end of this response), as well as the following corporate-wide information technology.
  - Predictive data analytic programs ReAct and Sepsis Alert enhance patient quality of care by closely monitoring even the most subtle changes in a patient's status, reducing readmissions to acute care hospitals, and ultimately enhancing quality of care.
  - A proprietary rehab-specific clinical information system (ACE-IT) interfaces Encompass patients' clinical information with acute care hospitals' clinical information systems to facilitate patient transfers, reduce readmissions, and enhance outcomes.
  - An internally-developed, real-time management reporting system (BEACON) enhances clinical and business processes to ensure that the high quality care provided by Encompass hospitals is delivered in the most cost-efficient manner.

- **Financial Resources and Strength** of Encompass provide the local hospitals with sufficient means to purchase needed equipment and technology, ensure the appropriate complement and number of staff are in place to care for patients, and the facility is designed and well-maintained with all of the latest amenities – all of which combine to enhance quality of care for the patient and family, as evidenced by Encompass Health's existing facilities.

Thus, BJC and Encompass Health will leverage demonstrated best practices, proven staffing models, comprehensive information technology, centralized administrative functions, supply chain efficiencies, and economies of scale to ensure that the new 40-bed hospital consistently provides the highest clinical outcomes in the most cost-effective manner.

Finally, the following excerpt from a Washington County, IL patient's letter best illustrates the positive impact the proposed project will have on patients.

Donna Hackstadt, former patient of The Rehabilitation Institute of St. Louis, states:

"I am writing to express my support for The Rehabilitation Institute of Southern Illinois, LLC's Certificate of Need application to build a comprehensive inpatient rehabilitation hospital in Shiloh, Illinois. I have been a resident of Washington County for many years and travel to the Belleville/Shiloh area for healthcare and sometimes as far as St. Louis.

I have been a hemi-pelvectomy amputee for 29 years. While I tried a prosthetic leg 25 years ago it was challenging and as a result I've been using crutches to walk ever since. In 2017, I was visiting my mother in a hospital in Shiloh when the doctor caring for her noticed my condition and was concerned that I was still using crutches for mobility after all these years. He suggested I go to the Hanger Clinic in St. Louis which does advanced prosthetic limbs for amputees. When I went they referred me to The Rehabilitation Institute of St. Louis (TRISL). I was admitted there in October 2017 and I was pleasantly surprised that the therapists at TRISL were so eager to help me, so patient with me, and worked with me for 11 days until I became proficient at using my new leg. I enjoyed being with other patients with amputations, we encouraged and motivated each

other during our therapy. I needed the intensity and frequency of the therapy as I had many years on crutches and I had to learn how to walk with a new leg. I followed up with TRISL again in 2018 for some outpatient therapy to refresh what I had learned and accomplished as an inpatient.

In southern Illinois we don't have the advanced level of inpatient rehabilitation therapy available like that of The Rehabilitation Institute of St. Louis. We have to travel great distances, through challenging traffic, and endure the inconvenience of driving all the way to St. Louis for care. It would be of great benefit to patients such as myself and many others if this level of expertise in rehabilitation was east of the river in Southern Illinois.

I do hope you will seriously consider the approval of a Certificate of Need to The Rehabilitation Institute of Southern Illinois, LLC to build an acute inpatient rehab hospital in St. Claire County. It would provide a much needed service to patients like me, as well as to many other citizens in our community."

6. Projected utilization further supports the need for the proposed project.

The forecasted utilization of the new 40-bed hospital, as shown below, further supports the need for the project.

Table 13
The Rehab Institute of Southern Illinois Projected Utilization

Indicator	Year 1	Year 2
Discharges	800	1,015
Days	9,855	12,483
Average Daily Census	27.0	34.2
Occupancy	67.5%	85.5%

Encompass Health

THESE ITEMS ARE STANDARD IN ALL NEW HOSPITALS

Rehabilitation Equipment & Technology

Clinical technologies are invaluable tools in the therapy process and offer patients an exciting and enjoyable experience during their road to recovery. Encompass Health's Therapy Innovations Committee (TIC) evaluates the most cutting-edge, innovative clinical technologies on the market today. The committee establishes and maintains technology standards for new hospitals and identifies best-in-class technologies for Disease Specific Certifications (DSC) to support the gold star quality of care HealthSouth is known for. Some examples of these technologies are as follows:

Bioness Vector Overhead Track System®

Bioness Vector is an overhead track and harness system that provides a safe ambulation environment for both therapist and patient. Without the fear of falling, patients can focus more fully on their tasks of gait and balance.

B.I.T.S Bioness Integrated Therapy System®

Using a 50" touch screen monitor, BITS is designed to improve visual abilities for a wide range of patients with visually-related learning problems, strabismus, amblyopia, and traumatic brain injury. BITS offers 16 unique programs with customizable features designed to enhance outcomes for physical and occupational therapy patients.

SaeboFlex®

Stroke survivors and other neurologically impaired patients use this custom-fitted hand and arm splint to increase shoulder, elbow, wrist and hand function. During therapy exercises, the splint is used to retrain the hand's grasp and release movements.

Encompass Health

Bioness H200®

When stroke, brain injury or spinal cord injury occur, a person's neurological abilities, like grasping, can be impaired. The innovative NESS H200 helps improve hand function and voluntary movement.

Bioness L300™

This small wireless device is worn on a patient's leg to help improve walking abilities. Through electrical stimulation, NESS L300 retrains lower leg muscles, increasing motion and blood circulation enabling the return to a more normal step.

Synchrony®

Unlike any other dysphagia rehabilitation solution available, Synchrony™ enables SLPs and patients to literally "See the Swallow" using virtual reality augmented sEMG biofeedback. This important capability helps SLPs evaluate the specific dynamics of a normal, effortful or Mendelsohn swallow in real time, while guiding a series of therapeutic exercise activities that are engaging and fun for patients.

Interactive Metronome™

Interactive Metronome is a brain-based rehabilitation assessment and training program created to improve a patient's ability to plan, organize and use language.

BURT®

BURT® is a user-friendly robot that assists in improving motor control and fine motor skills in the arms and hands. This robot contains integrated gaming software to practice movement patterns and provides customizable features to tailor to patient-specific rehabilitation treatments.

VitalStim®

For those who suffer from dysphagia, a common condition among stroke and brain injury survivors, this therapy greatly improves swallowing ability with electrical stimulation.

Alternatives
The Rehabilitation Institute of Southern Illinois, LLC

1. Maintain status quo and limit availability and accessibility to adult inpatient rehab beds, despite the HFSRB-identified need for 7 additional beds.

Maintaining the status quo would result in no enhanced access for patients currently leaving the state for Rehab services, or for those patients who are foregoing rehab services post-discharge altogether, or choosing to utilize less intensive services such as SNF in lieu of Rehab, when needed. Moreover, existing Rehab providers are unable to serve all patients in need. Rather, existing providers focus on a limited array of Rehab services so that even if one of the two existing providers proposed to add beds, the addition of beds at an existing provider would not materially increase access to Rehab services for HSA11 residents.

Conversely, the approval of the proposed freestanding Rehab will provide service area residents with an optimal solution to their inpatient rehab needs by offering high quality, low-cost services close to home. The new hospital will be a 50/50 joint venture between BJC HealthCare and Encompass Health, bringing the strength and support of two national health care entities to the proposed project. The proposed Rehab will be supported and strengthened by the proven policies, procedures, infrastructure, expertise, and commitment to local communities provided by both BJC and Encompass. For these reasons this alternative was rejected.

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

The applicants considered the establishment of a facility of less than 40 beds and rejected this alternative because the establishment of a facility of less than the proposed 40 beds would fail to meet the predicted need for locally available and accessible Rehab services. Moreover, a small 7-bed specialty rehab hospital is not feasible nor practical because it is inherently cost-prohibitive and inefficient. For example, construction of the necessary infrastructure (gym, day room, dialysis suite, kitchen, etc.) and minimal staff requirements needed to serve Rehab patients make this option a non-starter. Thus, BJC and Encompass did not consider a facility of less than 40 beds to be a viable option, particularly considering the quantified need for more than 40 additional beds in the analyses presented previously.

When all factors are considered, it is clear that the only viable alternative is for service area residents to have access to the needed 40 additional Rehab beds, and that the proposed joint venture hospital between BJC and Encompass is best positioned to address the residents' needs. For these reasons, this alternative was rejected.

3. Project as Proposed

The project, as proposed, reflects the most cost-effective, patient-centered, comprehensive means of ensuring access to quality care for patients in need of Rehab services. Consistent with Ill. Admin. Code Section 1110.110 (d)(1)(b), this project will be a joint venture that brings together two national healthcare leaders for a project that will meet all of the existing and future Rehab needs of this community. This project was designed to meet the needs of the surrounding community and provide Illinois residents with high quality care here in the state of Illinois.

Size of the Project
The Rehabilitation Institute of Southern Illinois, LLC

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
Rehab Hospital: Clinical Portions	35,812 BGSF	At least 26,400 BGSF (40-beds x 660/bed)	+ 9,412 BGSF	Yes**
Rehab Hospital: Non-Clinical Portions	11,937 BGSF	None	N/A	N/A
Total	47,749 BGSF	None	N/A	N/A

**The proposed project exceeds the state standard specific to clinical BGSF, due primarily to the Applicant's facility design that includes a large indoor therapy area, dedicated bariatric rooms, dedicated isolation rooms, and a dialysis unit. These specialized services enable The Rehab Institute to care for more medically complex patients that are typically hard-to-place in inpatient rehab programs.

Room Name	Room Numbers	Area (SF)	Comments
Section 250.2440 General Hospital Standards			
a) Admin and Public Areas			
a) 1) Main Entrance			The main entrance is designed to accommodate persons with physical disabilities.
Vestibule	200	75	
a) 2) Lobby	201	691	The lobby includes a Reception, computer niche and Waiting Space. Public toilet facilities for men and women and a drinking fountain are located around the corner, adjacent to the Lobby.
Reception	202		Includes a Reception desk. Those waiting will have access to the receptionists telephone as needed.
Waiting	203	384	
WC Storage	204	54	
Men's Public Restroom	208	184	
Women's Public Restroom	209	186	
Staff Tlt	210	60	
Storage	211	187	
Conference Room	212	271	
a) 3) Interview Space	217	284	Interviews will take place in Multipurpose Room 414 adjacent to the Lobby 420.
a) 4) General or Individual Office			The Admin. Suite is located adjacent to the Lobby and provides offices for administrative personnel.
HR Office	273	140	
HR Storage	274	50	
Admissions Office	262	219	
Admin.	271	87	
Admission	265	109	
CEO	264	195	
Director of Marketing	269	111	
Medical Director	266	116	
Director of Quality	267	111	
Controller	264	126	
Accounts Payable/Payroll	270	114	
a) 5) Multipurpose Room	259	362	The multipurpose room is designated for conferences, meetings and education purposes including a TV for visual aid.
a) 6) Medical Library Facilities			Medical Resources are located within the Admin. Suite
a) 7) Storage Areas	261	69	Multiple storage areas located in the Admin. Suite
b) Medical Records Unit	213	263	The Medical Records room provides enough space for the reviewing, dictating, sorting, recording and storage of medical records as required by the functional program.
c) Adjunct Diagnostic and Treatment			
c) 1) Laboratory Suite	341	266	A laboratory room is provided in the nursing unit sized accordingly to the functional program.
c) 1) A) work counter			A work counter is provided in the lab.
c) 1) B) lavatory or counter sink			A counter sink is provided for hand-washing.
c) 1) C) storage cabinet			Base and wall cabinets are provided for storage.
c) 1) D) blood storage			Provided by vendor.
c) 1) E) specimen collection			Specimen pass-through window provided between the lab and the adjacent patient toilet room.
c) 2) Morgue and Autopsy Suite	N/A		N/A

c) 3) Radiology Suite	N/A		N/A
c) 4) Pharmacy Suite	318	413	Pharmacy provided in the nursing unit.
c) 4) A) Administrative functions	319	111	Work space is provided for administrative functions, including requisitioning, recording and reporting, receiving, storage (including refrigeration) and accounting.
c) 4) B) Quality Control Area	N/A		N/A
c) 4) C) Locked storage for drugs and biologicals			Locked storage for drugs and biologicals is provided by shelving vendor (Coshatt)
c) 4) D) Dispensing Area			A dispensing area is provided.
c) 4) E) Hand-washing facilities			Hand-washing facilities are provided.
c) 4) E) i) drug info			Users can access a drug information area for reference materials and personnel.
c) 4) E) ii) sterile products	N/A		N/A
c) 5) Physical Therapy Suite			
c) 5) A) Shared Spaces			Physical Therapy and Occupational Therapy may share the use of the ADL suite.
c) 5) B) i) Office Space	229	143	A director of therapy office is provided within the Therapy Gym
c) 5) B) ii) Waiting Space	N/A		All patient rooms are private patient rooms, patients will wait in their rooms until their pre-scheduled time.
c) 5) B) iii)Treatment Areas	224, 225, 226	80/Each	Treatment areas are provided. Walls separate each individual area, and cubicle curtains separate each treatment area from the rest of the therapy gym. One hand-washing facility is provided for 3 treatment areas.
c) 5) B) iv) Wet and Soiled Linen	216	100	A soiled linen room is provided for the collection of wet and soiled linen and other material.
c) 5) B) v) Exercise Area	220	3667	An exercise area is provided in the therapy gym and the therapy yard.
c) 5) B) vi) Storage for Clean Linen, Supplies, Equipment	229	76	A clean linen room is provided for clean linen, supplies and equipment.
c) 5) B) vii) Patient Dressing Area and Toilet Rooms	N/A		This is an inpatient only hospital and therefore patients will dress in their private rooms where they will have access to a toilet room and a wardrobe. Patients have an assigned schedule time and will be ready ahead of arriving at the Therapy Gym.
c) 5) B) viii) Wheelchair and Stretcher Storage	230	100	Wheelchair and stretcher storage is provided.
c) 5) B) ix) Showers, Lockers, Service Sinks			Storage cabinets are provided. Showers are not provided in the Therapy gym due to this being an inpatient only hospital and each patient has their own private shower in their room.
c) 6) Occupational Therapy Suite	222,223	287, 71	An ADL Suite is provided within the Therapy Gym
c) 6) A) Shared spaces			Physical Therapy and Occupational Therapy may share the use of the ADL suite.
c) 6) B) i) Office Space (Charting)	219	517	An office is provided for the Director of Therapy, a charting room is provided for all other Therapy Staff
c) 6) B) ii) Activities Area w/ Sink or Lavatory			A sink is provided in each room of the ADL suite
c) 6) B) iii) Stage Space for Supplies and Equipment	222	287	Kitchen, bathroom, bedroom, and laundry spaces are provided
c) 6) B) iv) Patient Toilet Room	221	39	Provided adjacent to the ADL suite.
d) Nursing Unit			
d) 1) Patient Rooms	101-140	196/Each	(40-bed Hospital)
d) 1) A) Windows in each patient room			Each patient room is an outside room. Windows are provided for each patient room and are not of a size less than 7.5% of the square footage of the floor of the room.
d) 1) B) Minimum room areas 100 square feet clear in one-bed rooms			Each patient room is a private patient room with a clear floor space of 196 sq. ft.
d) 1) C) Minimum 3 feet clear at foot and sides of each bed			A minimum of 3 feet clear at the foot and sides of the bed is provided.

d) 1) D) Access to toilet room without entering the corridor			Each patient room has access to a toilet without entering the corridor.
d) 1) E) One toilet room shall not service more than 4 beds and not more than 2 patient rooms			Each patient room is equipped with its own toilet room.
d) 1) F) Toilet room shall contain water closet and a lavatory. Lavatory may be omitted if single bedroom contains lavatory			The toilet room shall include a water closet and a lavatory. The lavatory is omitted from the toilet room that serves not more than two single bedrooms since each such single bedroom contains a lavatory.
d) 1) G) Each patient shall have a wardrobe, locker, or closet for personal effects			Each patient has a wardrobe for hanging and storing personal effects.
d) 1) H) Visual privacy for each patient bed provided in multi-bed rooms	N/A		N/A
d) 2) Nurses' Service Center			
d) 2) A) Nurses' Station	328	643	A nurses' station with a work counter, storage areas, and communications equipment is provided.
d) 2) B) Nurses' Office	320	110	A nurses' office is provided.
d) 2) C) Hand-washing Facilities			Hand-washing facilities convenient to the nurses' station and the drug distribution station is provided. Another handwashing station is provided within the meds room (drug distribution station).
d) 2) D) Charting Facilities	329	85	Charting facilities are provided for nurses and doctors, including a work counter and charting racks.
d) 2) E) Staff Lounge w/ Mens/Womens Toilet Rooms	331	256	A staff lounge with men's and women's toilet rooms are provided.
Men's Staff Tlt Room	332	63	
Women's Staff Tlt Room	333	63	
d) 2) F) Closets or Compartments for Staff Personal Belongings			Lockers for the safekeeping of coats and personal effect of nursing personnel are provided in the staff lounge.
d) 2) G) Multipurpose Room	343	196	A multipurpose room is provided for conferences, demonstrations, and consultation. This room is located right in the nursing unit.
d) 2) H) Exam room	N/A		This room is omitted because all patient rooms are single bedrooms.
d) 2) I) One tub or shower for each 12 beds	N/A		Not applicable as each patient room has a private toilet/shower room within their private patient room.
d) 2) J) Nourishment Station	325	128	A nourishment room with a sink equipped with hand-washing, equipment for serving nourishment between scheduled meals, a refrigerator, storage cabinets, and a unit to provide ice for patient's service and treatment is provided.
d) 2) K) Drug Distribution Station (Meds)	324	128	Within this secured access room there are self-contained Pyxis units. The meds room is under the nursing staff's visual control due to its adjacent location to the main nurse station. The Meds room contains a work counter, refrigerator, and locked storage for biologicals and drugs.
d) 3) Service Area			
d) 3) A) Clean Workroom	312	178	A clean work room is provided in the Nursing Unit. The clean work room contains a work counter, hand-washing facilities, a nurse signal, and storage facilities. The clean holding room is part of a system for storage and distribution of clean and sterile supplies and materials.
d) 3) B) Clean Linen Storage	245, 218, 312	65, 108, 178	A Clean Linen room is provided in the Therapy Gym, Back-of-House and Nurse Unit (A separate designated area within the Cleanwork room is provided for clean linen storage.)
d) 3) C) Parking for Stretchers and Wheelchairs	337	41	Parking is provided in alcoves for stretchers and wheelchairs out of the path of normal traffic.

d) 3) D) Soiled Workroom	310	189	A soiled workroom is provided. The soiled workroom contains a clinical sink or equivalent flushing rim fixture, a nurse signal, a hand-washing sink, a waste receptacle, and a linen receptacle. The soiled holding room is part of a system for the collection and disposal of soiled materials.
Soiled Hold	245, 216, 310	65, 109, 189	A Soiled Hold room is provided in the Therapy Gym, Back-of-House and Nurse Unit (A separate designated area within the Soiled Workroom is provided for clean linen storage.)
d) 3) E) Equipment Storage	212, 231, 315,	132, 430, 102,	Rooms for the storage of equipment such as IV stands, inhalators, mattresses and walkers is provided.
d) 3) F) Emergency Equipment Storage	327	28	An alcove is provided for the storage of required emergency equipment within the Nurse Station. This equipment shall be under the direct control of the nursing staff.
d) 3) G) Sitz baths if req by program narrative	N/A		N/A. Sitz baths are not required by the program narrative.
d) 4) Isolation Room	107A, 119A	207/Each	2 rooms are provided for the isolation of patients with known or suspected communicable diseases. Each isolation room has an individual toilet equipped with a bedpan flushing attachment and lavatory. Both isolations rooms are private rooms and are otherwise planned as required for a standard patient room.
Isolation Room Ante Rooms	107, 119	69/Each	Isolation rooms are provided with an anteroom equipped with a hand-washing sink, trimmed with valves that can be operated without the use of hands, storage spaces for clean and soiled materials, and a space for gowning.
d) 5) Rooms for Disturbed Patients	112	196	There is one patient room designed for a disturbed patient for a duration of less than 24 hours. The design provides close observation and shall minimize the dangers of patient escape, suicide or injury. This may be provided in a special care room used for multiple purposes. This room shall be located either in the emergency unit or in a private room in a medical nursing unit, or as otherwise provided by the program narrative.
e) Intensive Care Units	N/A		N/A
f) Pediatric Nursing Unit	N/A		N/A
g) Psychiatric Nursing Unit	N/A		N/A
h) Newborn Care Unity	N/A		N/A
I) Surgical Suite	N/A		N/A
J) Obstetrics and Neonatal Suite	N/A		N/A
k) Emergency Suite (program calls for minimum level of emergency services and therefore will comply only with (k)(1), (k)(4), and (k)(10) with the remaining support spaces being located within the adjacent nursing unit.)	342	162	Emergency Exam room is provided in the Nursing Unit for emergency care.
k) (1) entrance	344	125	An entrance at grade level is provided less than 20 feet from the room with pedestrian and ambulance access.
k) (4) treatment area			The treatment area contains a handwashing sink trimmed with valves that are aseptically operated (knee/foot controls), general storage cabinets, medication dispensing Pyxis units, work counters, medical suction outlets, x-ray film illuminators,and space for storage equipment
k) (10) Toilet facilities	340	39	Provided adjacent to the Exam room
l) Outpatient Department	N/A		N/A
m) Service Departments			
m) 1) Dietary Facilities			

m) 1) A) General	251	745	Construction, equipment and installation complies with the standards specified in the Department's Food Service Sanitation Code and the Food Service Sanitation Manual, P.H. S. 93. Dietary facility services will be provided by the functional program and designed by a contracted kitchen specialist. Services will consist of a combination of on-site conventional food preparation system and a convenience food service system. Services will be provided for emergency food preparation and refrigeration.
m) 1) B) Functional Elements			
m) 1) B) i) Control Station for Receiving Food Supplies	244	144	A kitchen receiving room is provided for receiving food supplies.
m) 1) B) ii) Storage Space	254,252	171, 274	Adequate storage space is provided for normal and emergency supply needs, including food requiring cold storage and dry storage.
m) 1) B) iii) Food Preparation Facilities			Conventional food preparation systems have adequate space and equipment for preparing, cooking and baking. Convenience food service systems, such as frozen prepared meals, bulk packaged entrees, and individual packaged portions, or systems using contractual commissary service, have space and equipment for thawing, portioning, heating, cooking and baking.
m) 1) B) iv) Hand-washing Facilities			Hand-washing facilities are located in the food preparation area.
m) 1) B) v) Patients' Meal Service Facilities (Tray Assembly and Distribution)			Facilities provided for tray assembly and distribution.
m) 1) B) vi) Dining Space	258	1272	Dining space provided for ambulatory patients, staff, and visitors.
m) 1) B) vii) Warewashing Space	256	67	Warewashing space is located in a room separate from food preparation and serving areas. Commercial-type dishwashing equipment is provided. Space is also provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using areas. A hand-washing lavatory is conveniently available.
Tray Return	259	131	
m) 1) B) viii) Pot-Washing Facilities			Pot-washing facilities included in warewashing.
m) 1) B) ix) Storage Area			A storage area is provided for cans, carts, and mobile tray conveyors.
m) 1) B) x) Waste Storage Facilities	247	60	A waste storage facility is located in a separate room easily accessible to the outside for direct pickup or disposal.
m) 1) B) xi) Offices or Desk Spaces	253	91	An office is provided for the dietary service manager.
m) 1) B) xii) Men's and Women's Toilets Accessible to Dietary Staff	233, 234, 235, 236	104, 58, 104, 58	Men's and Women's locker room and toilet rooms are directly accessible to the Dietary Staff, adjacent to the kitchen. Hand-washing facilities are immediately available.
m) 1) B) xiii) Janitors' Closet	250	45	The janitors' closet is located within the dietary department. It contains a service sink and storage space for housekeeping equipment and supplies.
m) 1) B) xiv) Self-dispensing Ice-making Facilities			Ice-making facilities are provided by the contracted Kitchen vendor in their equipment.
m) 1) B) xv) Adequate Can, Cart and Mobile Tray Washing Facilities			Adequate can, cart and mobile tray washing facilities are provided directly outside the Back-of-House
m) 2) Central Stores			
m) 2) A) Off-Street Unloading Facilities			Off-street unloading facilities are provided in the service yard behind the facility.
m) 2) B) Receiving Areas	249A	55	A receiving area is provided.
m) 2) C) General Storage Rooms	249	463	General storage rooms meet the needs of the hospital located in back of house and throughout facility.

m) 2) D) Office Space	N/A		Desk provided in Central Supply per functional program
m) 3) Linen Services			Linen is to be processed off site.
m) 3) A) On-site Processing	N/A		Off-site processing is used.
m) 3) B) i) Soiled Linen Holding Room w/ Hand-Washing Facilities	246	72	A soiled linen holding room with facilities for hand-washing is provided.
m) 3) B) ii) Clean Linen, Receiving, Inspection and Storage Rooms	245	60	Clean linen, receiving, inspection and storage rooms are provided.
m) 3) B) iii) Cart Storage	235	147	
m) 3) B) iv) Office Space	238	100	
m) 4) Facilities for Cleaning and Sanitizing Carts			Provided in Service Yard
m) 5) Employees' Facilities	233, 234	155, 170	Locker Rooms provided with lockers, a toilet, and handwashing sink for Men and Women. Showers not required with functional program.
m) 6) Janitors' Closets	237	34	In addition to the janitors' closets called for in certain departments, sufficient janitors' closets are provided throughout the facility as required to maintain a clean and sanitary environment. Each contains a floor receptor or service sink and storage space for housekeeping equipment and supplies. Space for large housekeeping equipment and for back-up supplies may be located in other areas.
m) 7) Engineering Service and Equipment Areas			
m) 7) A) Rooms or separate buildings for boilers, mechanical equipment, and electrical equipment	240, 241, 241, 243	175, 463, 169, 233	Mechanical and Electrical rooms provided. Tele/Data 12' Min. from all electrical rooms.
m) 7) B) Engineer's space			Provided in maintenance room
m) 7) C) A maintenance shop	239	518	A maintenance room and maintenance office are provided.
m) 7) D) A storage room or rooms for building maintenance supplies			Provided in maintenance room
m) 7) E) Yard equipment storage			Provided in Service Yard
m) 8) Waste Processing services			
m) 8) A) Storage and Disposal	247	58	Waste storage is provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, compaction, containerization, removal, or by a combination of these techniques. Proper handling and disposal of radioactive waste substances is provided.
m) 8) B) Incineration			A gas, electric or oil-fired incinerator shall be provided for the complete destruction of pathological and infectious waste. Infectious waste shall include, but shall not be limited to, dressings and material from open wounds, laboratory specimens, and all waste material from isolation rooms.
m) 8) B) i) Incinerator Shall Be in a Separate Room or Placed Outdoors			The incinerator shall be in a separate room or placed outdoors.
m) 8) B) ii) Design and Construction of Incinerators and Trash Shoots in Accordance with NFPA 82			Design and construction of incinerators and trash chutes shall be in accordance with NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment.
m) 8) B) iii) Incinerators Shall Be Designed and Equipped to Conform to Local Air Pollution Regulations			Incinerators shall be designed and equipped to conform to requirements prescribed by air pollution regulations in the area.
m) 9) Storage			Suitable storage is provided per functional program.

Project Services Utilization
The Rehabilitation Institute of Southern Illinois, LLC

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1	Rehab Hospital	N/A	9,855 Days, 67.5% Occ.	85%	No
YEAR 2	Rehab Hospital	N/A	12,483 Days, 85.5% Occ.	85%	Yes

The projected utilization is based on the need for 40 additional beds to be located in and primarily serve residents of HSA11, and further supported by the physician and patient letters attached.

Attachment 15
Page 1

Comprehensive Physical Rehabilitation Service Specific Criteria
The Rehabilitation Institute of Southern Illinois, LLC

Applicable service-specific criteria follow. The relevant criteria is presented in **bold font** for ease of review.

b) Planning Area Need – Review Criterion
The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

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

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

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

The proposed project is for the establishment of a 40-bed inpatient comprehensive physical rehabilitation hospital needed to:

- Meet the HFSRB-identified need for seven (7) additional beds in HSA11; and
- Provide a local alternative to services in Missouri, where nearly half of HSA11 Rehab patients are now receiving inpatient rehab care, and patients from other southern Illinois currently travel for Rehab care as well.

The need for the proposed project is illustrated by the (a) quantified bed need analyses presented previously and (b) projected utilization of the new hospital, which is expected to exceed the 85% occupancy standard by Project Year 2.

2) Service to Planning Area Residents

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

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

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

The proposed new 40-bed hospital is being established for the primary purpose of providing needed Rehab health care services to the residents in HSA11. Letters of support and the bed need analysis in which the vast majority of discharges (approximately 82%) from HSA11 are driving the need for the new facility, support this statement and follow.

3) Service Demand – Establishment of Comprehensive Physical Rehabilitation
The number of beds proposed to establish Rehab service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest 2-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals. The applicant shall document subsection (b)(3)(A) and either subsection (b)(3)(B) or (C).

B) Projected Referrals
An applicant proposing to establish Rehab or to establish a new hospital shall submit the following:

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

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

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

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

Physicians located in and serving patients from HSA11 and Southern Illinois support the proposed project and intend to refer patients to the project, as shown in the following letters of support.

Because of the lack of sufficient beds and comprehensive Rehab services in HSA11 to meet the residents' needs, patients are currently leaving the state for Rehab services, foregoing rehab services post-discharge altogether, or choosing to utilize less intensive (and therefore less optimal) services such as SNF in lieu of rehab, when needed. For that reason, data documenting the number of rehab-appropriate HSA11 residents by ZIP Code follows the physicians' letters, further supporting the need for the proposed project and the expected high utilization by Project Year 2.

April 29, 2019

Courtney Avery
Board Administrator
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: The Rehabilitation Institute of Southern Illinois, LLC's Proposal to Establish a 40-bed Comprehensive Physical Rehabilitation Hospital in St. Clair County, HSA11

Dear Ms. Avery:

I am writing to express my support for The Rehabilitation Institute of Southern Illinois, LLC's Certificate of Need application to build a comprehensive inpatient rehabilitation hospital in Shiloh, Illinois. I have been a resident of Washington County for many years and travel to the Belleville/Shiloh area for healthcare and sometimes as far as St. Louis.

I have been a hemi-pelvectomy amputee for 29 years. While I tried a prosthetic leg 25 years ago it was challenging and as a result I've been using crutches to walk ever since. In 2017, I was visiting my mother in a hospital in Shiloh when the doctor caring for her noticed my condition and was concerned that I was still using crutches for mobility after all these years. He suggested I go to the Hanger Clinic in St. Louis which does advanced prosthetic limbs for amputees. When I went there they referred me to The Rehabilitation Institute of St. Louis (TRISL). I was admitted there in October 2017 and I was pleasantly surprised that the therapists at TRISL were so eager to help me, so patient with me, and worked with me for 11 days until I became proficient at using my new leg. I enjoyed being with other patients with amputations, we encouraged and motivated each other during our therapy. I needed the intensity and frequency of the therapy as I had many years on crutches and I had to learn how to walk with a new leg. I followed up with TRISL again in 2018 for some outpatient therapy to refresh what I had learned and accomplished as an inpatient.

In southern Illinois we don't have the advanced level of inpatient rehabilitation therapy available like that of The Rehabilitation Institute of St. Louis. We have to travel great distances, through challenging traffic, and endure the inconvenience of driving all the way to St. Louis for care. It would be of great benefit to patients such as myself and many others if this level of expertise in rehabilitation was east of the river in Southern Illinois.

I do hope you will seriously consider the approval of a Certificate of Need to The Rehabilitation Institute of Southern Illinois, LLC to build an acute inpatient rehab hospital in St. Claire County. It would provide a much needed service to patients like me, as well as to many other citizens in our community.

Sincerely yours,

Donna Hackstadt

Donna Hackstadt
Former patient of The Rehabilitation Institute of St. Louis

Washington University in St. Louis
SCHOOL OF MEDICINE

Grant V. Bochicchio, M.D., M.P.H., F.A.C.S.
Harry Edison Professor of Surgery
Chief, Section of Acute and Critical Care Surgery
Trauma, Acute Care/Emergency Surgery
Surgical Critical Care & Advanced Wound Management

May 14, 2019

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

Re: The Rehabilitation Institute of Southern Illinois, LLC's Proposal to Establish a 40-bed Comprehensive Physical Rehabilitation Hospital in St. Clair County, HSA11

Dear Ms. Avery,

I am a Board-certified General Surgeon and Medical Director of the Level I Trauma Services with the Barnes-Jewish Hospital in St. Louis Missouri. The focus of my practice is dedicated to trauma, emergency surgery, minimally invasive surgery, liver surgery, hepatobiliary surgery, and surgical critical care. As such I encounter countless numbers of patients who have survived life threatening traumatic events who require intensive post-acute rehabilitation in a comprehensive inpatient rehabilitation hospital. Inpatient rehab hospitals provide the advanced care and therapeutic technologies by physical, occupational, and speech therapists and rehabilitation trained physicians and nurses.

So many of our patients come to us from Southern Illinois. After having endured the fear and pain of their initial traumatic event they are anxious to get home and return to as normal, productive life as possible. Being near the familiarity of their community, family and friends is critically important for their emotional and physical well-being. Inclusion of the patient's family and friends in the post-acute rehabilitation therapy is important as they often become the extension of care once the patient goes home. The trauma patients who come to us from HSA11 (St. Claire, Clinton, Madison, and Monroe Counties in Southern Illinois) deserve to have inpatient rehabilitation hospital care in their home community so they have a chance for optimal recovery and return to activities of daily living. The same is true for patients from surrounding Southern Illinois counties as well.

Washington University School of Medicine, 660 South Euclid Avenue, Box 8109, St. Louis, Missouri 63110
Phone (314) 362-9347 Fax: (314) 362-5743

For example, in CY17, our Trauma Service cared for 227 patients from HSA11 who come through our ED and then were admitted for care. Virtually all of these patients would have benefitted from advanced medical care and rehabilitation that can only be provided in a comprehensive inpatient rehabilitation hospital like The Rehabilitation Institute of St. Louis. However, many patients unfortunately go to a lower level of care (such as a skilled nursing facility or home health) just to be close to home. Thus, those patients' rehabilitation journey is longer and perhaps not as effective.

If the proposed inpatient rehabilitation hospital is approved, we anticipate that all of our trauma patients from Southern Illinois would choose to receive the needed intensive inpatient rehab care closer to home, which means we expect to discharge more than 200 patients annually from our hospital to the new hospital in Shiloh rather than to a St. Louis, Missouri-based facility, or to a less intensive service such as SNF or home health.

For these reasons, I highly support and recommend the approval of this CON request to build a comprehensive inpatient rehabilitation hospital (The Rehabilitation Institute of Southern Illinois) in St. Claire County, Illinois to better serve the residents of that community.

Sincerely,

Grant V. Bochicchio, MD, MPH, FACS
Harry Edison Professor of Surgery
Chief, Section of Acute & Critical Care Surgery

Washington University School of Medicine, 660 South Euclid Avenue, Box 8109, St. Louis, Missouri 63110
Phone (314) 362-9347 Fax: (314) 362-5743

Washington University in St. Louis
SCHOOL OF MEDICINE

Department of Neurological Surgery

Ralph G. Dacey, Jr., M.D., FACS, FRCSI (Hon)
Henry G. and Edith R. Schwartz Professor and Chairman of Neurological Surgery
Neurosurgeon-in-Chief, Barnes-Jewish Hospital

May 7, 2019

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

Re: The Rehabilitation Institute of Southern Illinois, LLC's Proposal to Establish a 40-bed Comprehensive Physical Rehabilitation Hospital in St. Clair County, HSA11

Dear Ms. Avery,

I am a board certified neurosurgeon serving as the Chair of Neurosurgery Department at Washington University School of Medicine and Neurosurgeon-in-Chief at Barnes Jewish Hospital in St. Louis. I am writing today to express my interest and support for The Rehabilitation Institute of Southern Illinois, LLC's Certificate of Need request to build a 40-bed inpatient rehabilitation hospital in St. Claire County, Illinois. In my role as a practicing neurosurgeon I see the need on a daily basis for intensive inpatient rehabilitation for patients who have suffered a stroke, brain bleeds, cerebral tumors, and spinal cord tumors and injuries. These patients deserve this service close to home to not only have the opportunity to achieve the very best outcomes but also to maintain the very best quality of care.

In my role as the physician leader for neurosurgery my work goes beyond supervising our program. Our service is growing rapidly and implementing protocols, processes, quality metrics and cutting edge technology that ensures the best possible physicians are providing the best possible treatment options and outcomes for our patients. Inpatient rehabilitation is critically important for this population of patients. The availability of advanced technology, advanced education and training for the physicians, nurses, and therapists and evidence based rehabilitation medicine is paramount in the patient's road to optimal recovery and function.

Many of our patients live in Southern Illinois and travel great distances to receive their care at Barnes Jewish Hospital in St. Louis, Missouri. The patient's family and friends are challenged with visiting due

to the complexity of the drive to our hospital. It would be tremendously helpful for the patient and their family to receive their post-acute rehabilitation in the community that they live, so family or care-giver participation in therapy can be achieved easily.

Currently, we care for nearly 500 patients annually who live in Southern Illinois's HSA11, and for many more patients in other parts of Southern Illinois. The vast majority of our patients would benefit from inpatient rehab services. However, many of our patients choose to go closer to home, and therefore often end up going to a skilled nursing facility or home health care where the level of therapy isn't nearly as intensive or effective. If the proposed 40-bed rehab hospital in Shiloh is approved, I envision that over 150 patients per year could benefit from, and thus would receive inpatient rehabilitation in the proposed new hospital because it is closer to where they live.

The benefit of inpatient rehabilitation that is close, convenient for patients, families, and delivered by talented, trained clinicians that provide optimal outcomes and quality of life is so very important for the communities we serve. I urge you to support and grant approval for this CON application for The Rehabilitation Institute of Southern Illinois, LLC. Thank you.

Sincerely,

Ralph G. Dacey, Jr., M.D., FACS, FRCSI (Hon)
Henry G. and Edith R. Schwartz Professor and Chairman

RGD/js

BJC Medical Group

May 1, 2019

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

Re: The Rehabilitation Institute of Southern Illinois, LLC's CON for a 40-bed Comprehensive Physical Rehabilitation Hospital in St. Clair County, HSA11

Dear Ms. Avery,

I am writing to you requesting the Health Facilities and Services Review Board approve The Rehabilitation Institute of Southern Illinois, LLC's CON request to build a 40-bed Inpatient Rehabilitation Hospital in Shiloh, St. Clair County, HSA11.

I serve as medical director for the hospitalist service at Memorial Hospital in Belleville and Memorial Hospital East in Shiloh. My team of 20 of physicians and I care for approximately 70% of the admitted patients at Memorial Belleville and 100% of admitted patients at Memorial East. In my role as medical director of the hospitalist group, I've experienced countless stories of the excellent care provided to those we serve. I have firsthand knowledge of the need for the proposed 40-bed comprehensive physical rehabilitation ("CPR") hospital to be located in and serve residents of our communities.

As Hospitalists, we are the primary admitting physician for all of the hospitals' stroke and neurology patients. However, when time comes for the patient to be discharged, we have difficulty placing the patient in an inpatient rehab hospital because of the limited number of beds available and accessible in HSA11.

I understand here is documented need for additional beds in HSA11, which is consistent with my personal experience. The current gap results in less than optimal care for many HSA11 patients, who are either discharged to a lesser intensive setting such as SNF or home with home health care services, rather than the more appropriate inpatient rehab setting, forced to travel outside the state (typically into Missouri) for post-acute care best provided close to home with the support of loved ones or foregoing needed rehab care altogether. None of these choices result in optimal care. Thus, the proposed 40-bed new freestanding rehab hospital will address the current gap in care and meet the IFHSRB-identified need.

As a member of a busy Hospitalist group that cares for a significant number of patients each year, I expect the new hospital to provide a much-needed alternative close to patients' homes. Given the gap in care that exists in Southern Illinois between historical utilization and need, I expect the proposed project will have no adverse impact on any existing provider in HSA11, as there are more patients in need than can be served by the existing providers.
For example, from July 2017 through June 2018 we cared for 4,222 acute rehabilitation eligible patients at Memorial Belleville and Memorial East combined. Of those patients, we could potentially refer at least 8% or 338 patients to The Rehabilitation Institute of Southern Illinois for their post-acute inpatient rehabilitation.

We support and respectfully request approval of this CON for a 40-bed inpatient freestanding inpatient rehabilitation hospital. Thank you in advance for your consideration.

Sincerely yours,

Ahmad Rez, M.D.
Medical Director, BJCMG Hospitalist Service
Memorial Hospital Belleville and Memorial Hospital East

LINCOLN
SURGICAL
ASSOCIATES, LTD

May 2, 2019

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

Re: The Rehabilitation Institute of Southern Illinois, LLC's CON Application

Dear Ms. Avery:

I am writing to express my strong support for The Rehabilitation Institute of Southern Illinois, LLC's Certificate of Need application to build an acute comprehensive rehabilitation hospital in St. Clair County.

Part of my responsibility as Memorial Hospital East Medical Staff Vice President is to support the mission of the Medical Staff which includes credentialing and privileging, as well as quality assessment and improvement and governance with the goal of improving patient care delivery and clinical outcomes for those we serve. Clinical outcomes expected today are broad and go beyond the day patients are discharged from the hospital. We must assure every patient has a discharge plan of care to help reduce readmissions, complications, and infections as well as provide the best possible journey for their recovery.

Patients will benefit from an independent acute comprehensive rehabilitation hospital to serve St. Clair, Clinton, Madison, and Monroe Counties (HSA-11). The intensive physical, occupational, and speech therapies and the care specifically provided by rehab trained physicians and nurses result in lower lengths of stay, improved physical and cognitive functionality, and getting patients to activities of daily living more quickly. The increased probability of returning patients back to their home/community is far greater after having been cared for in an acute comprehensive rehabilitation hospital setting. Patient outcomes are better when they receive care close to home and can be supported by family and friends. Many of our patients require the advanced rehabilitative care that is currently limited in this area. As a result those patients choose a lower level of care such as a SNF or home health just so they can remain close to home. Patients today have to travel quite a distance to receive the necessary level of care for optimal outcomes, and for most patients and their families that simply isn't an option.

I urge you to approve the Certificate of Need for The Rehabilitation Institute of Southern Illinois to build a 40-bed free-standing acute comprehensive rehabilitation hospital in St. Clair County/Southern Illinois. It would fill a significant void in providing services to patients like those we see in our facility. Thank you for your consideration of this important request.

Sincerely,

Kevin Barnett, M.D.
Vice President, Memorial Hospital East Medical Staff

Memorial Hospital East
Medical Office Building
1414 Cross Street, Suite 330
Shiloh, IL 62269

618.277.7400 *phone*
618.398.9607 *after hours*
618.277.7422 *fax*

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BJC Medical Group

May 1, 2019

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

Re: The Rehabilitation Institute of Southern Illinois, LLC application to establish a 40-bed Comprehensive Physical Rehabilitation Hospital in St. Clair County, HSA11

Dear Ms. Avery,

I am writing to support for The Rehabilitation Institute of Southern Illinois, LLC's Certificate of Need application to build an acute comprehensive rehabilitation hospital and facility in St. Clair County. As an orthopedic surgeon on Memorial's Medical Staff, my colleagues and I treat many patients that I know could benefit from advanced medical and physical inpatient rehabilitation care.

The medical community of St. Clair County and surrounding area currently has a deficit of comprehensive rehabilitation services. Although there are skilled nursing facilities and outpatient physical therapy businesses in the area, these services are limited to transient and limited treatment of focused disorders such as strokes, lower extremity fractures, and other conditions in the elderly or are transitional way stations for those with sub-acute medical condition healing.

There is not a rehabilitation hospital in this community that has the advanced technologies and specifically rehabilitation trained physicians, nurses, physical, occupational and speech therapists to offer comprehensive and multidisciplinary rehabilitation modalities and services for those with medical conditions such as neurological disorders including stroke, cancer and spinal cord injury.

It is documented that access to a rehabilitation hospital such as this decreases acute care facility length of stay, facilitates physical and cognitive recovery and the end goal of return to the workforce and functional daily activities. I have had many patients in the past decade receive services at The Rehabilitation Institute of St. Louis. My first hand experiences with them are positive with patients consistently realizing their goals. Facility operations demonstrate experience and reliability. Unfortunately, many patients are unable to experience this level of expertise because the distance and driving into St. Louis can be challenging. Our community is growing as are the healthcare needs of the area. Memorial East in Shiloh and the under construction, Siteman Cancer Center there illustrates the demand for services in this area. The addition of this proposed rehabilitation institute will only enhance the growth and development of strong healthcare services in this region.

I ask serious consideration and approval a Certificate of Need to approve The Rehabilitation Institute of Southern Illinois, LLC for an independent acute comprehensive rehab hospital in St. Clair County. It would provide an important and needed service to patients and their families in the local and surrounding communities.

Sincerely yours,

Kevin Baumer

Kevin Baumer, M.D.

Orthopedic Section Head

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KALVIN L. WHITE, D.O.

May 2, 2019

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

Re: The Rehabilitation Institute of Southern Illinois, LLC's CON Application

Dear Ms. Avery:

I am writing to express my strong support for The Rehabilitation Institute of Southern Illinois, LLC's Certificate of Need application to build an acute comprehensive rehabilitation hospital in St. Clair County.

Part of my responsibility as Memorial Hospital Belleville Medical Staff President is to support the mission of the Medical Staff which includes credentialing and privileging, as well as quality assessment and improvement and governance with the goal of improving patient care delivery and clinical outcomes for those we serve. Clinical outcomes expected today are broad and go beyond the day patients are discharged from the hospital. We must assure every patient has a discharge plan of care to help reduce readmissions, complications, and infections as well as provide the best possible journey for their recovery.

Patients will benefit from an independent acute comprehensive rehabilitation hospital to serve St. Clair, Clinton, Madison, and Monroe Counties (HSA-11). The intensive physical, occupational, and speech therapies and the care specifically provided by rehab trained physicians and nurses result in lower lengths of stay, improved physical and cognitive functionality, and getting patients to activities of daily living more quickly. The increased probability of returning patients back to their home/community is far greater after having been cared for in an acute comprehensive rehabilitation hospital setting. Patient outcomes are better when they receive care close to home and can be supported by family and friends. Many of our patients require the advanced rehabilitative care that is currently limited in this area. As a result those patients choose a lower level of care such as a SNF or home health just so they can remain close to home. Patients today have to travel quite a distance to receive the necessary level of care for optimal outcomes, and for most patients and their families that simply isn't an option.

I urge you to approve the Certificate of Need for The Rehabilitation Institute of Southern Illinois to build a 40-bed free-standing acute comprehensive rehabilitation hospital in St. Clair County/Southern Illinois. It would fill a significant void in providing services to patients like those we see in our facility. Thank you for your consideration of this important request.

Sincerely,

Randy Feeman, MD
President, Memorial Hospital Belleville Medical Staff

Attachment 19
Page 4g

TEAMHealth.

May 1, 2019

Emergency Medicine, West Group
www.teamhealth.com

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

Re: The Rehabilitation Institute of Southern Illinois, LLC's CON Application

Dear Ms. Avery,

I am writing this letter of support on behalf of Memorial Hospital Belleville and Memorial Hospital East Emergency Services. As the Emergency Services Medical Director for both Memorial Belleville and Memorial East, I am responsible for overall management of our physicians and allied health providers as well as oversight of the patient care delivery, including patient safety and clinical protocols. We are the front door for the vast majority of patients admitted to our hospitals including those who return for services, may be readmitted for post discharge complications or those who were perhaps not ready or prepared to be discharged home. It is this population of patients that would greatly benefit from inpatient rehabilitative medical care and therapy to help them achieve much higher physical and cognitive function and readiness before going home.

Over the years, patients have come to the emergency department who are extremely debilitated. They may have suffered a stroke, have increased episodes of falling, increasing weakness or loss of cognitive functioning. Once we evaluate them and determine their course of treatment, the patient often doesn't meet criteria for acute care hospital admission but does meet criteria for and would benefit from acute inpatient rehabilitation.

As most of these patients are elderly, with limited resources, they want to remain within their community for care. It prevents their loved ones from participating in their rehab due to the distance and traffic they would have to navigate. By allowing The Rehabilitation Institute of Southern Illinois to build a new 40-bed inpatient rehabilitation hospital, pain and suffering – physical, emotional, financial for the patient and their family will be minimized or alleviated.

The new inpatient rehabilitation hospital will enable us to be more efficient with limited resources. By offering the right care, at the right place, and the right time, for the right cost, we can help patients avoid additional hospital stays and increased healthcare costs. With the current landscape, it is difficult to get a patient to a rehabilitation hospital within the Metro East area. Being able to have these patients quickly transferred to the level of care that they need also helps our community, freeing up emergency department and hospital inpatient beds for others who need care.

It is for all of these reasons, most importantly achieving optimum patient outcomes and satisfaction, that I strongly urge you and the Health Facilities and Services Review Board in Illinois to approve The Rehabilitation Institute of Southern Illinois LLC's Certificate of Need request.

Sincerely yours,

Ketan Patel, MD

Ketan Patel, M.D.
Medical Director Emergency Services
Chair, Department of Emergency Medicine

Attachment 19
Page 4h

Rehab-Appropriate Discharges by ZIP Code, HSA11 July 2017 – June 2018	
Resident ZIP Code	**Rehab-Appropriate Discharges**
62001 - ALHAMBRA	66
62002 - ALTON	1,374
62010 - BETHALTO	410
62018 - COTTAGE HILLS	157
62021 - DORSEY	36
62024 - EAST ALTON	423
62025 - EDWARDSVILLE	863
62026 - EDWARDSVILLE	2
62034 - GLEN CARBON	435
62035 - GODFREY	702
62040 - GRANITE CITY	1,901
62046 - HAMEL	27
62048 - HARTFORD	57
62058 - LIVINGSTON	35
62059 - LOVEJOY	20
62060 - MADISON	199
62061 - MARINE	67
62062 - MARYVILLE	235
62067 - MORO	72
62074 - NEW DOUGLAS	45
62084 - ROXANA	73
62087 - SOUTH ROXANA	66
62090 - VENICE	48
62095 - WOOD RIVER	477
62097 - WORDEN	114
62201 - EAST SAINT LOUIS	246
62202 -	7
62203 - EAST SAINT LOUIS	355
62204 - EAST SAINT LOUIS	320
62205 - EAST SAINT LOUIS	442
62206 - EAST SAINT LOUIS	553
62207 - EAST SAINT LOUIS	302
62208 - FAIRVIEW HEIGHTS	614
62215 - ALBERS	54
62216 - AVISTON	79
62218 - BARTELSO	49

Comprehensive Physical Rehabilitation Service Specific Criteria
The Rehabilitation Institute of Southern Illinois, LLC

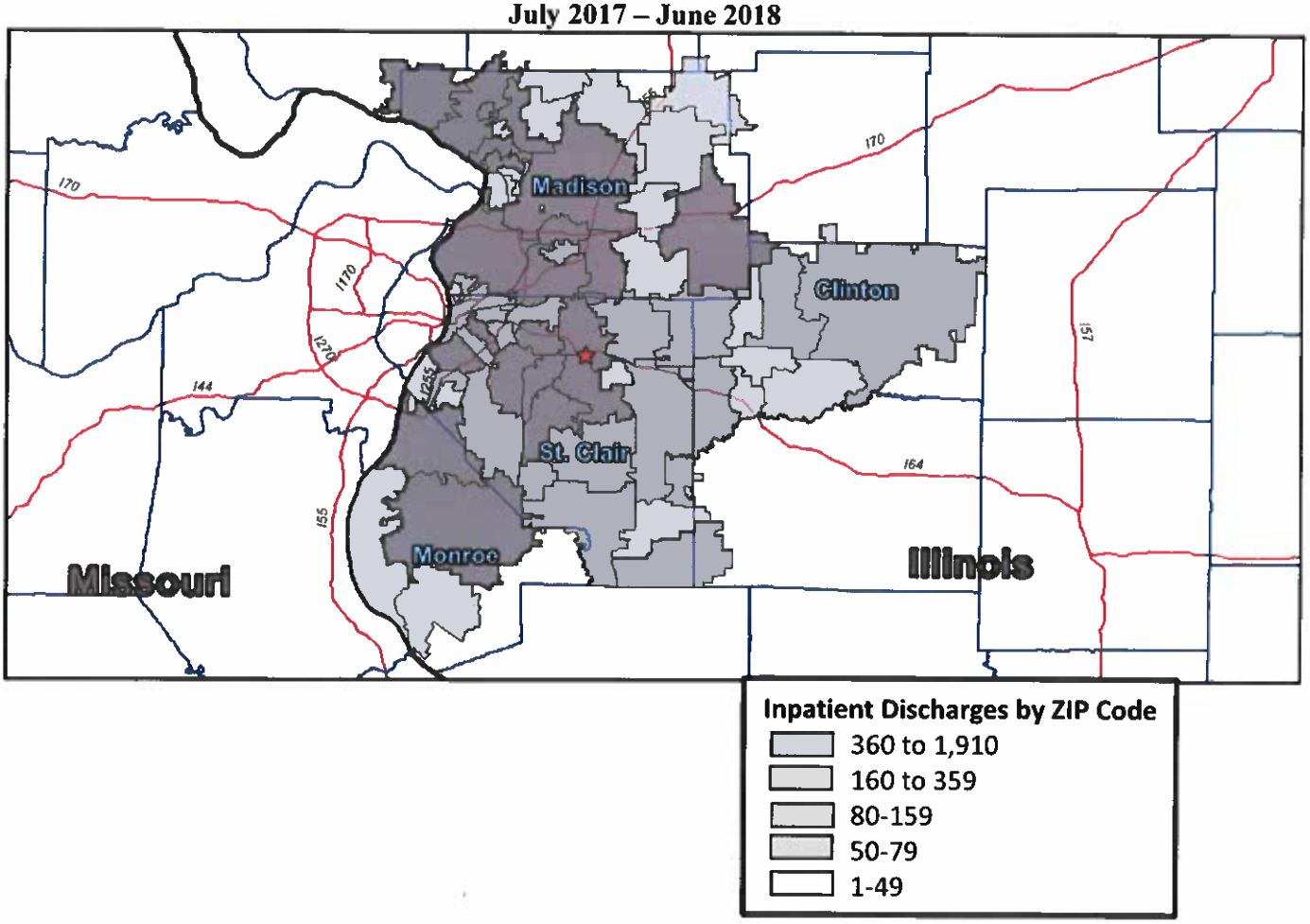
Rehab-Appropriate Discharges by ZIP Code, HSA11 July 2017 – June 2018	
Resident ZIP Code	**Rehab-Appropriate Discharges**
62219 -	34
62220 - BELLEVILLE	711
62221 - BELLEVILLE	900
62222 -	17
62223 - BELLEVILLE	680
62225 - SCOTT AIR FORCE BASE	40
62226 - BELLEVILLE	1,174
62230 - BREESE	212
62231 - CARLYLE	274
62232 - CASEYVILLE	324
62234 - COLLINSVILLE	1,141
62236 - COLUMBIA	433
62239 - DUPO	204
62240 - EAST CARONDELET	76
62243 - FREEBURG	198
62244 - FULTS	28
62245 - GERMANTOWN	49
62248 - HECKER	18
62249 - HIGHLAND	515
62250 -	16
62252 -	1
62254 - LEBANON	227
62255 - LENZBURG	37
62256 -	8
62257 - MARISSA	135
62258 - MASCOUTAH	267
62260 - MILLSTADT	285
62264 - NEW ATHENS	142
62265 - NEW BADEN	171
62266 -	8
62269 - O FALLON	1,044
62279 -	2
62281 - SAINT JACOB	75
62282 - SAINT LIBORY	20
62285 - SMITHTON	134
62289 - SUMMERFIELD	20
62293 - TRENTON	156

Comprehensive Physical Rehabilitation Service Specific Criteria
The Rehabilitation Institute of Southern Illinois, LLC

Rehab-Appropriate Discharges by ZIP Code, HSA11 July 2017 – June 2018	
Resident ZIP Code	**Rehab-Appropriate Discharges**
62294 - TROY	413
62295 - VALMEYER	42
62298 - WATERLOO	639
Total	**21,795**
Source: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database.	

The following map shows the distribution of rehab-appropriate general acute care discharges by ZIP Code for HSA11 residents. (The darker the color, the more rehab-appropriate discharges.)

HSA11 Rehab-Appropriate General Acute Care Discharges by ZIP Code July 2017 – June 2018



5) Service Accessibility

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

A) Service Restrictions

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

- **i) The absence of the proposed service within the planning area;**
- **ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;**
- **iii) Restrictive admission policies of existing providers;**
- **iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;**
- **v) For purposes of this subsection (b)(5) only, all services within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.**

B) Supporting Documentation

The applicant shall provide the following documentation, as applicable, concerning existing restrictions to service access:

- **i) The location and utilization of other planning area service providers;**
- **ii) Patient location information by zip code;**
- **iii) Independent time-travel studies;**
- **iv) A certification of waiting times;**
- **v) Scheduling or admission restrictions that exist in area providers;**
- **vi) An assessment of area population characteristics that document that access problems exist; and**
- **vii) Most recently published IDPH Hospital Questionnaire.**

The Rehab Institute of Southern Illinois, LLC is being proposed to improve access to needed Rehab services for planning area residents. HFSRB has identified an existing gap in care for HSA11 residents by quantifying a need for seven (7) additional beds based solely on HSA11 hospitals' patient days and projected population. Thus, patients who are currently traveling out-of-state to receive needed Rehab care are excluded from that calculated need, as are patients who are currently either discharged to a lesser intensive setting such as skilled nursing facility or home with home health care services, or are foregoing needed rehab care altogether.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Rehabilitation Institute of Southern Illinois, LLC

The response to Purpose of the Project (Attachment 12) provides much detail and supporting documentation regarding the area population's characteristics documenting that access problems exist for patients in need of Rehab services. As previously shown:

- The vast majority (72.2%) of HSA11 residents who currently receive Rehab inpatient care receive that care out-of-state (in a Missouri hospital). (*See* Table 6, Attachment 12.)

- For HSA11 patients remaining in an Illinois hospital for general acute care services that are appropriate for rehab care upon discharge, only 2.2% of those patients received Rehab care compared to 8.0% of HSA11 patients who were discharged from a general acute care hospital in Missouri.

- Conversely, approximately 17% of HSA11 residents with a diagnosis appropriate for rehab care were discharged to SNF while only 11% of HSA11 patients discharged from a Missouri hospital were referred to SNF.

- The above statistics are supported by the physician letters attesting to the need for the proposed project, and their intention to refer patients to the new Rehab hospital.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Rehabilitation Institute of Southern Illinois, LLC

c) Unnecessary Duplication/Maldistribution – Review Criterion

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

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

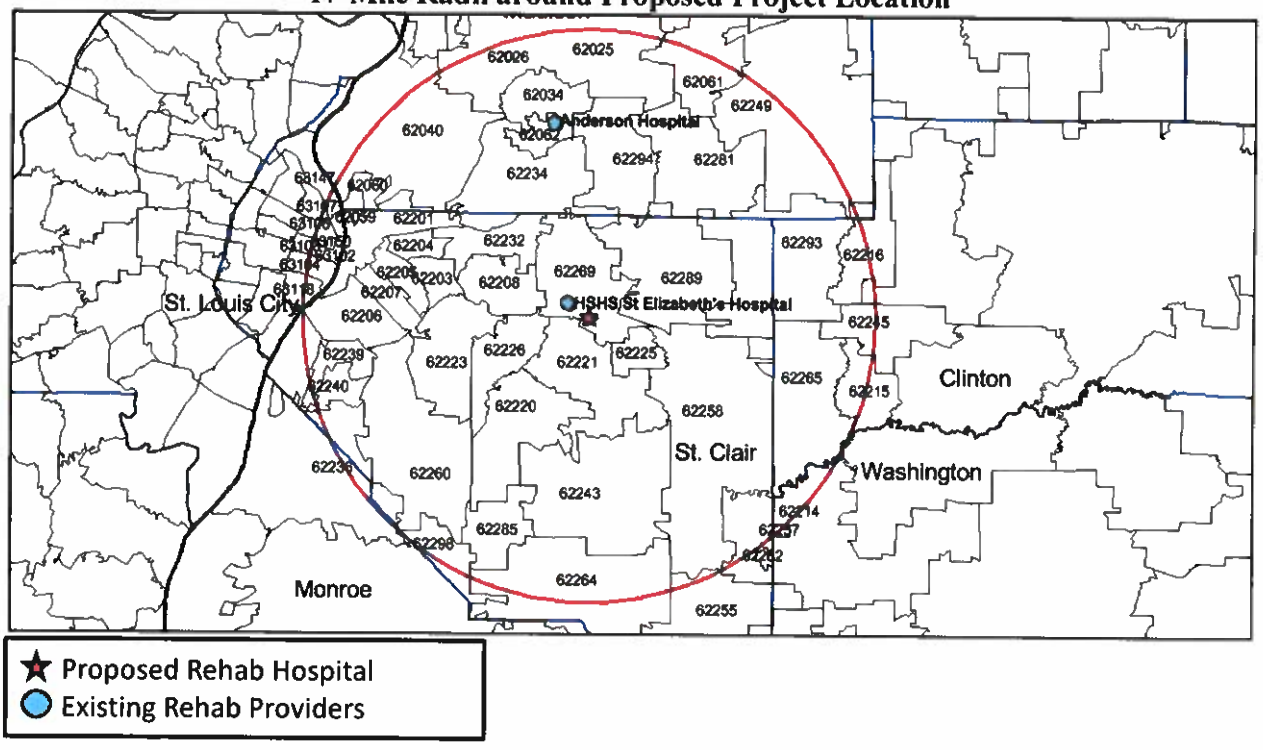
B) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and

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

The proposed project will not result in an unnecessary duplication of services because it is responsive to the HFSRB-identified need and to provide locally accessible and available services for HSA11 residents currently traveling out-of-state for care.

The following ZIP Code map shows the proposed new hospital in relation to the existing Rehab providers within the 17 mile radius. Two general acute care hospitals in the 17-mile radius provide Rehab services: Anderson Hospital (20-bed unit) and St. Elizabeth's – O'Fallon (16-bed unit).

17-Mile Radii around Proposed Project Location



Attachment 19
Page 10

ZIP Codes within 17-Mile Radius of Proposed Rehab Hospital Site					
ZIP Code	**State**	**County**	**City**	**2019 Total Population**	**2024 Total Population**
62025	IL	Madison	Edwardsville	34,489	34,929
62034	IL	Madison	Glen Carbon	14,528	14,794
62040	IL	Madison	Granite City	40,744	39,821
62059	IL	St. Clair	Lovejoy	760	778
62060	IL	Madison	Madison	4,601	4,482
62061	IL	Madison	Marine	1,590	1,580
62062	IL	Madison	Maryville	8,303	8,562
62201	IL	St. Clair	East Saint Louis	6,993	6,801
62203	IL	St. Clair	East Saint Louis	7,153	6,830
62204	IL	St. Clair	East Saint Louis	6,970	6,667
62205	IL	St. Clair	East Saint Louis	8,285	8,004
62206	IL	St. Clair	East Saint Louis	14,132	13,426
62207	IL	St. Clair	East Saint Louis	7,863	7,543
62208	IL	St. Clair	Fairview Heights	17,797	17,612
62214	IL	Washington	Addieville	1,035	1,006
62215	IL	Clinton	Albers	1,771	1,744
62216	IL	Clinton	Aviston	2,708	2,774
62220	IL	St. Clair	Belleville	18,559	18,108
62221	IL	St. Clair	Belleville	27,189	27,198
62223	IL	St. Clair	Belleville	16,181	15,736
62225	IL	St. Clair	Scott AF Base	5,728	5,879
62226	IL	St. Clair	Belleville	29,123	28,803
62232	IL	St. Clair	Caseyville	7,021	6,962
62234	IL	Madison	Collinsville	32,395	32,053
62236	IL	Monroe	Columbia	13,529	13,887
62239	IL	St. Clair	Dupo	4,654	4,526
62240	IL	St. Clair	East Carondelet	1,791	1,750
62243	IL	St. Clair	Freeburg	5,776	5,730
62245	IL	Clinton	Germantown	1,855	1,834
62249	IL	Madison	Highland	16,579	16,764
62257	IL	St. Clair	Marissa	2,689	2,582
62258	IL	St. Clair	Mascoutah	9,726	9,874
62260	IL	St. Clair	Millstadt	7,167	7,105
62264	IL	St. Clair	New Athens	3,175	3,123
62265	IL	Clinton	New Baden	4,522	4,518
62269	IL	St. Clair	O Fallon	33,455	34,073
62281	IL	Madison	Saint Jacob	2,710	2,823
62285	IL	St. Clair	Smithton	4,719	4,791

Comprehensive Physical Rehabilitation Service Specific Criteria
The Rehabilitation Institute of Southern Illinois, LLC

ZIP Codes within 17-Mile Radius of Proposed Rehab Hospital Site					
ZIP Code	**State**	**County**	**City**	**2019 Total Population**	**2024 Total Population**
62289	IL	St. Clair	Summerfield	376	367
62293	IL	Clinton	Trenton	4,568	4,578
62294	IL	Madison	Troy	15,016	15,467
62298	IL	Monroe	Waterloo	17,365	17,758
63102	MO	St. Louis City	St. Louis	2,309	2,411
63103	MO	St. Louis City	St. Louis	8,513	8,773
63104	MO	St. Louis City	St. Louis	18,663	18,513
63106	MO	St. Louis City	St. Louis	11,313	11,267
63107	MO	St. Louis City	St. Louis	11,016	10,675
63118	MO	St. Louis City	St. Louis	25,356	24,803
63147	MO	St. Louis City	St. Louis	10,333	9,994
Total				**553,093**	**550,078**

Source: Environics Analytics (EA) ©Claritas, LLC 2019.
Notes: includes ZIP Codes with resident population. Total population for the ZIP Code, whether in whole or in part included with the 17-mile radius, included in the population estimate.

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

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

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

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

The proposed project will not result in maldistribution of services. In fact, following the opening of the proposed 40-bed Rehab, the HSA11 beds per 1,000 population for ages 65+ will fortunately increase to a level closer to, but still below, the statewide average, as shown below.

Beds per 1,000 Population Ages 65+		
Geographic Region	**2019 (Current)**	**2024 (With 40 New Beds)**
HSA11	0.358	0.656
Statewide	0.753	0.668

Sources: Inventory of Health Care Facilities and Services and Need Determinations, HFSRB 9/1/2017 and 3/11/2019 Update; MUR Report, 2018 Hospital Industry Data Institute; and Illinois Department of Public Health Certificate of Need Population Projections, 2014.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

Absent the addition of beds, HSA11 residents will continue to either forego needed Rehab services altogether or, alternatively, travel outside the state for care, neither of which are viable options for patients in a community with an increasing population ages 65+. As such, the proposed project will not redirect or serve patients currently served by either Anderson Hospital or St. Elizabeth's – O'Fallon. Thus, the proposed project will have no impact on either hospital's occupancy.

e) Staffing

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

BJC and Encompass Health both have in place numerous innovative approaches to recruit and retain staff members at their hospital facilities, thus The Rehab Institute does not anticipate having difficulty hiring the necessary resources for the proposed project. In fact, a distinct advantage that the proposed project has in terms of recruitment is the level of professional engagement, challenge, and satisfaction employees have working with other professionals across disciplines. Moreover, because of the significant resources of BJC and Encompass to recruit nationally, the proposed project will have no material impact on existing health care providers in the service area.

The following information details the ability of Encompass, as a rehab-centric organization, to recruit needed staff for the proposed project.

The three primary components of Encompass' employee recruitment and retention strategy are described below, and include:

- Competitive Compensation and Benefits
- National Recruitment Strategy
- Relationships with Local Universities and Colleges

Competitive Compensation and Benefits
Encompass Health offers competitive packages that include a range of benefits including medical and dental insurance coverage, generous paid time off (PTO) plans, health savings accounts (HSAs), 401K savings and investment programs, basic term life and optional group term life insurance, disability insurance, an employee stock benefit plan and tuition reimbursement as well as a scholarship program. Encompass Health also offers employee health nurse services and employee wellness activities focused on maintaining the health and wellness of the entire Encompass Health team.

To retain staff, Encompass Health provides benefits such as continuing education including in-person courses, live webinars as well as web-based education and online instruction modules. Encompass provides clinical career ladders for therapists, nurses, and staff. Continuing education funds are also allocated to support additional educational opportunities for clinical staff. Encompass Health also offers reimbursement for professional licenses and national professional association membership dues. For example, Encompass supports rehab nurses in attaining their Certified Rehabilitation Registered Nurse (CRRN) certification through additional training materials and financial incentives upon completion of the certification. It is Encompass' stated goal to increase the number of nurses with CRRN certification, which ultimately improves clinical outcomes, patient satisfaction, and employee engagement and satisfaction.

Employee recognition and development activities and opportunities include employee celebration activities, employee family social activities, employee of the quarter/year recognition, quarterly town hall meetings, departmental recognition programs, career ladders for select positions, employee activities committees, employee suggestion committees, management development programs and mentoring programs.

National Recruitment Strategy
Encompass Health has a dedicated recruitment team that utilizes various avenues to ensure job positions are marketed to the right individuals. One way that is achieved is through partnerships with national associations including, for example:

- American Physical Therapy Association Combined Sections Meeting (APTA CSM)
- Annual APTA events
- APTA National Student Conclave
- American Occupational Therapy Association (AOTA)
- AOTA National Student Conclave
- Association of Rehabilitation Nurses (ARN)
- American Speech-Language-Hearing Association (ASHA)
- American Academy of Physical Medicine and Rehabilitation (AAPM&R)
- National Black Nurses Association
- National Hispanic Nurses Association

Additionally, Encompass leverages automated software to purchase, place, and optimize job searches throughout top media sources including various websites such as Indeed, Glassdoor, LinkUp, ZipRecruiter, Monster, SimplyHired, CollegeRecruiter, StartWire, and Jobs2Careers. Positions are also posted on EncompassHealth.com (search engine optimized), as well as Nexxt.com, indeed.com, linkedin.com, APTA, AOTA and CareerBuilder. Job positions are also posted on social media, utilizing Facebook, Twitter and LinkedIn.

Relationships with Local Universities and Colleges
Encompass develops relationships/training programs with local universities and colleges, community colleges and other training agencies to create and support a nation-wide workforce. With over 600 affiliation agreements throughout the nation with universities and schools for allied health professionals, prospective employees become acquainted with Encompass Health and existing hospitals become familiar with the skills they possess (enabling future recruitment capabilities once operational).

In addition, Encompass continually invests in the future pipeline of top talent by investing in the relationships with local schools through lunch-n-learns, resume workshops and participation in career fair events.

f) Performance Requirements – Bed Capacity Minimums

1) The minimum freestanding facility size for comprehensive physical rehabilitation is a minimum facility capacity of 100 beds.

2) The minimum hospital unit size for comprehensive physical rehabilitation is 16 beds.

The Applicant proposes to construct a 40-bed freestanding Rehab hospital in order to meet the planning area needs, as documented elsewhere in this application.

g) Assurances

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

Please see the following page for a letter from the Rehab Institute representative regarding the projected utilization of the proposed project. As shown, the new facility is expected to reach and maintain the occupancy standard in CON Project Year 2.

The Rehabilitation Institute of Southern Illinois, LLC
2001 Frank Scott Parkway East
Shiloh, IL 62269

May 6, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

RE: Criterion 1110.205(g), Assurances

Dear Ms. Avery:

As representative of The Rehabilitation Institute of Southern Illinois, LLC, I, Walter Smith, attest to the Applicant's ability to achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for comprehensive physical medicine services by the second year of operation after the project completion.

Sincerely,

Walter Smith
Director, State Regulatory Affairs
Encompass Health Corporation
Authorized Representative

Subscribed and Sworn to before me this 6th day of May, 2019.

Notary Public

LISA CORNETT GOLDEN
MY COMMISSION EXPIRES
OCTOBER 31, 2022
NOTARY PUBLIC
STATE OF ALABAMA

Attachment 19

Availability of Funds
The Rehabilitation Institute of Southern Illinois, LLC

The total estimated project cost is $30,998,250. The Applicant/Licensee will fund the project through cash and cash equivalents obtained from Encompass Health and Metro East Services, the 50/50 joint venture partners.

BJC HealthCare (ultimate parent to Metro East) has sufficient internal resources to fund its share of project costs and necessary working capital as demonstrated in its letter of proof of project funding and its most recent audited financial statements, which follow.

In 2018, Encompass Health Corporation's operating activities generated $762 Million and as of the end of 2018, the company had $69 Million of unrestricted cash on its balance sheet. In addition, Encompass Health Corporation has at its discretion a $700 Million Revolving Credit Facility, of which approximately $633 Million was available as of February 28, 2019. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed project. In addition to the commitment for this project, Encompass Health Corporation is also committed to providing the necessary working capital for this proposed project. Encompass Health Corporation has sufficient resources to fully fund these expenditures in addition to its other ongoing obligations.

Please see the following letters confirming proof of project funding and most recent audited financial statements for BJC HealthCare and Encompass Health.

Encompass Health

9001 Liberty Parkway
Birmingham, AL 35242

encompasshealth.com

May 13, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: The Rehabilitation Institute of Southern Illinois, LLC
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.120(a) Available Funds Certification
Criterion 1120.140A. Reasonableness of Financing Arrangements

Dear Ms. Avery:

In accordance with the verification requirements of 735 ILCS 5/1-109 of the Illinois Code of Civil Procedure, I hereby certify under the penalty of perjury the following:

1. The Rehabilitation Institute of Southern Illinois, LLC Project costs will be funded with $30,998,250, of which Encompass Health Corporation, an Applicant, will fund up to 50% of the Project, in the amount of $15,499,125 from internal cash resources including cash and equivalents and/or available line of credit facilities.

2. Encompass Health, an Applicant, will fund up to 50% of the Project's necessary working capital and operating deficits through the first full fiscal year when the project achieves the target utilization of 85% of average annual occupancy.

3. Encompass Health, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. In 2018, Encompass Health Corporation's operating activities generated $762 Million and as of the end of 2018, the company had $69 Million of unrestricted cash on its balance sheet. In addition, Encompass Health Corporation has at its discretion a $700 Million Revolving Credit Facility, of which approximately $621 Million was available as of February 28, 2019. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed Project. We have sufficient resources to fully fund these expenditures in addition to our other ongoing obligations.

This letter shall also serve as a confirmation of our analysis of the funding options for this Project. Funding the Project through cash and securities is the lowest cost option.

I hereby certify this is true and based upon my personal knowledge and under the penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely yours,

Jennifer Solomon
Director, Corporate Treasury
Encompass Health Corporation

Subscribed and Sworn before to me this 13th day of May, 2019.

Notary Public

[Seal]

Attachment 33

BJC HealthCare

May 13, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: The Rehabilitation Institute of Southern Illinois, LLC
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.120(a) Available Funds Certification
Criterion 1120.140A. Reasonableness of Financing Arrangements

Dear Ms. Avery:

In accordance with the verification requirements of 735 ILCS 5/1-109 of the Illinois Code of Civil Procedure, I hereby certify under the penalty of perjury the following:

1. BJC HealthCare, an Applicant, will fund up to 50% of The Rehabilitation Institute of Southern Illinois, LLC Project costs, up to the amount of $15,499,125, from internal cash resources including cash and equivalents and/or unrestricted board-designated investments.

2. BJC HealthCare, an Applicant, will fund up to 50% of the Project's necessary working capital and operating deficits through the first full fiscal year when the project achieves the target utilization of 85% of average annual occupancy.

3. BJC HealthCare, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. As of December 31, 2018, BJC HealthCare had $4,151.3 Million of cash, cash equivalents, and unrestricted board-designated investments on its balance sheet. These amounts offer more than adequate internal resource funds for the proposed Project costs and necessary working capital.

This letter shall also serve as a confirmation of our analysis of the funding options for this Project. Funding the Project through cash and securities is the lowest cost option.

BJC HealthCare

I hereby certify this is true and based upon my personal knowledge and under the penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely yours,

Christy Moore
Vice President

Sworn and subscribed to before me this 4th day of May, 2019.

Signature of Notary

[Seal]

NOTARY PUBLIC NOTARY SEAL STATE OF MISSOURI

DAPHNE L. WILCUT
My Commission Expires
February 21, 2023
St. Louis City
Commission #15146250

CONSOLIDATED FINANCIAL STATEMENTS

BJC HealthCare
Years Ended December 31, 2018 and 2017
With Report of Independent Auditors

Ernst & Young LLP

Attachment 33

BJC HealthCare

Consolidated Financial Statements

Years Ended December 31, 2018 and 2017

Contents

Attachment 33

Ernst & Young LLP
The Plaza in Clayton
Suite 1300
190 Carondelet Plaza
St. Louis, MO 63105-3434

Tel: +1 314 290 1000
Fax: +1 314 290 1882
ey.com

Report of Independent Auditors

The Board of Directors
BJC HealthCare

We have audited the accompanying consolidated financial statements of BJC HealthCare (BJC), which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Building a better working world

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of BJC HealthCare at December 31, 2018 and 2017, and the consolidated results of its operations and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Adoption of ASU No. 2014-09, "Revenue from Contracts with Customers"

As discussed in Note 1 to the consolidated financial statements, BJC changed its method for recognizing revenue as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2014-09, "Revenue from Contracts with Customers," effective January 1, 2018. Our opinion is not modified with respect to this matter.

Ernst + Young LLP

March 8, 2019

BJC HealthCare

Consolidated Balance Sheets
(Dollars in Millions)

	December 31 2018	2017
Assets		
Current assets:		
Cash and cash equivalents	$ 52.8	$ 58.8
Accounts receivable:		
Patients	786.4	721.0
Other	88.2	82.9
Other current assets	228.3	214.2
Total current assets	1,155.7	1,076.9
Investments	5,573.3	5,552.7
Property and equipment, net	3,186.1	3,130.2
Other noncurrent assets	236.9	261.5
Total assets	$ 10,152.0	$ 10,021.3
Liabilities and net assets		
Current liabilities:		
Current maturities of long-term debt	$ 22.5	$ 7.7
Long-term debt puttable within one year or subject to self-liquidity	350.3	429.1
Other current liabilities	994.1	907.1
Total current liabilities	1,366.9	1,343.9
Noncurrent liabilities:		
Long-term debt	1,696.1	1,640.7
Self-insurance liabilities	161.4	165.7
Pension/postretirement liabilities	377.8	553.6
Other noncurrent liabilities	345.1	381.1
Total noncurrent liabilities	2,580.4	2,741.1
Total liabilities	3,947.3	4,085.0
Net assets:		
Without donor restrictions	5,683.7	5,391.7
Noncontrolling interest in subsidiary	–	18.9
Total without donor restrictions	5,683.7	5,410.6
With donor restrictions	521.0	525.7
Total net assets	6,204.7	5,936.3
Total liabilities and net assets	$ 10,152.0	$ 10,021.3

See accompanying notes.

BJC HealthCare

Consolidated Statements of Operations and Changes in Net Assets
(Dollars in Millions)

	Year Ended December 31	
	2018	**2017**
Revenues without donor restrictions:		
Patient service revenue	**$ 5,094.3**	$ 4,799.2
Other operating revenue	**232.6**	193.9
Total revenues without donor restrictions	**5,326.9**	4,993.1
Expenses:		
Salaries and benefits	**2,529.5**	2,360.7
Supplies and other	**2,319.9**	2,119.6
Depreciation and amortization	**358.8**	320.0
Interest	**59.3**	38.5
Total expenses	**5,267.5**	4,838.8
Operating income	**59.4**	154.3
Investment earnings, net	**54.7**	471.6
Unrealized gains on interest rate swap contracts, net	**27.0**	11.6
Other nonoperating expense, net	**(35.2)**	(221.8)
Excess of revenues over expenses	**105.9**	415.7
Net loss attributable to noncontrolling interest	**–**	(15.6)
Excess of revenues over expenses attributable to BJC HealthCare	**$ 105.9**	$ 431.3

BJC HealthCare

Consolidated Statements of Operations and Changes in Net Assets (continued)

(Dollars in Millions)

	December 31, 2018			December 31, 2017		
	Total	Controlling	Noncontrolling	Total	Controlling	Noncontrolling
Net assets without donor restrictions:						
Excess (deficit) of revenues over expenses	$ 105.9	$ 105.9	$ –	$ 415.7	$ 431.3	$ (15.6)
Pension and other postretirement liability adjustment	165.3	165.3	–	(184.3)	(184.3)	–
Value of noncontrolling interest in net assets of acquired entity	–	18.9	(18.9)	–	–	–
Net assets released for property acquisitions	1.9	1.9	–	2.1	2.1	–
Increase (decrease) in net assets without donor restrictions	273.1	292.0	(18.9)	233.5	249.1	(15.6)
Net assets with donor restrictions:						
Contributions, bequests, and grants	37.5	37.5	–	54.2	54.2	–
Investment (losses) earnings	(4.9)	(4.9)	–	44.4	44.4	–
Net assets released from restrictions	(35.9)	(35.9)	–	(30.0)	(30.0)	–
Other	(1.4)	(1.4)	–	6.3	6.3	–
(Decrease) increase in net assets with donor restrictions	(4.7)	(4.7)	–	74.9	74.9	–
Increase (decrease) in net assets	268.4	287.3	(18.9)	308.4	324.0	(15.6)
Net assets at beginning of year	5,936.3	5,917.4	18.9	5,627.9	5,593.4	34.5
Net assets at end of year	$ 6,204.7	$ 6,204.7	$ –	$ 5,936.3	$ 5,917.4	$ 18.9

See accompanying notes.

BJC HealthCare

Consolidated Statements of Cash Flows
(Dollars in Millions)

	Year Ended December 31 2018	2017
Operating activities		
Increase in net assets	$ 268.4	$ 308.4
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Unrealized (gains) on interest rate swaps	(27.0)	(11.6)
Restricted contributions	(37.5)	(54.2)
Depreciation and amortization	358.8	320.0
Pension and other postretirement liability adjustment	(165.3)	184.3
Loss on bond refinancing	–	6.8
Increase in patient accounts receivable	(65.4)	(2.0)
Increase in other current assets	(19.4)	(11.5)
Increase (decrease) in other current liabilities	83.7	(11.9)
Investments classified as trading, net	68.5	(150.1)
Decrease (increase) in other assets	24.6	(24.6)
(Decrease) in self-insurance liabilities	(1.0)	(1.8)
(Decrease) increase in other noncurrent liabilities	(19.8)	43.3
Net cash provided by operating activities	468.6	595.1
Investing activities		
Purchases of property and equipment, net	(414.7)	(519.8)
Sales and distributions of interests in alternative investments	481.1	762.5
Purchases of interests in alternative investments	(570.2)	(1,084.6)
Net cash used in investing activities	(503.8)	(841.9)
Financing activities		
Principal payments on debt	(82.7)	(503.7)
Proceeds from issuance of debt	74.4	597.2
Restricted contributions	37.5	54.2
Proceeds from line of credit	23.3	103.0
Payments on line of credit	(23.3)	–
Net cash provided by financing activities	29.2	250.7
Net (decrease) increase in cash and cash equivalents	(6.0)	3.9
Cash and cash equivalents, beginning of year	58.8	54.9
Cash and cash equivalents, end of year	$ 52.8	$ 58.8

See accompanying notes.

1. Organization and Summary of Significant Accounting Policies

Nature of Organization

BJC HealthCare (BJC or the System) is a regional healthcare delivery system operating in Missouri and southern Illinois. BJC is the sole corporate member of Barnes-Jewish Hospital (Barnes-Jewish), Christian Health Services Development Corporation (Christian), Missouri Baptist Medical Center (MBMC), St. Louis Children's Hospital (Children's), Progress West Hospital (PWH), and Memorial Regional Health Services (MRHS) (collectively, the Institutions).

BJC is a Missouri not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and has received an Internal Revenue Service (IRS) determination letter stating that it is exempt from federal income taxes on its related income pursuant to Section 501(a) of the Code. The Institutions are also Missouri or Illinois not-for-profit corporations as described in Section 501(c)(3) of the Code, and are recognized as exempt from federal income taxes pursuant to BJC's Group Ruling dated March 25, 2002.

CH Allied Services, Inc. (CHAS), an affiliate of Christian, leases and operates Boone Hospital Center (BHC) in Columbia, Missouri. The owner and lessor of BHC is the Board of Trustees of Boone County Hospital (BHC Lessor). The financial position and results of operations of BHC are included in BJC's consolidated financial statements. The lease agreement (the Lease) extends to December 31, 2020, with continuing five-year terms thereafter unless the Lease is terminated. Either party has the option to terminate the Lease during the current term or any successive five-year term by giving notice two years prior to the end of the then-current term. In December 2018, BJC gave notice of termination, effective December 31, 2020. Upon termination, certain assets recorded in BJC's consolidated financial statements will revert to the BHC Lessor, and BJC will record a charge equal to the amount of BHC's net assets without donor restrictions due to a change in control over the assets. At December 31, 2018, net assets without donor restrictions of BHC included in the consolidated financial statements totaled $129.2.

Beginning in 2008 through the end of the Lease, BHC is required to spend no less than 7% of BHC total revenues for capital expenditures for each successive three-year period (the Capital Expenditure Requirement). Per the Lease, capital expenditures will be counted in the year expended, except for capital expenditures for BJC system-wide capital initiatives, which are counted in and allocated to the Capital Expenditure Requirement when allocated to BHC. Net capital expenditures and BHC's allocation of BJC system wide capital initiatives totaled $12.1 and $14.8 for the years ended December 31, 2018 and 2017, respectively.

1. Organization and Summary of Significant Accounting Policies (continued)

Upon the termination of the Lease, any shortfall of the required capital expenditures will be paid by BJC to the Trustees prior to the final cash split calculation. Both the Trustees and the Hospital have agreed to carry the respective shortfalls forward to the future year's capital expenditure requirement calculation without designating cash or excluding cash from the annual cash split computation. As of December 31, 2018 and 2017, the shortfall of required capital expenditures, totaled $44.0 and $34.5, respectively.

Effective January 1, 2016, BJC entered into a strategic affiliation agreement through MRHS. MRHS is the sole corporate member of certain affiliated not-for-profit corporations, including Protestant Memorial Medical Center Inc. (dba Memorial Hospital – Belleville), Metro-East Services, Inc. (dba Memorial Hospital – East), Memorial Foundation, Inc. (MFI), and various other affiliated entities. As part of the affiliation agreement, BJC committed $125.0 in funding through 2025 for strategic capital expenditures and physician recruitment. As of December 31, 2018, BJC has spent $45.9 against this commitment. In addition, BJC committed to fund routine capital needs equal to 5% of net revenue through 2022. Effective January 1, 2018, BJC became the sole corporate member of MRHS. At that time, the BJC board designated $100.0 to be used exclusively for the benefit of MRHS and promoting health in the southern Illinois community.

Consolidation

The accompanying consolidated financial statements include the accounts of BJC and its controlled subsidiary. All significant intercompany transactions and account balances have been eliminated in the consolidated financial statements.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual amounts could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with original, short-term maturities of less than 90 days.

1. Organization and Summary of Significant Accounting Policies (continued)

Investments and Investment Earnings

Investments include assets held under the Lease, self-insurance agreements, amounts contributed by donors with stipulated restrictions, and unrestricted investments, some of which are set aside by the Board of Directors (the Board) over which it retains control and may, at its discretion, subsequently use for other purposes. Investments in equity and debt securities are measured at fair value.

For purposes of recognizing investment earnings as a component of excess of revenues over expenses, all investments, except for alternative investments, are considered to be trading securities. Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in excess of revenues over expenses unless the income or loss is restricted by donor or law. Gains and losses with respect to disposition of marketable securities are based on the average cost method. Investment earnings related to net assets with donor restrictions are added to or deducted from the net assets with donor restrictions balance.

Within established investment policy guidelines, BJC may enter into various exchange-traded and over-the-counter derivative contracts, including futures, options, swaps, and forward contracts. BJC has not designated its derivatives related to marketable securities as hedges, and the change in fair value of these derivatives is recognized in excess of revenues over expenses.

BJC invests in alternative investments (primarily hedge funds and private equity and credit funds), generally through limited liability corporations (LLCs) and limited liability partnerships (LLPs), which are reported using the equity method of accounting based on information provided by the respective LLCs and LLPs.

The values provided by the respective organizations are based on historical cost, appraisals, or other estimates that require varying degrees of judgment. Management has utilized the best available information for reported values, which in some instances are valuations as of an interim date not more than 90 days before year-end. Generally, the net asset value of BJC's holdings reflects net contributions to the organization and an allocated share of realized and unrealized investment income and expenses. Returns from equity method investments, whether realized or unrealized, are included in investment earnings in excess of revenues over expenses.

1. Organization and Summary of Significant Accounting Policies (continued)

Investment securities purchased and sold are reported based on trade date. Due to the difference between the trade date and the settlement date, BJC reports receivables for securities sold but not settled and reports liabilities for securities purchased but not settled. These receivables and payables are settled from within the investment portfolio and are presented on a net basis within investments in the consolidated balance sheets.

Securities Lending Program

BJC participates in securities-lending transactions with its investment custodian whereby a portion of its securities are loaned to selected, established brokerage firms in return for securities from the brokers as collateral for the securities loaned, usually on a short-term basis. Collateral provided by the brokerage firms generally approximates 102% of the fair value of the securities on loan and is adjusted for daily market fluctuations. BJC earns a rebate on the loaned securities. Neither BJC nor its investment custodian has the ability to pledge or sell securities received as collateral unless a borrower defaults.

BJC's defined benefit pension plan also participates in a securities lending arrangement as more fully described in Note 11.

Interest Rate Swaps

BJC uses interest rate swap contracts in managing its capital structure. BJC recognizes these derivative instruments as either assets or liabilities in the consolidated balance sheets at fair value. BJC does not account for any of its interest rate swap contracts as hedges, and accordingly, realized and unrealized gains and losses are reflected in excess of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets. BJC also does not offset fair value amounts recognized for derivative instruments and fair value amounts recognized for cash collateral posted.

Inventory

Inventory, which consist principally of medical supplies and pharmaceuticals, are stated at lower of cost or market. Cost is generally determined using average cost.

1. Organization and Summary of Significant Accounting Policies (continued)

Property and Equipment

Property and equipment are recorded at cost, if purchased, or at fair value at the date of donation, if donated. Depreciation is provided on a straight-line basis over the estimated useful lives of the property. BJC follows the American Hospital Association guidelines for assigning useful lives to property and equipment purchased. BJC capitalizes certain internally developed software costs in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 350-44, *Internal-Use Software*. Interest cost incurred in connection with borrowings to finance major construction and facility expansion is capitalized during the construction period and subsequently amortized over the lives of the related assets.

BJC evaluates long-lived assets used in operations for impairment as events and changes in circumstances indicate that the carrying amount of such assets might not be recoverable. Assets are grouped at the lowest level for which there is identifiable cash flows that are largely independent of the cash flows of other groups of assets, which generally is at the hospital level. Impairment write-downs are recognized in operating income at the time the impairment is identified.

Net Assets

Net Assets Without Donor Restrictions

Net assets without donor restrictions are those whose use by BJC has not been limited by donors and are available for general operating use at the discretion of the Board. This category includes both net assets designated by the Board for a specific purpose and Board-designated endowments. Board-designated endowments are net assets that are designated by the Board for a specific purpose and treated like an endowment (quasi-endowments). The Board may change this designation in accordance with BJC policies.

Net Assets With Donor Restrictions

Net assets with donor restrictions include those whose use by BJC has been limited by donors for a specific time period or purpose, primarily for research and education, special programs, patient care, operations, and property and equipment. This category also includes net assets restricted by donors to be maintained in perpetuity; the income from these funds is used primarily for special programs, research and education, operations, and patient care or added back to the corpus in

(Dollars in Millions)

1. Organization and Summary of Significant Accounting Policies (continued)

accordance with donor restrictions. This category also includes quasi-endowments where the donor has advised that the funds can be treated like an endowment but may also be utilized in accordance with the donor's purpose restriction. The Board may change this designation in accordance with donor restrictions and BJC policies.

Net assets without donor restrictions consisted of the following at December 31:

	2018	2017
Operating	$ 4,841.8	$ 4,630.0
Board designated:		
Quasi-endowment funds	159.6	165.6
Research and education	3.2	3.5
Patient care	270.6	274.4
Special programs	17.1	17.9
MRHS & health promotion	100.0	–
Community benefit & other	291.4	300.3
	$ 5,683.7	$ 5,391.7

Net assets with donor restrictions consisted of the following at December 31:

	2018	2017
Endowment funds	$ 272.7	$ 278.8
Quasi-endowment funds	65.5	66.3
Research and education	59.5	57.6
Pledges receivable	46.4	49.8
Patient care	34.4	29.7
Held by third party trustees	27.9	31.5
Special programs	8.5	6.2
Community benefit & other	3.1	3.6
Property and equipment	3.0	2.2
	$ 521.0	$ 525.7

(Dollars in Millions)

1. Organization and Summary of Significant Accounting Policies (continued)

Patient Service Revenue and Patient Accounts Receivable

Patient service revenue and patient accounts receivable are reported at the amount that reflects the consideration to which BJC expects to be entitled in exchange for providing patient care.

Contributions, Bequests, and Pledges

Unrestricted contributions and bequests are reported in other nonoperating expense, net when pledged. Restricted contributions and bequests are reported as additions to net assets with donor restrictions. Restricted pledges are recorded at fair value in the year notification is received as an addition to net assets with donor restrictions. Management believes these are Level 2 fair value measurements (as defined in Note 10) recorded on a nonrecurring basis. Pledges receivable totaling $46.1 and $50.2 are included in other accounts receivable and other noncurrent assets at December 31, 2018 and 2017, respectively. These pledges are recorded at their net present value based on the expected timing of pledge fulfillment using an average credit adjusted discount rate of 4.3% and 3.8% in 2018 and 2017, which approximates fair value at the date the pledge is received. Management believes total pledges will be received as follows:

	2018	2017
Within one year	$ 9.7	$ 9.9
One to five years	24.9	28.7
After five years	23.9	25.8
	58.5	64.4
Less present value factor	(12.0)	(13.7)
Less allowance for uncollectible pledges	(0.4)	(0.5)
	$ 46.1	$ 50.2

Performance Indicator

BJC's performance indicator is excess of revenues over expenses, which includes all changes in net assets without donor restrictions other than contributions of property, pension and other postretirement liability adjustments, and the impact of noncontrolling interest in a subsidiary.

1. Organization and Summary of Significant Accounting Policies (continued)

Operating and Nonoperating Income

BJC's primary mission is to meet the healthcare needs in its service areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, physician services, and other healthcare services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to BJC's primary mission are considered to be nonoperating. All unrestricted activities of BJC's wholly-controlled affiliated Foundations (the Foundations), including contribution and grant activity, are recorded in other nonoperating expense, net.

Income Taxes

The authoritative guidance in ASC 740, *Income Taxes*, creates a single model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing the minimum recognition threshold a tax position is required to meet before being recognized in the financial statements. Under the requirements of this guidance, tax-exempt organizations could be required to record an obligation as the result of a tax position they have historically taken on various tax exposure items. BJC has not recognized a liability for uncertain tax positions.

New Accounting Standards Not Yet Adopted

In February 2016, the FASB issued Accounting Standards Update (ASU) 2016-02, *Leases (Topic 842)*. The ASU requires the rights and obligations arising from the lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheets. The ASU will require disclosures to help the financial statement users better understand the amount, timing, and uncertainty of cash flows arising from leases. The ASU is effective for BJC beginning January 1, 2019 and will be applied using a modified retrospective approach. The primary effect of the ASU will be to record right-of-use assets and obligations for current operating leases which is estimated to increase assets and liabilities between $175 and $200 on the consolidated balance sheets. The transition adjustment is not estimated to have a material impact on the consolidated statement of operations.

In June 2018, the FASB issued ASU 2018-08, *Not-for-Profit Entities (Topic 958): Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. This ASU provides a more robust framework to determine when a transaction should be accounted for as a contribution or as an exchange transaction and provides additional guidance about how to

1. Organization and Summary of Significant Accounting Policies (continued)

determine whether a contribution is conditional. This ASU is effective January 1, 2019 and will be applied on a modified prospective basis. The adoption of this ASU did not have a significant effect on BJC's consolidated financial statements.

New Accounting Standards Adopted

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU 2014-09 converged and replaced existing revenue recognition guidance, including industry specific guidance, and requires an entity to recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The ASU also requires an entity to disclose sufficient information to enable the financial statement users to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. On January 1, 2018, this ASU was adopted by BJC on a full retrospective basis. The most significant change was related to the determination of bad debt expense. Under the previous standards, BJC's estimate for amounts not expected to be collected was based upon historical experience and presented as bad debt expense. Under the new standards, BJC's estimate for amounts not expected to be collected based on historical experience is a reduction to the transaction price. However, subsequent changes in the estimate of collectability due to a change in the financial status of a payor, for example due to bankruptcy, will be recognized as bad debt expense as a component of total expenses. The prior period consolidated financial statements presented were adjusted to reflect these changes. The adoption of the ASU resulted in no material impact to operating income or the excess of revenues over expenses on BJC's consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. This ASU is intended to improve the net asset classification requirements and the information presented in the financial statements and notes about a not-for-profit entity's liquidity, financial performance and cash flows. The main provisions of this ASU include: presentation of two classes of net assets versus the previously required three; recognition of capital gifts for construction as a net asset without donor restrictions when the associated long-lived asset is placed in service; and recognition of underwater endowment funds as a reduction in net assets with donor restrictions. The ASU also enhances disclosures for board designated amounts, composition of net assets without donor restrictions, liquidity, and expenses by both their natural and functional classification. On January 1, 2018, this standard was adopted

1. Organization and Summary of Significant Accounting Policies (continued)

by BJC on a retrospective basis. The prior period consolidated financial statements presented were adjusted to reflect these changes. The adoption of the ASU resulted in no material impact to BJC's consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Postretirement Benefit Cost.* This ASU changes how employers that sponsor defined benefit pension plans present the cost of the benefits in the consolidated statements of operations and changes in net assets. The service cost component of net periodic benefit cost related to defined benefit pension plans will be reported in the same financial statement line as other compensation costs arising from services rendered during the period. The other components of net periodic benefit cost are required to be presented separately from service cost and outside of operating income. Only the service cost component of net periodic benefit cost will be eligible for capitalization in assets. BJC early adopted this ASU as of January 1, 2018 using a prospective approach. The adoption of the ASU resulted in no material impact to BJC's consolidated financial statements.

Reclassifications

Certain balances in the 2017 consolidated balance sheet, consolidated statement of operations and changes in net assets, and footnote disclosures have been reclassified to conform to current year presentation. The effect of such reclassifications did not change total net assets, net assets without donor restrictions, operating income, or excess of revenues over expenses.

2. Patient Service Revenue, Other Operating Revenue and Uncompensated Care

BJC provides healthcare services in healthcare facilities, which include inpatient, outpatient and ambulatory care facilities, physician practices and other sites. BJC recognizes patient service revenue at the amount that reflects the consideration to which BJC expects to be paid for providing patient care. Patient service revenue is recognized as performance obligations based on the nature of the services provided by BJC are satisfied. Performance obligations satisfied over time relate to patients in BJC hospitals receiving inpatient acute care services from admission to the point when services are no longer required, which is generally at the time of discharge. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected or actual charges. Outpatient services are performance obligations satisfied at a point in time and revenue is recognized when goods or services are provided and BJC

2. Patient Service Revenue, Other Operating Revenue and Uncompensated Care (continued)

does not believe it is required to provide additional goods or services. Management believes this method provides a fair depiction of the transfer of services over the term of performance obligations based on the inputs needed to satisfy the obligations.

BJC has elected to apply the optional exemption provided in FASB (ASC) 606-10-50-14(a) because substantially all of its performance obligations relate to contracts with a duration of less than one year. Therefore, BJC is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially satisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

BJC uses a portfolio approach to account for categories of patient contracts as a collective group rather than recognizing revenue on an individual contract basis. The portfolios consist of major payor classes for inpatient revenue and outpatient revenue. Based on the historical collection trends and other analysis, BJC believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

BJC determines the transaction price, which involves significant estimates and judgment, based on standard charges for goods and services provided, reduced by explicit and implicit price concessions, including contractual adjustments provided to third-party payors, discounts provided to uninsured and underinsured patients in accordance with policy and/or implicit price concessions based on the historical collection experience of patient accounts. BJC determines the transaction price associated with services provided to patients who have third-party payor coverage with Medicare, Medicaid, managed care programs, and other third-party payors based on reimbursement terms per contractual agreements, discount policies and historical experience. Payment arrangements with those payors include prospectively determined rates per admission or visit, reimbursed costs, discounted charges, per diem rates, and value based payments. Reported costs and/or services provided under certain of the arrangements are subject to retroactive audit and adjustment. Patient service revenue increased by $23.6 and $1.8 in 2018 and 2017, respectively, as a result of changes in estimates due to settlements of prior fiscal years' cost reports, Medicaid settlements, and the disposition of other payor audits and settlements. Operating income increased by $15.9 and $1.6 in 2018 and 2017, respectively, as a result of these changes in

(Dollars in Millions)

2. Patient Service Revenue, Other Operating Revenue and Uncompensated Care (continued)

estimates. Future changes in Medicare and Medicaid programs and reduction in funding levels could have an adverse effect on BJC. There were no other significant changes to the judgements used to determine the transaction price in prior periods.

In support of its mission, BJC provides care to uninsured and underinsured patients. BJC provides charity care to patients who lack financial resources and are deemed to be medically indigent. Under its Financial Assistance Policy (FAP), BJC provides medically necessary care to patients in the community with inadequate financial resources at discounts of up to 100% of charges using a sliding scale that is based on patient household income as a percentage (up to 300%) of the federal poverty level guidelines. The FAP also contains a catastrophic financial assistance provision that limits a patient's total financial responsibility to BJC. Since BJC does not pursue collection of these amounts, the discounted amounts are not reported as patient service revenue. BJC uses presumptive eligibility screening procedures for free care and recognizes patient service revenue on services provided to self-pay patients at the discounted rate at the time services are rendered. The estimated cost of charity care was $178.0 and $164.9 in 2018 and 2017, respectively. Costs are estimated using the ratio of BJC's costs to its charges and applying it to gross charity charges.

In rare instances, BJC receives payment in advance of the services provided and considers these amounts to represent contract liabilities. Contract liabilities at December 31, 2018 were not significant.

Management has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the payors and line of business that renders services to patients. The composition of patient service revenue by payor was as follows:

	2018	2017
Medicare	$ 1,717.7	$ 1,597.1
Medicaid	723.8	699.8
Managed Care	2,485.2	2,331.1
Other	151.3	155.7
Self-pay	16.3	15.5
	$ 5,094.3	$ 4,799.2

(Dollars in Millions)

2. Patient Service Revenue, Other Operating Revenue and Uncompensated Care (continued)

The composition of the patient service revenue by service line was as follows:

	2018	2017
HealthCare Facilities	$ 4,740.7	$ 4,479.5
Physician practices	184.4	166.8
Other and eliminations	169.2	152.9
	$ 5,094.3	$ 4,799.2

BJC routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans or policies (e.g., Medicare, Medicaid, managed care payors, and commercial insurance policies). As of December 31, 2018 and 2017, 34% and 35% of patient accounts receivable were collectible from government payors. The remaining 66% and 65% of patient accounts receivable in 2018 and 2017, respectively, were collectible from managed care payors, commercial insurance payors, and uninsured and underinsured patients.

As of December 31, 2018 and 2017, BJC expects to collect approximately 21% and 23% respectively, of all amounts due from uninsured and underinsured patients (including patients with deductibles and copayment balances due for which third party coverage exists for part of the bill).

Other operating revenue is recognized at an amount that reflects the consideration BJC expects to be entitled in exchange for providing goods and services. The amounts recognized reflect consideration due from customers, third-party payors and others. Primary categories of other revenue include retail pharmacy revenue, tuition for the Goldfarb School of Nursing, grant revenue, cafeteria revenue, parking revenue, corporate billing for administrative services, and other miscellaneous activities.

3. Affiliation Agreement with Washington University

BJC has an affiliation agreement with Washington University (the University) that expires on December 31, 2027, but which may be canceled upon one-year written notice by either party. Under the terms of the affiliation agreement, the University trains and supervises medical residents and manages certain clinical and research activities of BJC. The annual expense for these services provided by the University under the affiliation agreement is based on a fixed payment ($8.1 in

(Dollars in Millions)

3. Affiliation Agreement with Washington University (continued)

2018 and $7.9 in 2017) plus a payment (Affiliation Agreement Variable Payment) based on the combined net operating income of Barnes-Jewish, Barnes-Jewish West County Hospital (one of Barnes-Jewish's wholly controlled affiliates), and Children's. Amounts expensed as supplies and other in the consolidated statements of operations and changes in net assets for these services under the affiliation agreement totaled $116.0 and $115.4 in 2018 and 2017, respectively. Payments to the University under the affiliation agreement are made on a semiannual basis.

In addition to the affiliation agreement, BJC has supplemental agreements with the University whereby BJC pays the University for certain purchased services and leased facilities and equipment. These supplemental agreements have varying terms with fixed and variable payment arrangements. Amounts expensed as supplies and other for these services totaled $215.7 and $183.2 in 2018 and 2017, respectively.

In addition, BJC received $50.5 and $31.0 from the University in 2018 and 2017, respectively, for certain purchased services and leased facilities and equipment. These amounts are included in other operating revenue in the consolidated statements of operations and changes in net assets.

Through the Foundations, BJC provides support to the University through various grants. These expenses are included in other nonoperating expense, net and net assets released from restrictions and total $37.2 and $47.5 in 2018 and 2017, respectively. Grants payable are included in other current and other noncurrent liabilities totaling $184.4 and $211.8 at December 31, 2018 and 2017, respectively. Management believes total grants payable will be paid as follows:

	2018	2017
Within one year	$ 153.2	$ 164.0
One to five years	28.4	41.0
After five years	2.8	6.8
	$ 184.4	$ 211.8

During 2017, BJC and the University amended the affiliation agreement whereby the University agreed to a ceiling on the Affiliation Agreement Variable Payment for the years 2018 to 2027 in exchange for an unconditional commitment of $200.0 to support precision medicine and faculty recruitment, payable in equal annual installments from 2018 to 2027. In 2017, the present value of this commitment was $176.0 and was included in other nonoperating expense, net in the

(Dollars in Millions)

3. Affiliation Agreement with Washington University (continued)

consolidated statements of operations and changes in net assets. The outstanding commitment as of December 31, 2018 and 2017 is recognized in the consolidated balance sheets in other current liabilities and other noncurrent liabilities of $20.0 and $20.0, respectively and $138.0 and $156.0, respectively.

As of December 31, 2018, BJC has unrecorded, conditional commitments to the University to fund two medical research and education initiatives in amounts up to $143.8, to be paid over the next ten years, if certain criteria are met.

4. Financial Assets and Liquidity Resources

As of December 31, 2018, financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital expenditures not financed with debt, were as follows:

	2018
Financial assets:	
Cash and cash equivalents	$ 52.8
Accounts receivable	874.6
Other current assets	143.3
Investments	5,601.5
Total financial assets	6,672.2
Less:	
Board designated investments	(601.9)
Investments with donor restrictions	(439.4)
Funds held for others	(58.8)
Assets limited as to use	(127.8)
Pledges receivable with restrictions	(8.6)
Investments with liquidity more than one year	(1,562.7)
Total financial assets available within one year	3,873.0
Liquidity resources:	
Unused line of credit	297.0
Total financial assets and liquidity resources available within one year	$ 4,170.0

(Dollars in Millions)

4. Financial Assets and Liquidity Resources (continued)

As part of BJC's investment policy, BJC holds highly liquid investments to enhance its ability to satisfy liquidity. To manage liquidity, BJC maintains a general operating line of credit that may be drawn upon as needed to manage cash flows. In addition, BJC maintains a hybrid dedicated bank line of credit to support general operating requirements and tenders associated with variable rate demand bonds. BJC has $103.0 outstanding under the lines of credit at December 31, 2018 and 2017, respectively.

The availability of certain amounts within the board designated investments may change in accordance with Board policies at any time.

5. Investments

The following is a summary of investments included in the consolidated balance sheets:

	2018	2017
Unrestricted investments	$ 4,098.5	$ 4,181.0
Securities on loan	36.2	104.4
Held at Foundations	1,339.0	1,158.7
Assets limited as to use:		
Under self-insurance trusts	36.5	47.2
Under the Lease	53.1	53.1
Under captive insurance agreement	38.2	33.2
	5,601.5	5,577.6
Less current portion of self-insurance trusts	(28.2)	(24.9)
	$ 5,573.3	$ 5,552.7

(Dollars in Millions)

5. Investments (continued)

The following is a summary of the composition of investments as of December 31:

	2018	2017
Cash and short-term investments	$ 203.4	$ 156.0
Income securities:		
U.S. government and agency obligations	428.3	491.5
Corporate debt securities	963.4	1,017.4
Asset-backed and securitized bonds and notes	463.9	343.0
Equity securities	37.5	71.6
Alternative investments:		
Hedge funds	769.4	654.5
Private equity and credit funds	1,826.8	1,700.1
Other investments:		
Fixed income – commingled funds	241.0	235.0
Equity – commingled funds	609.7	835.4
Common/collective trusts	45.6	50.2
Other	17.3	19.3
Accrued interest and dividends receivable	13.5	13.1
	5,619.8	5,587.1
Less current portion of self-insurance trusts	(28.2)	(24.9)
	5,591.6	5,562.2
Amounts due to brokers	(36.1)	(43.0)
Amounts due from brokers	17.8	33.5
	$ 5,573.3	$ 5,552.7

BJC's investments are exposed to various kinds and levels of risk. Income securities expose BJC to interest rate risk, credit risk, and liquidity risk. As interest rates change, the value of many fixed-income securities with fixed interest rates is affected. Credit risk is the risk that the obligor of the security will not fulfill its obligation. Liquidity risk is affected by the willingness of market participants to buy and sell given securities.

5. Investments (continued)

Equity securities expose BJC to market risk, performance risk, and liquidity risk. Market risk is the risk associated with major movements of the equity markets, both domestic and international. Performance risk is the risk associated with a particular company's operating performance. Liquidity risk, as previously defined, tends to be higher for international and small domestic capitalization equity companies.

Alternative investments have similar risks as income and equity securities although there may be additional risks. These investments consist principally of noncontrolling interests in LLPs and LLCs. Because these funds are invested through LLCs and LLPs, the underlying net asset value of the investments is based on valuations provided by the managers. Nearly all of the hedge fund manager valuations are independently priced or verified by third-party administrators. Certain hedge fund investments also have restrictions on the timing of withdrawals, up to 1 year from December 31, 2018, which may reduce liquidity. Private equity and credit investments have contractual commitments to provide capital contributions during the investment period, up to seven years from initial investment date, and restrictions on the timing of withdrawals, up to 15 years from initial investment date, which may reduce liquidity. BJC has unfunded commitments of $874.4 to private equity and credit funds as of December 31, 2018. Due to the uncertainty surrounding whether the contractual commitments will require funding during the contractual period, future minimum payments to meet these commitments cannot be reasonably estimated. These committed amounts are expected to be primarily satisfied by distributions from existing investments.

BJC may hold swaps, currency forwards, and fixed income futures derivatives as part of its investment strategy. These contracts are subject to counterparty credit risk, the risk that contractual obligations of the counterparties (including BJC) will not be fulfilled. Counterparty credit risk is managed by requiring high credit standards for BJC's counterparties, as well as collateral posting requirements. The counterparties to these contracts are financial institutions that carry investment-grade credit ratings.

These contracts contain collateral provisions applicable to both parties that mitigate credit risk. Pursuant to the collateral posting requirements under the contracts at December 31, 2018, BJC posted $19.2 and at December 31, 2017 counterparties posted $0.7.

(Dollars in Millions)

5. Investments (continued)

At December 31, 2018 and 2017, the notional value of derivatives was approximately $691.2 and $410.7, respectively. The fair value of derivatives in an asset position, included in investments in the consolidated balance sheets, was $0.6 and $1.9 at December 31, 2018 and 2017, respectively, while the fair value of derivatives in a liability position, included in other noncurrent liabilities in the consolidated balance sheets, was $19.8 and $0.9 at December 31, 2018 and 2017, respectively. BJC recognized a loss of $26.1 and a gain of $35.1 in 2018 and 2017, respectively, which are recorded in investment earnings within the consolidated statements of operations and changes in net assets.

At December 31, 2018 and 2017, investments include the fair value of securities on loan of $36.2 and $104.4, respectively. Posted collateral for these securities on loan at December 31, 2018 and 2017 totaled $37.0 and $107.0, respectively and is included in investments in the consolidated balance sheets.

Investment earnings for the years ended December 31 is summarized as follows:

	2018	2017
Interest and dividends	$ 162.6	$ 127.1
Net realized gains	79.1	323.2
Net unrealized (losses) gains	(191.9)	65.7
Total investment earnings, net	$ 49.8	$ 516.0
Included in investment earnings	$ 54.7	$ 471.6
Included in net assets with donor restrictions	(4.9)	44.4
Total investment earnings, net	$ 49.8	$ 516.0

Total investment earnings, net includes internal and external investment management fees.

(Dollars in Millions)

6. Property and Equipment

A summary of property and equipment, net, as of December 31 is as follows:

	2018	2017
Land and land improvements	**$ 212.0**	$ 204.1
Building and improvements	**2,879.2**	2,184.1
Equipment	**3,439.3**	3,663.2
	6,530.5	6,051.4
Less accumulated depreciation	**(3,801.8)**	(3,786.8)
	2,728.7	2,264.6
Construction-in-progress	**457.4**	865.6
	$ 3,186.1	$ 3,130.2

At December 31, 2018, BJC had outstanding commitments of $254.5 related to all property activities, including construction, architecture, information systems, and engineering services. Net interest capitalized in 2018 and 2017 totaled $3.0 and $19.0, respectively.

During 2017, BJC evaluated the carrying value of the long-lived assets at one of its hospitals which had experienced on-going operating losses as a result of reductions in Medicare and Medicaid reimbursement and increases in uninsured and underinsured patients. Based on this evaluation, BJC determined that the full carrying value of the hospital's long-lived assets was no longer recoverable and recorded an impairment charge of $11.3, included in depreciation and amortization expense, to reduce the property and equipment to estimated fair value. Although operating losses have continued, at December 31, 2018, the carrying value of assets estimated fair value and no impairment charge was recorded. Fair value was based on a market approach, comparing the asset group to similar assets that have been sold or offered for sale, adjusted for differences, such as historical financial condition and performance, expected economic benefits, and physical characteristics, all of which constitute unobservable Level 3 inputs. Management believes the assumptions used are consistent with those a market participant would use.

(Dollars in Millions)

7. Other Current Assets and Liabilities

Other current assets consist of the following as of December 31:

	2018	2017
Inventory	$ 109.8	$ 103.8
Due from third-party payors	33.5	35.9
Prepaid expenses	56.8	49.6
Current portion of self-insurance trust	28.2	24.9
	$ 228.3	$ 214.2

Other current liabilities consist of the following as of December 31:

	2018	2017
Accounts payable	$ 119.6	$ 124.8
Accrued payroll and related liabilities	240.1	249.9
Accrued expenses and other	155.7	139.8
Due to third-party payors	36.5	33.2
Due to Washington University	349.0	334.5
Contingent liabilities (see Note 15)	65.0	–
Current portion of self-insurance liabilities	28.2	24.9
	$ 994.1	$ 907.1

(Dollars in Millions)

8. Long-term Debt

Long-term debt consists of the following at December 31:

	2018	2017
Series 2011A-B, 2012E, 2013B, 2016A-B, 2017A-I, variable rate term bonds, privately placed, interest (rates from 2.05% to 2.71% at December 31, 2018) set at prevailing market rates, due through 2058	**$ 980.0**	$ 1,055.0
Series 2008A-E variable rate demand bonds subject to self-liquidity, interest (rates from 1.66% to 1.75% at December 31, 2018) set at prevailing rates, due through 2038	**354.1**	357.8
Series 2013A, Series 2013C, Series 2014, Series 2015A, and Series 2017D fixed rate debt, interest rates from 3.23% to 5.00%, due through 2058	**610.2**	540.1
Line of credit	**103.0**	103.0
Other	**14.6**	14.6
	2,061.9	2,070.5
Add unamortized debt issuance costs and debt premiums, net	**7.0**	7.0
Less current maturities of long-term debt	**(22.5)**	(7.7)
Less long-term debt puttable within one year or subject to self-liquidity	**(350.3)**	(429.1)
	$ 1,696.1	$ 1,640.7

BJC maintains an Obligated Group structure under its Master Indenture agreement (the Master Indenture), dated as of April 4, 2006. The Obligated Group members are jointly and severally liable for all notes issued under the Master Indenture and represent those organizations that own or operate the principal healthcare facilities of BJC.

8. Long-term Debt (continued)

The Master Indenture permits BJC to issue Master Notes thereunder to evidence or secure additional indebtedness on behalf of the Obligated Group. The Obligated Group members are responsible for making all payments required with respect to obligations under the Master Indenture. The aggregate par amount of obligations outstanding under the Master Indenture (other than obligations that have been legally defeased and that are not considered to be outstanding) totaled $2,047.3 and $2,055.9 at December 31, 2018 and 2017, respectively. The Master Indenture imposes various covenants and conditions on BJC, including covenants related to debt service coverage, additional indebtedness, permitted liens, and the use and maintenance of facilities. Management believes BJC is in compliance with these covenants and conditions as of December 31, 2018.

At December 31, 2018 and 2017, BJC had $354.1 and $357.8, respectively, of variable rate demand bonds that are supported by self-liquidity. The variable rate demand bonds, while subject to long-term amortization periods, may be tendered to BJC at the option of bondholders subject to certain notice period requirements. If the variable rate demand bonds subject to self-liquidity are not remarketed upon the exercise of put options, management would utilize internal or external sources to provide the necessary liquidity.

As part of BJC's strategic affiliation with MRHS, BJC provided a guaranty of the payment obligations relating to the outstanding Series 2013 Memorial Group, Inc. bonds. As part of this guaranty, the bonds assumed the covenants and conditions of the BJC Master Indenture. In June 2017, $198.0 of tax-exempt Series 2017A-C variable rate refunding bonds were issued by the Health and Educational Facilities Authority of the State of Missouri on behalf of BJC. The proceeds of these bonds were used to fully defease and redeem the Series 2013 Memorial Group, Inc. bonds outstanding. BJC recorded a loss on refinancing of $6.2 in 2017 related to this transaction, which is included in supplies and other in the consolidated statements of operations and changes in net assets. The Series 2017A-C bonds mature in 2054.

In December 2017, $400.0 of tax-exempt Series 2017D-I variable rate bonds were issued by the Health and Educational Facilities Authority of the State of Missouri on behalf of BJC. The proceeds of these bonds were used to reimburse BJC for the payment of certain capital expenditures. The Series 2017D-I bonds mature in 2058. In 2017, the System incurred $0.8 in costs related to new issuances, which will be amortized over the life of the bonds.

(Dollars in Millions)

8. Long-term Debt (continued)

In December 2017, BJC retired the Series 2005B and 2012A-D bonds outstanding. BJC recorded a loss on retirement of $0.6 in 2017 related to this transaction, which is included in supplies and other in the consolidated statements of operations and changes in net assets. The amount of Series 2005B and 2012A-D bonds outstanding at the time of retirement was $270.4.

In May 2018, BJC converted Series 2017D bonds from variable rate term bonds, puttable starting in 2018, to fixed rate bonds with no put option. The System incurred $0.6 in costs related to the conversion, which will be amortized over the life of the bonds.

At December 31, 2018, BJC has a general operating line of credit of $300.0. This facility has a five-year term expiring August 2020. In addition, BJC has a $100.0 hybrid dedicated bank line of credit expiring in August 2020. The hybrid facility has the dual function of supporting general operating requirements and tenders associated with the variable rate demand bonds. BJC has $103.0 outstanding under the lines of credit at December 31, 2018 and 2017.

Scheduled principal payments on long-term debt, including new market tax credits and obligations subject to short-term remarketing as due according to their long-term amortization schedule are as follows:

	Scheduled
Year ending December 31:	
2019	$ 22.5
2020	8.1
2021	8.3
2022	16.7
2023	17.2

The amount of interest paid, net of interest capitalized, totaled $47.6 and $30.8 in 2018 and 2017, respectively.

9. Interest Rate Swaps

BJC uses interest rate swap contracts to manage interest rate risk associated with its variable rate debt obligations. BJC is a party to multiple interest rate swap contracts that effectively convert various variable rate bonds to fixed rates. Interest rate swap contracts between BJC and third parties (counterparties) provide for the periodic exchange of payments between the parties based on changes in a defined index, typically 68% of the one-month or three-month London InterBank Offered Rate (LIBOR), and a fixed rate. These contracts are subject to counterparty credit risk, the risk that contractual obligations of the counterparties (including BJC) will not be fulfilled. Concentrations of credit risk relate to groups of counterparties that have similar economic or industry characteristics that would cause their ability to meet contractual obligations to be similarly affected by changes in economic or other conditions.

Counterparty credit risk is managed by requiring high credit standards for BJC's counterparties and, in certain cases, collateral posting requirements. The counterparties to these contracts are financial institutions that carry investment-grade credit ratings.

Certain interest rate swap contracts contain collateral provisions applicable to both parties to mitigate credit risk above a specified mark-to-market posting threshold that is based on either a fixed dollar amount or on each counterparty's credit rating.

Pursuant to the collateral posting requirements under the swap contracts, at December 31, 2018 and 2017, BJC posted $5.8 and $31.8, respectively, as collateral, which is reported as other noncurrent assets in the consolidated balance sheets. BJC does not anticipate nonperformance by its counterparties.

During June 2017, BJC entered into a fixed payer interest swap contract with JP Morgan Chase Bank, N.A. with a notional amount of $198.0, which will mature in 2047.

At December 31, 2018 and 2017, the notional amount of BJC's outstanding interest rate swap contracts is $961.0 and $976.4, respectively.

(Dollars in Millions)

9. Interest Rate Swaps (continued)

The fair value of BJC's outstanding interest rate swaps at December 31 is as follows:

Derivatives Not Designated as Hedging Instruments	Balance Sheet Location	2018	2017
Interest rate swap contracts	Other noncurrent liabilities	$ (68.0)	$ (88.7)
Interest rate swap contracts	Other noncurrent assets	8.9	2.6

The effects of BJC's interest rate swaps in the consolidated statements of operations and changes in net assets for the years ended December 31 are as follows:

Derivatives Not Designated as Hedging Instruments	Location of Gain (Loss) on Derivatives Recognized in Excess of Revenues Over Expenses	Amount of Gain (Loss) on Derivatives Recognized in Excess of Revenues Over Expenses 2018	2017
Interest rate swap contracts	Unrealized gain on interest rate swap contracts	$ 27.0	$ 11.6
Interest rate swap contracts	Interest	(8.8)	(9.2)

10. Fair Value Measurements

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. *ASC 820, Fair Value Measurements and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to unobservable inputs (Level 3 measurement).

10. Fair Value Measurements (continued)

Certain of BJC's financial assets and financial liabilities are measured at fair value on a recurring basis, including money market, fixed income and equity instruments, and derivative contracts. The three levels of the fair value hierarchy and a description of the valuation methodologies used for instruments measured at fair value are as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities as of the reporting date. Level 1 primarily consists of financial instruments, such as money market securities and listed equities.

Level 2 – Pricing inputs other than quoted prices included in Level 1 that are either directly observable or that can be derived or supported from observable data as of the reporting date. Instruments in this category include certain U.S. government agency and sponsored entity debt securities and interest rate swap contracts and derivatives.

Level 3 – Pricing inputs include those that are significant to the fair value of the financial asset or financial liability and are not observable from objective sources. In evaluating the significance of inputs, BJC generally classifies assets or liabilities as Level 3 when their fair value is determined using unobservable inputs that individually, or when aggregated with other unobservable inputs, represent more than 10% of the fair value of the assets or liabilities. These inputs may be used with internally developed methodologies that result in management's best estimate of fair value.

(Dollars in Millions)

10. Fair Value Measurements (continued)

Financial assets and liabilities measured at fair value on a recurring basis were determined using the following inputs at December 31, 2018:

		Fair Value Measurements Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Investments:				
Cash and short-term investments	$ 203.4	$ 203.4	$ –	$ –
Income securities:				
U.S. government and agency obligations	428.3	–	428.3	–
Corporate debt securities	963.4	–	963.4	–
Asset-backed and securitized bonds and notes	463.9	–	328.1	135.8
Equity securities	37.5	37.5	–	–
Other	17.3	–	17.3	–
Subtotal	2,113.8	240.9	1,737.1	135.8
Assets not at fair value:				
Hedge funds	769.4			
Private equity and credit funds	1,826.8			
Assets (fair value determined using NAV practical expedient):				
Fixed income – commingled funds	241.0			
Equity – commingled funds	609.7			
Common/collective trusts	45.6			
Accrued interest and dividends receivable	13.5			
Total investments	$ 5,619.8			
Derivatives	$ 8.9	–	8.9	–
Deferred compensation agreements	45.3	45.3	–	–
Total financial assets	$ 5,674.0	$ 286.2	$ 1,746.0	$ 135.8
Liabilities				
Derivatives	$ 19.8	$ –	$ 19.8	$ –
Interest rate swap contracts	68.0	–	68.0	–
Total financial liabilities	$ 87.8	$ –	$ 87.8	$ –

(Dollars in Millions)

10. Fair Value Measurements (continued)

Financial assets and liabilities measured at fair value on a recurring basis were determined using the following inputs at December 31, 2017:

		Fair Value Measurements Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Investments:				
Cash and short-term investments	$ 156.0	$ 156.0	$ –	$ –
Income securities:				
U.S. government and agency obligations	491.5	–	491.5	–
Corporate debt securities	1,017.4	–	1,017.4	–
Asset-backed and securitized bonds and notes	343.0	–	273.6	69.4
Equity securities	71.6	71.6	–	–
Other	19.3	0.2	19.1	–
Subtotal	2,098.8	227.8	1,801.6	69.4
Assets not at fair value:				
Hedge funds	654.5			
Private equity and credit funds	1,700.1			
Assets (fair value determined using NAV practical expedient):				
Fixed income – commingled funds	235.0			
Equity – commingled funds	835.4			
Common/collective trusts	50.2			
Accrued interest and dividends receivable	13.1			
Total investments	$ 5,587.1			
Derivatives	$ 2.6	–	2.6	–
Deferred compensation agreements	46.4	46.4	–	–
Total financial assets	$ 5,636.1	$ 274.2	$ 1,804.2	$ 69.4
Liabilities				
Derivatives	$ 0.9	$ –	$ 0.9	$ –
Interest rate swap contracts	88.7	–	88.7	–
Total financial liabilities	$ 89.6	$ –	$ 89.6	$ –

(Dollars in Millions)

10. Fair Value Measurements (continued)

The following table is a roll forward of assets classified in Level 3 of the valuation hierarchy defined above:

	Asset-Backed and Securitized Bonds and Notes
Fair value at January 1, 2017	$ 124.2
Purchases	51.1
Settlements	(102.8)
Investment earnings	6.6
Transfers in and/or out of Level 3	(9.7)
Fair value at December 31, 2017	69.4
Purchases	**134.0**
Settlements	**(78.4)**
Investment earnings	**1.4**
Transfers in and/or out of Level 3	**9.4**
Fair value at December 31, 2018	**$ 135.8**

The fair values of the securities included in Level 1 were determined through quoted market prices. The fair values of Level 2 securities (primarily income securities) were determined through evaluated bid prices based on recent trading activity, and other relevant information, including market interest rate curves and referenced credit spreads, or estimated prepayment rates provided by third-party pricing services where quoted market values are not available. Any securities with fewer than two received broker quotes are categorized as Level 3 assets. With regards to the currency forwards and swaps, which are included in other Level 2 securities, observable market data is used to build an implied volatility figure which is input into a Black-Scholes model to determine fair value. The fair values for fixed income futures were derived through observable market data obtained from a pricing vendor.

10. Fair Value Measurements (continued)

The fair values of the interest rate swap contracts are determined based on the present value of expected future cash flows using discount rates appropriate with the risks involved. The valuations reflect a credit spread adjustment to the LIBOR discount curve in order to reflect the credit value adjustment for nonperformance risk. The BJC credit spread adjustment is derived from other comparably rated entities' bonds priced in the market. Due to the volatility of the capital markets, there is a reasonable possibility of changes in fair value and additional gains (losses) in the near term subsequent to December 31, 2018.

Level 3 assets of $135.8 and $69.4 as of December 31, 2018 and 2017, respectively, include certain asset-backed and securitized notes and bonds. These underlying securities trade less frequently than other fixed income instruments, which generate potential liquidity risk. In the event pricing cannot be obtained through quoted prices in active markets, these securities are priced using an option-adjusted discounted cash flow model.

BJC transfers assets in and/or out of Level 3 as significant inputs, including performance attributes, used for the fair value measurement become observable or unobservable. BJC transferred $9.4 of securitized notes and bonds from Level 2 to Level 3 in 2018 as fewer observable market inputs were obtained. BJC transferred $9.7 of securitized notes and bonds from Level 3 to Level 2 in 2017 by obtaining additional observable market inputs in the form of multiple corroborating broker quotes. BJC recognizes transfers as of the end of the reporting period. There were no transfers between Level 1 and Level 2 in 2018 or 2017.

The carrying value of cash and cash equivalents, accounts receivable, and other current assets and liabilities are reasonable estimates of their fair value due to the short-term nature of these financial instruments. The value of pledges receivable is estimated by management to approximate fair value as of the date the pledge is received. Management believes these are Level 2 fair value measurements recorded on a nonrecurring basis.

(Dollars in Millions)

11. Postretirement Benefits

BJC sponsors the BJC Defined Contribution Plan, a 401(k) defined contribution plan that covers substantially all employees, excluding MRHS. Employer contributions to this plan are based on a percentage of participating employees' contributions to a related 403(b) plan. BJC contributed $33.1 and $26.2 to this plan during 2018 and 2017, respectively, which is included in salaries and benefits in the consolidated statements of operations and changes in net assets.

BJC sponsors a defined-benefit pension plan (the Plan) covering a majority of all full-time employees who have met certain age requirements and have completed one year of service. Benefits are based on years of service and employee earnings. BJC's minimum funding policy is to contribute annually amounts actuarially determined to fund the benefits of the Plan. In 2018 and 2017, BJC had no minimum required pension contributions.

The following table sets forth the funded status of the Plan and accrued pension cost as of December 31 as actuarially determined:

	2018	2017
Change in projected benefit obligation		
Projected benefit obligation at beginning of year	$ 2,899.9	$ 2,410.1
Service cost	118.0	104.6
Interest cost	102.8	97.0
Actuarial (gain) loss	(267.1)	354.2
Benefits paid	(74.5)	(66.0)
Projected benefit obligation at end of year	2,779.1	2,899.9
Change in plan assets		
Fair value of plan assets at beginning of year	2,349.9	1,946.4
Actual earnings on plan assets	2.3	280.1
Employer contributions	126.8	189.4
Benefits paid	(74.5)	(66.0)
Fair value of plan assets at end of year	2,404.5	2,349.9
Unfunded status	$ (374.6)	$ (550.0)
Accumulated benefit obligation at end of year	$ 2,491.7	$ 2,560.2
Unfunded status (based on accumulated benefit obligation)	$ (87.2)	$ (210.3)

(Dollars in Millions)

11. Postretirement Benefits (continued)

The unfunded status is included in pension/postretirement liabilities in the consolidated balance sheets. BJC has other postretirement plans with unfunded benefit obligations of $3.2 and $3.6 at December 31, 2018 and 2017, respectively.

Included in net assets without donor restrictions at December 31 are the following amounts that have not yet been recognized in net periodic pension cost:

	2018	2017
Unrecognized actuarial losses	$ 898.3	$ 873.9
Unrecognized prior service cost	0.1	0.1
	$ 898.4	$ 874.0

Changes in plan assets and benefit obligations recognized in net assets without donor restrictions for the year ended December 31 are as follows:

	2018	2017
Unrecognized actuarial loss (gain)	$ (105.7)	$ 218.4
Amortization of actuarial losses	(59.2)	(34.6)
Amortization of prior service cost	–	(0.1)
	$ (164.9)	$ 183.7

The pension and other postretirement liability adjustment of $165.3 for the year ended December 31, 2018, in the consolidated statements of operations and changes in net assets includes $0.4 related to the other postretirement plans.

The prior service cost and actuarial loss included in net assets without donor restrictions and expected to be recognized in net periodic pension cost during the year ending December 31, 2019, total $0 and $34.3, respectively. The impact of the change in discount rate on the projected benefit obligation of the Plan was a decrease of approximately $270.1 at December 31, 2018.

(Dollars in Millions)

11. Postretirement Benefits (continued)

No plan assets are expected to be returned to BJC during the year ending December 31, 2018.

	2018	2017
Weighted-average assumptions used to determine benefit obligations for the year ended December 31		
Discount rate	**4.47%**	3.87%
Rate of increase in compensation levels	**3.37**	3.41
Weighted-average assumptions used to determine expense for the year ended December 31		
Discount rate for benefit obligations	**3.87%**	4.57%
Rate of compensation increases	**3.41**	3.38
Expected long-term rate of return	**7.00**	7.00
Mortality Projection Scale	**MSS-2018**	MSS-2017

BJC determines the long-term rate of return for plan assets in consultation with its external investment advisor. BJC reviews historical market performance by investment asset class along with current economic outlooks for asset class performance in order to estimate its long-term rate of return assumption. Peer data and historical returns are reviewed to check for reasonableness of BJC's long-term rate of return assumption.

	2018	2017
Components of net periodic benefit cost:		
Service cost	**$ 118.0**	$ 104.6
Interest cost	**102.8**	97.0
Expected earnings on plan assets	**(163.6)**	(144.3)
Amortization of prior service cost	**–**	0.1
Recognized net actuarial loss	**59.2**	34.6
Net periodic benefit cost	**$ 116.4**	$ 92.0

The plan's assets are invested in a portfolio designed to obtain competitive investment earnings and long-term investment growth, consistent with actuarial assumptions, with a reasonable and prudent level of risk. Diversification is achieved by allocating funds to various asset classes and investment styles and by retaining multiple investment managers with complementary philosophies, styles and approaches. The Plan may hold swaps, currency forwards, and fixed

(Dollars in Millions)

11. Postretirement Benefits (continued)

income futures derivatives as part of its investment strategy. Derivatives may be used to gain market exposure in an efficient and timely manner. Plan assets may also be loaned to established brokerage firms in return for securities collateral. At December 31, 2018 and 2017, plan assets on loan included in the fair value of plan assets totaled $7.3 and $5.6, respectively. Posted collateral for these securities on loan at December 31, 2018 and 2017 totaled $7.4 and $5.7, respectively.

BJC's defined benefit pension plan asset allocation by asset category is as follows:

	2018		2017	
Asset Category	**Target Asset Allocation**	**Actual Asset Allocation**	**Target Asset Allocation**	**Actual Asset Allocation**
Cash	–%	**0.5%**	–%	1.4%
Growth	31.0	**35.1**	42.0	40.4
Income	29.0	**22.4**	28.0	24.8
Illiquid	40.0	**42.0**	30.0	33.4
Total	100.0%	**100.0%**	100.0%	100.0%

The growth asset category consists of public equities and hedge funds. The income category includes fixed income funds and securities. Lastly, the illiquid asset category includes limited partnership investments in private equity and credit funds.

(Dollars in Millions)

11. Postretirement Benefits (continued)

The fair value of pension plan assets was determined using the following inputs at December 31, 2018:

		Fair Value Measurements Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 116.3	$ 116.3	$ –	$ –
Income securities:				
U.S. government and agency obligations	17.8	–	17.8	–
Corporate debt securities	233.8	–	233.8	–
Asset-backed and securitized bonds and notes	136.0	–	64.5	71.5
			–	–
Equity securities	33.5	33.5	–	–
Other	4.3	–	4.3	–
Subtotal		149.8	320.4	71.5
Assets (fair value determined using NAV practical expedient):				
Hedge funds	427.9			
Private equity and credit funds	1,092.8			
Fixed income – commingled funds	41.6			
Equity – commingled funds	166.9			
Common/collective trusts	131.7			
Accrued interest and dividends receivable	3.6			
Amounts due (to) from brokers, net	11.1			
	$ 2,417.3			
Liabilities				
Derivatives in a liability position	$ 12.8	–	12.8	–
Fair value of Plan assets	$ 2,404.5	$ 149.8	$ 307.6	$ 71.5

(Dollars in Millions)

11. Postretirement Benefits (continued)

The fair value of pension plan assets was determined using the following inputs at December 31, 2017:

		Fair Value Measurements Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 76.2	$ 76.2	$ –	$ –
Income securities:				
U.S. government and agency obligations	131.6	–	131.6	–
Corporate debt securities	254.2	–	254.2	–
Asset-backed and securitized bonds and notes	148.8	–	84.0	64.8
Equity securities	41.3	41.3	–	–
Other	3.9	–	3.9	–
Subtotal		117.5	473.7	64.8
Assets (fair value determined using NAV practical expedient):				
Hedge funds	322.8			
Private equity and credit funds	880.9			
Fixed income – commingled funds	40.2			
Equity – commingled funds	420.8			
Common/collective trusts	38.1			
Accrued interest and dividends receivable	3.4			
Amounts due (to) from brokers, net	(12.0)			
	$ 2,350.2			
Liabilities				
Derivatives in a liability position	$ 0.3	–	0.3	–
Fair value of Plan assets	$ 2,349.9	$ 117.5	$ 473.4	$ 64.8

(Dollars in Millions)

11. Postretirement Benefits (continued)

The following table is a roll forward of the pension plan assets classified in Level 3 of the valuation hierarchy defined above:

	Asset-Backed and Securitized Bonds and Notes
Fair value at January 1, 2017	$ 43.9
Purchases, sales and settlements, net	16.2
Actual earnings on plan assets	4.0
Transfers in and/or out of Level 3	0.7
Fair value at December 31, 2017	64.8
Purchases, sales and settlements, net	**8.8**
Actual earnings on plan assets	**(0.5)**
Transfers in and/or out of Level 3	**(1.6)**
Fair value at December 31, 2018	**$ 71.5**

Fair value methodologies for Level 1 and Level 2 assets are consistent with the inputs described in Note 10. BJC transfers assets in and/or out of Level 3 as significant inputs, including performance attributes, used for the fair value measurement become observable or unobservable. BJC transferred $1.6 of securitized notes and bonds from Level 3 to Level 2 in 2018 by obtaining additional observable market inputs in the form of multiple corroborating broker quotes. BJC transferred $0.7 of securitized notes and bonds from Level 2 to Level 3 in 2017, as fewer observable market inputs were obtained. BJC recognizes transfers as of the end of the reporting period.

Private equity and credit investments have contractual commitments to provide capital contributions during the investment period, up to seven years from initial investment date, and restrictions on the timing of withdrawals, up to 15 years from initial investment date, which may reduce liquidity. Certain hedge fund investments also have restrictions on the timing of withdrawals, up to one year from December 31, 2018, which may reduce liquidity. These investments represent the Plan's ownership interest in the NAV of the respective partnership.

(Dollars in Millions)

11. Postretirement Benefits (continued)

Management opted to use the NAV per share, or its equivalent, as a practical expedient for fair value of the Plan's interest in hedge funds, private equity and credit funds and commingled funds. Valuations provided by the respective fund's management consider variables, such as the financial performance of underlying investments, recent sales prices of underlying investments, and other pertinent information. At December 31, 2018, the Plan has unfunded commitments of $673.0 to private equity and credit funds. Due to the uncertainty surrounding whether the contractual commitments will require funding during the contractual period, future minimum payments to meet these commitments cannot be reasonably estimated. These committed amounts are expected to be primarily satisfied by the liquidation of existing investments from the Plan's assets.

A summary of expected cash flows for contributions and amounts to be paid to the Plan's participants and beneficiaries is as follows:

Expected employer contribution in 2019	$	73.5
Expected benefit payments:		
2019		88.6
2020		97.7
2021		108.0
2022		117.3
2023		126.9
2024–2028		771.7

12. Professional and General Liability Insurance

BJC self-insures for professional and general liability claims to the extent of certain self-insured limits. Substantially all BJC services are covered under the BJC self-insurance program. Effective November 15, 2006, self-insured retentions were between $3.0 (for all hospitals except Barnes-Jewish, St. Louis Children's, and MRHS) and $8.0 (for Barnes-Jewish and Children's) per occurrence with no aggregate. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of self-insured limits. Effective November 15, 2017, MRHS was added to the BJC umbrella insurance policies with a retroactive date of August 1, 2010. At December 31, 2018 and 2017, BJC recorded a liability for the self-insurance program of $174.1 and $178.1, respectively, included in other current liabilities and self-insurance liabilities in the consolidated balance sheets. In addition, at December 31, 2018 and 2017, BJC recorded insurance receivables of $8.6 and $8.7, respectively, included in other noncurrent assets in the consolidated balance sheets.

(Dollars in Millions)

12. Professional and General Liability Insurance (continued)

The estimated cost of claims is actuarially determined based upon past experience, and is discounted using a discount rate of 4.00% in 2018 and 3.00% in 2017. The reserve includes provisions for asserted and unasserted claims and incidents that have occurred but have not been reported. BJC has revocable self-insurance trusts totaling $36.5 and $47.2 as of December 31, 2018 and 2017, respectively, which are used for the payment of professional and general liability claim settlements and expenses. During 2018 and 2017, $32.7 and $37.0, respectively, of professional and general liability expenses were included in supplies and other in the consolidated statements of operations and changes in net assets.

13. Operating Leases

BJC leases certain real estate and equipment under operating leases, which may include renewal options and escalation clauses. Future minimum lease payments for all noncancelable operating leases that have initial or remaining terms of one year or more are as follows:

Year ending December 31:	
2019	$ 31.4
2020	36.1
2021	25.1
2022	19.1
2023	15.3
Thereafter	146.4
	$ 273.4

Lease expense under operating leases for the years ended December 31, 2018 and 2017, totaled $89.1 and $83.2, respectively.

(Dollars in Millions)

14. Functional Classification of Expenses

BJC provides healthcare services, including inpatient, outpatient, ambulatory, long-term care and community-based services to individuals within its geographic areas supported by its facilities. Administrative services include administration, finance and accounting, information technology, public relations, human resources, legal and other functions. Expenses are allocated to healthcare services and administrative services based on the functional department for which they are incurred. Departmental expenses may include various allocations of costs based on direct assignment, expenses or other methods.

Expenses by functional classification for the year ended December 31, 2018 consist of the following:

	2018		
	Healthcare Services	**Administrative Services**	**Total**
Salaries and benefits	**$ 2,335.7**	**$ 193.8**	**$ 2,529.5**
Supplies and other	**2,145.1**	**174.8**	**2,319.9**
Depreciation and amortization	**232.4**	**126.4**	**358.8**
Interest	**59.2**	**0.1**	**59.3**
Total	**$ 4,772.4**	**$ 495.1**	**$ 5,267.5**

Expenses by functional classification for the year ended December 31, 2017 consist of the following:

	2017		
	Healthcare Services	**Administrative Services**	**Total**
Salaries and benefits	$ 2,173.7	$ 187.0	$ 2,360.7
Supplies and other	1,977.2	142.4	2,119.6
Depreciation and amortization	148.1	171.9	320.0
Interest	38.4	0.1	38.5
Total	$ 4,337.4	$ 501.4	$ 4,838.8

15. Contingencies

The U.S. Department of Justice and other federal agencies continue to commit resources dedicated to regulatory investigations and compliance audits of healthcare providers. BJC is not exempt from these regulatory efforts and has received correspondence from federal agencies with regard to such initiatives. In consultation with legal counsel, management estimates these matters will be resolved without material adverse effect on BJC's consolidated financial position or consolidated results of operations. BJC has an established formal corporate compliance function designed to monitor compliance with applicable laws and regulations.

BJC is involved as both plaintiff and defendant in litigation arising in the ordinary course of business. After consultation with legal counsel, management believes that these matters will be resolved without a material adverse effect on BJC's consolidated financial position, operating results or cash flows.

In October 2013, a petition was filed against BJC in the Circuit Court of the City of St. Louis, Missouri, alleging violations of wage and hour laws. On February 5, 2018, the class was certified to include all current and former non-exempt (hourly) employees at BJC's Missouri entities from October 21, 2008 through June 9, 2015. In 2018, BJC determined that a contingent liability could be reasonably estimated and recorded $65.0, which is included in supplies and other in the consolidated statements of operations and changes in net assets.

16. Endowments

The Foundations' endowments consist of funds established for a variety of purposes. The Foundations' endowments include both donor-restricted endowment funds and funds designated by the Foundations' Boards of Directors to function as endowments. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions in accordance with U.S. GAAP.

The Foundations have interpreted Missouri's enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (the Missouri Statute) as requiring the preservation of the fair value of the original gift as of the gift date of a donor-restricted endowment fund, absent explicit donor stipulations to the contrary.

16. Endowments (continued)

As a result of this interpretation, the Foundations classify as net assets with donor restrictions (a time restriction in perpetuity): (a) the original value of gifts donated to a permanent endowment, (b) the original value of subsequent gifts to a permanent endowment and (c) accumulations to a permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the endowment fund that is not classified as net assets with donor restrictions (a time restriction in perpetuity) is classified as net assets with donor restrictions (a purpose restriction) and are appropriated for expenditure by the Foundations in a manner consistent with the standards prescribed by the Missouri Statute.

In accordance with the Missouri Statute, when investing, reinvesting, purchasing, acquiring, exchanging, selling, managing property, appropriating appreciation, developing and applying investment and spending policies and accumulating income, the Board of Directors of each affiliated foundation shall act with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with these matters would use in the conduct of an enterprise of like character and with like aims to accomplish the purposes of the institution receiving the benefit of the institutional endowment fund.

In exercising such judgment, the Foundations shall consider the following factors in making a determination to appropriate or accumulate donor-restricted funds:

- The duration and preservation of the fund
- The purposes of the Foundation and the endowment fund
- General economic conditions
- The possible effects of inflation and deflation
- The expected total return from income and appreciation of investments
- Other resources of the Foundation
- The investment policies of the Foundation

(Dollars in Millions)

16. Endowments (continued)

At December 31, 2018, the endowment net asset composition by type of fund consisted of the following:

	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	$ –	$ 272.7	$ 272.7
Board-designated endowment funds	159.5	–	159.5
Total funds	$ 159.5	$ 272.7	$ 432.2

At December 31, 2017, the endowment net asset composition by type of fund consisted of the following:

	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	$ –	$ 278.8	$ 278.8
Board-designated endowment funds	165.6	–	165.6
Total funds	$ 165.6	$ 278.8	$ 444.4

(Dollars in Millions)

16. Endowments (continued)

For the years ended December 31, 2018 and 2017, the changes in the endowment net assets are as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
Endowment net assets, January 1, 2017	$ 150.0	$ 251.2	$ 401.2
Investment return:			
Investment income	2.6	3.5	6.1
Net appreciation	17.5	27.4	44.9
Total investment return	20.1	30.9	51.0
Contributions	–	6.1	6.1
Appropriations, net of recoveries	(6.1)	(9.6)	(15.7)
Other changes	1.6	0.2	1.8
Endowment net assets, December 31, 2017	165.6	278.8	444.4
Investment return:			
Investment income	**3.3**	**4.8**	**8.1**
Net depreciation	**(5.5)**	**(9.1)**	**(14.6)**
Total investment return	**(2.2)**	**(4.3)**	**(6.5)**
Contributions	**–**	**7.8**	**7.8**
Appropriations, net of recoveries	**(7.4)**	**(10.6)**	**(18.0)**
Other changes	**3.5**	**1.0**	**4.5**
Endowment net assets, December 31, 2018	**$ 159.5**	**$ 272.7**	**$ 432.2**

Return Objectives and Risk Parameters

The Foundations have adopted investment and spending policies for endowment assets that attempt to provide a stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the organization must hold in perpetuity or for a donor-specified period(s), as well as board-designated funds. Under this policy, as approved by the Foundations' Boards of Directors, the endowment net assets are invested in a manner that is intended to produce results that exceed the price and yield results of their relevant benchmarks while assuming a reasonable level of investment risk. The Foundations expect their endowment funds, over time, to

16. Endowments (continued)

generate a total annualized rate of return, net of fees, 5% greater than the rate of inflation, as measured by the Consumer Price Index (CPI), over a rolling five-year period. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives

To satisfy their long-term rate-of-return objectives, the Foundations rely on a total return strategy in which investment earnings are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends, net of fees).

Spending Policy

The Foundations have adopted a policy in which earnings are allocated annually for spending ranging from 2% to 5% of the 36-month rolling average market value or three-year average market value of the endowment fund investment pool.

In establishing this policy, the Foundations consider the long-term expected return on the endowment whereby the current policy allows the endowment assets to grow at an average of CPI annually. The Foundation for Barnes-Jewish Hospital provides additional annual support for endowment administration of up to 1%. All other Foundations pay for endowment administration using non-endowment earnings and unrestricted donations.

17. Subsequent Events

BJC evaluated events and transactions occurring subsequent to December 31, 2018 through March 8, 2019, the date the consolidated financial statements were issued. During this period, there were no subsequent events that required recognition or disclosure in the consolidated financial statements.

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Attachment 33

PART IV

Item 15. Exhibits and Financial Statement Schedules

Financial Statements

See the accompanying index on page F-1 for a list of financial statements filed as part of this report.

Financial Statement Schedules

None.

Exhibits

See Exhibit Index immediately following page F-77 of this report.

Item 16. Form 10-K Summary

Not applicable.

Attachment 33

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Report to be signed on its behalf by the undersigned, thereunto duly authorized.

ENCOMPASS HEALTH CORPORATION

By: /s/ MARK J. TARR

Mark J. Tarr
President and Chief Executive Officer

Date: February 27, 2019

[Signatures continue on the following page]

Attachment 33

POWER OF ATTORNEY

Each person whose signature appears below hereby constitutes and appoints Patrick Darby his true and lawful attorney-in-fact and agent with full power of substitution and re-substitution, for him in his name, place and stead, in any and all capacities, to sign any and all amendments to this Report and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, and hereby grants to such attorney-in-fact and agent, full power and authority to do and perform each and every act and thing requisite and necessary to be done, as fully to all intents and purposes as he might or could do in person, hereby ratifying and confirming all that said attorney-in-fact and agent or his substitute or substitutes may lawfully do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, this Report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signature	Capacity	Date
/s/ MARK J. TARR **Mark J. Tarr**	President and Chief Executive Officer and Director	February 27, 2019
/s/ DOUGLAS E. COLTHARP **Douglas E. Coltharp**	Executive Vice President and Chief Financial Officer	February 27, 2019
/s/ ANDREW L. PRICE **Andrew L. Price**	Chief Accounting Officer	February 27, 2019
/s/ LEO I. HIGDON, JR. **Leo I. Higdon, Jr.**	Chairman of the Board of Directors	February 27, 2019
/s/ JOHN W. CHIDSEY **John W. Chidsey**	Director	February 27, 2019
/s/ DONALD L. CORRELL **Donald L. Correll**	Director	February 27, 2019
/s/ YVONNE M. CURL **Yvonne M. Curl**	Director	February 27, 2019
/s/ CHARLES M. ELSON **Charles M. Elson**	Director	February 27, 2019
/s/ JOAN E. HERMAN **Joan E. Herman**	Director	February 27, 2019
/s/ LESLYE G. KATZ **Leslye G. Katz**	Director	February 27, 2019
/s/ JOHN E. MAUPIN, JR **John E. Maupin, Jr.**	Director	February 27, 2019
/s/ Nancy M. Schlichting **Nancy M. Schlichting**	Director	February 27, 2019
/s/ L. EDWARD SHAW, JR. **L. Edward Shaw, Jr.**	Director	February 27, 2019

Attachment 33

Item 15. Financial Statements

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of Encompass Health Corporation:

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Encompass Health Corporation and its subsidiaries (the "Company") as of December 31, 2018 and December 31, 2017, and the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and December 31, 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

Change in Accounting Principle

As discussed in Note 1 to the consolidated financial statements, the Company changed the manner in which it accounts for net operating revenues in 2018.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) ("PCAOB") and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the

company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
February 27, 2019

We have served as the Company's auditor since 2003.

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Operations

	For the Year Ended December 31,		
	2018	2017	2016
	(In Millions, Except Per Share Data)		
Net operating revenues	$ 4,277.3	$ 3,913.9	$ 3,642.6
Operating expenses:			
Salaries and benefits	2,354.0	2,154.6	1,985.9
Other operating expenses	585.1	531.6	490.6
Occupancy costs	78.0	73.5	71.3
Supplies	158.7	149.3	140.0
General and administrative expenses	220.2	171.7	133.4
Depreciation and amortization	199.7	183.8	172.6
Government, class action, and related settlements	52.0	—	—
Total operating expenses	3,647.7	3,264.5	2,993.8
Loss on early extinguishment of debt	—	10.7	7.4
Interest expense and amortization of debt discounts and fees	147.3	154.4	172.1
Other income	(2.2)	(4.1)	(2.9)
Equity in net income of nonconsolidated affiliates	(8.7)	(8.0)	(9.8)
Income from continuing operations before income tax expense	493.2	496.4	482.0
Provision for income tax expense	118.9	145.8	163.9
Income from continuing operations	374.3	350.6	318.1
Income (loss) from discontinued operations, net of tax	1.1	(0.4)	—
Net income	375.4	350.2	318.1
Less: Net income attributable to noncontrolling interests	(83.1)	(79.1)	(70.5)
Net income attributable to Encompass Health	$ 292.3	$ 271.1	$ 247.6
Weighted average common shares outstanding:			
Basic	97.9	93.7	89.1
Diluted	99.8	99.3	99.5
Earnings per common share:			
Basic earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	$ 2.97	$ 2.88	$ 2.77
Discontinued operations	0.01	—	—
Net income	$ 2.98	$ 2.88	$ 2.77
Diluted earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	$ 2.92	$ 2.84	$ 2.59
Discontinued operations	0.01	—	—
Net income	$ 2.93	$ 2.84	$ 2.59
Amounts attributable to Encompass Health:			
Income from continuing operations	$ 291.2	$ 271.5	$ 247.6
Income (loss) from discontinued operations, net of tax	1.1	(0.4)	—
Net income attributable to Encompass Health	$ 292.3	$ 271.1	$ 247.6

The accompanying notes to consolidated financial statements are an integral part of these statements.

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Comprehensive Income

	For the Year Ended December 31,		
	2018	2017	2016
		(In Millions)	
COMPREHENSIVE INCOME			
Net income	$ 375.4	$ 350.2	$ 318.1
Other comprehensive loss, net of tax:			
Net change in unrealized (loss) gain on available-for-sale securities:			
Unrealized net holding (loss) gain arising during the period	—	(0.1)	0.1
Other comprehensive (loss) income before income taxes	—	(0.1)	0.1
Provision for income tax expense related to other comprehensive loss items	—	—	(0.1)
Other comprehensive loss, net of tax:	—	(0.1)	—
Comprehensive income	375.4	350.1	318.1
Comprehensive income attributable to noncontrolling interests	(83.1)	(79.1)	(70.5)
Comprehensive income attributable to Encompass Health	$ 292.3	$ 271.0	$ 247.6

The accompanying notes to consolidated financial statements are an integral part of these statements.

Encompass Health Corporation and Subsidiaries

Consolidated Balance Sheets

	As of December 31,	
	2018	2017
	(In Millions, Except Share Data)	
Assets		
Current assets:		
Cash and cash equivalents	$ 69.2	$ 54.4
Restricted cash	59.0	62.4
Accounts receivable	467.7	472.1
Prepaid expenses and other current assets	66.2	113.3
Total current assets	662.1	702.2
Property and equipment, net	1,634.8	1,517.1
Goodwill	2,100.8	1,972.6
Intangible assets, net	443.4	403.1
Deferred income tax assets	42.9	34.4
Other long-term assets	291.0	235.1
Total assets[1]	$ 5,175.0	$ 4,864.5
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	$ 35.8	$ 32.3
Accounts payable	90.0	78.4
Accrued payroll	188.4	172.1
Accrued interest payable	24.4	24.7
Other current liabilities	333.9	210.0
Total current liabilities	672.5	517.5
Long-term debt, net of current portion	2,478.6	2,545.4
Self-insured risks	119.6	110.1
Other long-term liabilities	85.6	75.2
	3,356.3	3,248.2
Commitments and contingencies		
Redeemable noncontrolling interests	261.7	220.9
Shareholders' equity:		
Encompass Health shareholders' equity:		
Common stock, $.01 par value; 200,000,000 shares authorized; issued: 112,492,690 in 2018; 111,690,547 in 2017	1.1	1.1
Capital in excess of par value	2,588.7	2,747.4
Accumulated deficit	(885.2)	(1,176.2)
Accumulated other comprehensive loss	—	(1.3)
Treasury stock, at cost (13,566,209 shares in 2018 and 13,385,019 shares in 2017)	(427.9)	(418.5)
Total Encompass Health shareholders' equity	1,276.7	1,152.5
Noncontrolling interests	280.3	242.9
Total shareholders' equity	1,557.0	1,395.4
Total liabilities[1] **and shareholders' equity**	$ 5,175.0	$ 4,864.5

(1) Our consolidated assets as of December 31, 2018 and December 31, 2017 include total assets of variable interest entities of $197.5 million and $264.1 million, respectively, which cannot be used by us to settle the obligations of other entities. Our consolidated liabilities as of December 31, 2018 and December 31, 2017 include total liabilities of the variable interest entities of $50.8 million and $52.5 million, respectively. See Note 3, *Variable Interest Entities*.

The accompanying notes to consolidated financial statements are an integral part of these statements.

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Encompass Health Corporation and Subsidiaries

Consolidated Statements of Shareholders' Equity

	Encompass Health Common Shareholders							
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated Deficit	Accumulated Other Comprehensive Loss	Treasury Stock	Noncontrolling Interests	Total
	(In Millions)							
December 31, 2015	90.1	$ 1.1	$ 2,821.0	$ (1,696.0)	$ (1.2)	$ (527.4)	$ 167.9	$ 765.4
Net income	—	—	—	247.6	—	—	56.4	304.0
Receipt of treasury stock	(0.5)	—	—	—	—	(11.6)	—	(11.6)
Dividends declared ($0.94 per share)	—	—	(84.9)	—	—	—	—	(84.9)
Stock-based compensation	—	—	21.4	—	—	—	—	21.4
Stock options exercised	0.6	—	13.1	—	—	(7.8)	—	5.3
Distributions declared	—	—	—	—	—	—	(54.2)	(54.2)
Repurchases of common stock in open market	(1.7)	—	—	—	—	(65.6)	—	(65.6)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	19.6	19.6
Fair value adjustments to redeemable noncontrolling interests	—	—	(10.9)	—	—	—	—	(10.9)
Windfall tax benefits from share-based compensation	—	—	17.3	—	—	—	—	17.3
Other	0.4	—	4.0	—	—	(2.3)	3.1	4.8
December 31, 2016	88.9	1.1	2,781.0	(1,448.4)	(1.2)	(614.7)	192.8	910.6
Net income	—	—	—	271.1	—	—	61.2	332.3
Receipt of treasury stock	(0.9)	—	—	—	—	(19.8)	—	(19.8)
Dividends declared ($0.98 per share)	—	—	(95.2)	—	—	—	—	(95.2)
Stock-based compensation	—	—	21.3	—	—	—	—	21.3
Stock options exercised	1.1	—	20.4	—	—	(19.3)	—	1.1
Stock warrants exercised	0.7	—	26.6	—	—	—	—	26.6
Distributions declared	—	—	—	—	—	—	(50.5)	(50.5)
Repurchases of common stock in open market	(0.9)	—	—	—	—	(38.1)	—	(38.1)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	46.2	46.2
Fair value adjustments to redeemable noncontrolling interests	—	—	(67.0)	—	—	—	—	(67.0)
Conversion of convertible debt, net of tax	8.9	—	53.7	—	—	274.5	—	328.2
Other	0.5	—	6.6	1.1	(0.1)	(1.1)	(6.8)	(0.3)
December 31, 2017	98.3	1.1	2,747.4	(1,176.2)	(1.3)	(418.5)	242.9	1,395.4
Net income	—	—	—	**292.3**	—	—	**69.2**	**361.5**
Receipt of treasury stock	**(0.2)**	—	—	—	—	**(8.3)**	—	**(8.3)**
Dividends declared ($1.04 per share)	—	—	**(103.7)**	—	—	—	—	**(103.7)**
Stock-based compensation	—	—	**28.9**	—	—	—	—	**28.9**
Stock options exercised	**0.1**	—	**3.2**	—	—	—	—	**3.2**
Distributions declared	—	—	—	—	—	—	**(71.1)**	**(71.1)**
Capital contributions from consolidated affiliates	—	—	—	—	—	—	**38.8**	**38.8**
Fair value adjustments to redeemable noncontrolling interests	—	—	(91.0)	—	—	—	—	(91.0)
Other	**0.7**	—	**3.9**	**(1.3)**	**1.3**	**(1.1)**	**0.5**	**3.3**
December 31, 2018	**98.9**	**$ 1.1**	**$ 2,588.7**	**$ (885.2)**	**$ —**	**$ (427.9)**	**$ 280.3**	**$ 1,557.0**

The accompanying notes to consolidated financial statements are an integral part of these statements.

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	For the Year Ended December 31,		
	2018	2017	2016
		(In Millions)	
Cash flows from operating activities:			
Net income	$ 375.4	$ 350.2	$ 318.1
(Income) loss from discontinued operations, net of tax	(1.1)	0.4	—
Adjustments to reconcile net income to net cash provided by operating activities—			
Provision for government, class action, and related settlements	52.0	—	—
Depreciation and amortization	199.7	183.8	172.6
Amortization of debt-related items	4.0	8.7	13.8
Loss on early extinguishment of debt	—	10.7	7.4
Equity in net income of nonconsolidated affiliates	(8.7)	(8.0)	(9.8)
Distributions from nonconsolidated affiliates	8.3	8.6	8.5
Stock-based compensation	85.9	47.7	27.4
Deferred tax expense	(9.1)	60.8	132.9
Other, net	9.2	3.4	0.1
Changes in assets and liabilities, net of acquisitions—			
Accounts receivable	7.0	(31.5)	(66.3)
Prepaid expenses and other assets	11.5	(12.6)	(3.3)
Accounts payable	6.6	7.5	6.3
Accrued payroll	14.8	24.4	21.4
Other liabilities	6.1	4.8	11.8
Net cash provided by (used in) operating activities of discontinued operations	0.8	(0.6)	(0.7)
Total adjustments	388.1	307.7	322.1
Net cash provided by operating activities	762.4	658.3	640.2
Cash flows from investing activities:			
Acquisition of businesses, net of cash acquired	(143.9)	(38.8)	(48.1)
Purchases of property and equipment	(254.5)	(225.8)	(177.7)
Additions to capitalized software costs	(16.0)	(19.2)	(25.2)
Proceeds from disposal of assets	0.4	12.3	23.9
Proceeds from sale of restricted investments	11.6	4.2	0.1
Purchases of restricted investments	(13.3)	(8.5)	(1.3)
Other, net	(8.8)	(7.2)	(1.7)
Net cash provided by investing activities of discontinued operations	—	—	0.1
Net cash used in investing activities	(424.5)	(283.0)	(229.9)

(Continued)

Attachment 33

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Cash Flows (Continued)

	For the Year Ended December 31,		
	2018	2017	2016
		(In Millions)	
Cash flows from financing activities:			
Principal payments on debt, including pre-payments	(20.6)	(129.9)	(202.1)
Principal borrowings on notes	13.2	—	—
Borrowings on revolving credit facility	325.0	273.3	335.0
Payments on revolving credit facility	(390.0)	(330.3)	(313.0)
Principal payments under capital lease obligations	(17.9)	(15.3)	(13.3)
Repurchases of common stock, including fees and expenses	—	(38.1)	(65.6)
Dividends paid on common stock	(100.8)	(91.5)	(83.8)
Purchase of equity interests in consolidated affiliates	(65.1)	—	—
Proceeds from exercising stock warrants	—	26.6	—
Distributions paid to noncontrolling interests of consolidated affiliates	(75.4)	(51.9)	(64.9)
Taxes paid on behalf of employees for shares withheld	(8.3)	(19.8)	(11.6)
Contributions from consolidated affiliates	12.6	20.8	3.5
Other, net	6.1	(3.8)	(0.6)
Net cash used in financing activities	(321.2)	(359.9)	(416.4)
Increase (decrease) in cash, cash equivalents, and restricted cash	16.7	15.4	(6.1)
Cash, cash equivalents, and restricted cash at beginning of year	116.8	101.4	107.5
Cash, cash equivalents, and restricted cash at end of year	$ 133.5	$ 116.8	$ 101.4
Reconciliation of Cash, Cash Equivalents, and Restricted Cash			
Cash and cash equivalents at beginning of period	$ 54.4	$ 40.5	$ 61.6
Restricted cash at beginning of period	62.4	60.9	45.9
Cash, cash equivalents, and restricted cash at beginning of period	$ 116.8	$ 101.4	$ 107.5
Cash and cash equivalents at end of period	$ 69.2	$ 54.4	$ 40.5
Restricted cash at end of period	59.0	62.4	60.9
Restricted cash included in other long-term assets at end of period	5.3	—	—
Cash, cash equivalents, and restricted cash at end of period	$ 133.5	$ 116.8	$ 101.4
Supplemental cash flow information:			
Cash (paid) received during the year for —			
Interest	$ (149.6)	$ (150.5)	$ (164.3)
Income tax refunds	0.6	1.9	1.4
Income tax payments	(115.4)	(96.4)	(33.3)
Supplemental schedule of noncash financing activities:			
Conversion of convertible debt	$ —	$ 319.4	$ —

The accompanying notes to consolidated financial statements are an integral part of these statements.

1. Summary of Significant Accounting Policies:

Organization and Description of Business—

Encompass Health Corporation, incorporated in Delaware in 1984, including its subsidiaries, is one of the nation's largest providers of post-acute healthcare services, offering both facility-based and home-based post-acute services in 36 states and Puerto Rico through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. We manage our operations and disclose financial information using two reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. See Note 18, *Segment Reporting*.

On July 10, 2017, we announced the plan to rebrand and change our name from HealthSouth Corporation to Encompass Health Corporation. On October 20, 2017, our board of directors approved an amended and restated certificate of incorporation in order to change the name effective as of January 1, 2018. Along with the corporate name change, the NYSE ticker symbol for our common stock changed from "HLS" to "EHC." Our operations in both business segments transitioned to the Encompass Health branding in 2018.

Basis of Presentation and Consolidation—

The accompanying consolidated financial statements of Encompass Health and its subsidiaries were prepared in accordance with generally accepted accounting principles in the United States of America and include the assets, liabilities, revenues, and expenses of all wholly-owned subsidiaries, majority-owned subsidiaries over which we exercise control, and, when applicable, entities in which we have a controlling financial interest.

We use the equity method to account for our investments in entities we do not control, but where we have the ability to exercise significant influence over operating and financial policies. Consolidated *Net income attributable to Encompass Health* includes our share of the net earnings of these entities. The difference between consolidation and the equity method impacts certain of our financial ratios because of the presentation of the detailed line items reported in the consolidated financial statements for consolidated entities compared to a one line presentation of equity method investments.

We use the cost method to account for our investments in entities we do not control and for which we do not have the ability to exercise significant influence over operating and financial policies. In accordance with the cost method, these investments are recorded at the lower of cost or fair value, as appropriate.

We eliminate all significant intercompany accounts and transactions from our financial results.

Variable Interest Entities—

Any entity considered a variable interest entity ("VIE") is evaluated to determine which party is the primary beneficiary and thus should consolidate the VIE. This analysis is complex, involves uncertainties, and requires significant judgment on various matters. In order to determine if we are the primary beneficiary of a VIE, we must determine what activities most significantly impact the economic performance of the entity, whether we have the power to direct those activities, and if our obligation to absorb losses or receive benefits from the VIE could potentially be significant to the VIE.

Use of Estimates and Assumptions—

The preparation of our consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) revenue reserves for contractual adjustments and uncollectible amounts; (2) fair value of acquired assets and assumed liabilities in business combinations; (3) asset impairments, including goodwill; (4) depreciable lives of assets; (5) useful lives of intangible assets; (6) economic lives and fair value of leased assets; (7) income tax valuation allowances; (8) uncertain tax positions; (9) fair value of stock options and restricted stock containing a market condition; (10) fair value of redeemable noncontrolling interests; (11) reserves for self-insured healthcare plans; (12) reserves for professional, workers' compensation, and comprehensive general insurance liability risks; and (13) contingency and litigation reserves. Future events and their effects cannot be predicted with certainty; accordingly, our

accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Risks and Uncertainties—

As a healthcare provider, we are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things:

- licensure, certification, and accreditation;
- policies, either at the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements);
- coding and billing for services;
- requirements of the 60% compliance threshold under The Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of patient information and medical records;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our hospitals, equipment, personnel, services, capital expenditure programs, operating procedures, contractual arrangements, and patient admittance practices, as well as the way in which we deliver home health and hospice services.

If we fail to comply with applicable laws and regulations, we could be required to return portions of reimbursements deemed after the fact to have not been appropriate. We could also be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals or agencies, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement. Because Medicare comprises a significant portion of our *Net operating revenues*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. Specifically, reductions in reimbursements, substantial damages, and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operation, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation.

Historically, the United States Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on the increases in and, in some cases, significant roll-backs or reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. There can be no assurance that future governmental initiatives will not result in pricing roll-backs or freezes or reimbursement reductions. Because we receive a significant percentage of our revenues from Medicare, such changes in legislation might have a material adverse effect on our financial position, results of operations, and cash flows.

In addition, there are increasing pressures from many third-party payors to control healthcare costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and nongovernmental third-party payors are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services. We could be adversely affected in some of the markets where we operate if we are unable to negotiate and maintain favorable agreements with third-party payors.

Our third-party payors may also, from time to time, request audits of the amounts paid, or to be paid, to us. We could be adversely affected in some of the markets where we operate if the auditing payor alleges substantial overpayments were made to us due to coding errors or lack of documentation to support medical necessity determinations.

As discussed in Note 17, *Contingencies and Other Commitments*, we are a party to a number of lawsuits. We cannot predict the outcome of litigation filed against us. Substantial damages or other monetary remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Net Operating Revenues—

Our *Net operating revenues* disaggregated by payor source and segment are as follows (in millions):

	Inpatient Rehabilitation			Home Health and Hospice			Consolidated		
	Year Ended December 31,			Year Ended December 31,			Year Ended December 31,		
	2018	2017	2016	2018	2017	2016	2018	2017	2016
Medicare	$2,451.7	$2,313.6	$2,187.8	$ 794.5	$ 662.9	$ 565.9	$3,246.2	$2,976.5	$2,753.7
Medicare Advantage	306.5	261.0	226.9	88.6	74.8	59.0	395.1	335.8	285.9
Managed care	343.3	335.6	325.4	33.2	29.1	26.2	376.5	364.7	351.6
Medicaid	101.3	93.2	84.5	11.6	4.3	25.8	112.9	97.5	110.3
Other third-party payors	49.0	49.9	50.3	—	—	—	49.0	49.9	50.3
Workers' compensation	27.4	27.5	29.6	1.5	0.1	0.1	28.9	27.6	29.7
Patients	18.7	18.4	17.9	0.8	0.7	0.5	19.5	19.1	18.4
Other income	48.3	42.1	42.0	0.9	0.7	0.7	49.2	42.8	42.7
Total	$3,346.2	$3,141.3	$2,964.4	$ 931.1	$ 772.6	$ 678.2	$4,277.3	$3,913.9	$3,642.6

We record *Net operating revenues* on an accrual basis using our best estimate of the transaction price for the type of service provided to the patient. Our estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, potential adjustments that may arise from payment and other reviews, and uncollectible amounts. Our accounting systems calculate contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Adjustments related to payment reviews by third-party payors or their agents are based on our historical experience and success rates in the claims adjudication process. Estimates for uncollectible amounts are based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors.

Management continually reviews the revenue transaction price estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms that result from contract renegotiations and renewals. Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation, we may receive reimbursement for healthcare services authorized and provided that is different from our estimates, and such differences could be material. In addition, laws and regulations governing the Medicare and Medicaid programs are complex, subject to interpretation, and are routinely modified for provider reimbursement. All healthcare providers participating in the Medicare and Medicaid programs are required to meet certain financial reporting requirements. Federal regulations require submission of annual cost reports covering medical costs and expenses associated with the services provided under each hospital, home health, and hospice provider number to program beneficiaries. Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to Encompass Health under these reimbursement programs. These audits often require several years to reach the final determination of amounts earned under the programs. If

actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

The Centers for Medicare and Medicaid Services ("CMS") has been granted authority to suspend payments, in whole or in part, to Medicare providers if CMS possesses reliable information an overpayment, fraud, or willful misrepresentation exists. If CMS suspects payments are being made as the result of fraud or misrepresentation, CMS may suspend payment at any time without providing prior notice to us. The initial suspension period is limited to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the United States Department of Health and Human Services Office of Inspector General (the "HHS-OIG") or the United States Department of Justice (the "DOJ"). Therefore, we are unable to predict if or when we may be subject to a suspension of payments by the Medicare and/or Medicaid programs, the possible length of the suspension period, or the potential cash flow impact of a payment suspension. Any such suspension would adversely impact our financial position, results of operations, and cash flows.

Pursuant to legislative directives and authorizations from Congress, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. As a matter of course, we undertake significant efforts through training and education to ensure compliance with Medicare requirements. However, audits may lead to assertions we have been underpaid or overpaid by Medicare or submitted improper claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid. In some circumstances auditors assert the authority to extrapolate denial rationales to large pools of claims not actually audited, which could increase the impact of the audit. We cannot predict when or how these audit programs will affect us.

Medicare Administrative Contractors ("MACs"), under programs known as "widespread probes," have conducted pre-payment claim reviews of our Medicare billings and in some cases denied payment for certain diagnosis codes. The majority of the denials we have encountered in these probes relate to determinations regarding medical necessity and provision of therapy services. We dispute, or "appeal," most of these denials, and for claims we choose to take to administrative law judge hearings, we have historically experienced a success rate of approximately 70%. This historical success rate is a component of our estimate of transaction price as discussed above. The resolution of these disputes can take in excess of three years, and we cannot provide assurance as to our ongoing and future success of these disputes. When the amount collected related to denied claims differs from the amount previously estimated, these collection differences are recorded as an adjustment to *Net operating revenues*.

In August 2017, CMS announced the Targeted Probe and Educate ("TPE") initiative. Under the TPE initiative, MACs use data analysis to identify healthcare providers with high claim error rates and items and services that have high national error rates. Once a MAC selects a provider for claims review, the initial volume of claims review is limited to 20 to 40 claims. The TPE initiative includes up to three rounds of claims review if necessary with corresponding provider education and a subsequent period to allow for improvement. If results do not improve sufficiently after three rounds, the MAC may refer the provider to CMS for further action, which may include extrapolation of error rates to a broader universe of claims or referral to a ZPIC or RAC (defined below). We cannot predict the impact of the TPE initiative on our ability to collect claims on a timely basis.

In connection with CMS approved and announced Recovery Audit Contractors ("RACs") audits related to inpatient rehabilitation facilities ("IRFs"), we received requests from 2013 to 2018 to review certain patient files for discharges occurring from 2010 to 2018. These RAC audits are focused on identifying Medicare claims that may contain improper payments. RAC contractors must have CMS approval before conducting these focused reviews which cover issues ranging from billing documentation to medical necessity. Medical necessity is an assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting.

CMS has also established contractors known as the Zone Program Integrity Contractors ("ZPICs"). These contractors conduct audits with a focus on potential fraud and abuse issues. Like the RACs, the ZPICs conduct audits and have the ability to refer matters to the HHS-OIG or the DOJ. Unlike RACs, however, ZPICs do not receive a specific financial incentive based on the amount of the error as a result of ZPIC audits. We have, from time to time, received ZPIC record requests which have resulted in claim denials on paid claims. We have appealed substantially all ZPIC denials arising from these audits using the same process we follow for appealing other denials by contractors. CMS has announced its intention to rename ZPICs as Unified Program Integrity Contractors.

To date, the Medicare claims that are subject to these post-payment audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2018, and not all of these patient file requests have resulted in payment denial determinations by the audit contractor. Because we have confidence in the medical judgment of both the referring and admitting physicians who assess the treatment needs of their patients, we have appealed substantially all claim denials arising from these audits using the same process we follow for appealing denials of certain diagnosis codes by MACs. Due to the delays announced by CMS in the related adjudication process, we believe the resolution of any claims that are subsequently denied as a result of these claim audits could take in excess of three years. In addition, because we have limited experience with ZPICs and RACs in the context of claims reviews of this nature, we cannot provide assurance as to the timing or outcomes of these disputes. As such, we make estimates for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs. As the ultimate results of these audits impact our estimates of amounts determined to be due to Encompass Health under these reimbursement programs, our reserve for claims that are part of this post-payment claims review process are recorded to *Net operating revenues*. During 2018, 2017, and 2016, our adjustment to *Net operating revenues* for claims that are part of this post-payment claims review process was not material.

Our performance obligations relate to contracts with a duration of less than one year. Therefore, we elected to apply the optional exemption to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. These unsatisfied or partially unsatisfied performance obligations primarily relate to services provided at the end of the reporting period.

We are subject to changes in government legislation that could impact Medicare payment levels and changes in payor patterns that may impact the level and timing of payments for services rendered.

Inpatient Rehabilitation Revenues

Inpatient rehabilitation segment revenues are recognized over time as the services are provided to the patient. The performance obligation is the rendering of services to the patient during the term of their inpatient stay. Revenues are recognized (or measured) using the input method as therapy, nursing, and auxiliary services are provided based on our estimate of the respective transaction price. Revenues recognized by our inpatient rehabilitation segment are subject to a number of elements which impact both the overall amount of revenue realized as well as the timing of the collection of the related accounts receivable. Factors considered in determining the estimated transaction price include the patient's total length of stay for in-house patients, each patient's discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Such additional factors are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes.

Home Health and Hospice Revenues

Home Health

Under the Medicare home health prospective payment system, we are paid by Medicare based on episodes of care. The performance obligation is the rendering of services to the patient during the term of the episode of care. An episode of care is defined as a length of stay up to 60 days, with multiple continuous episodes allowed. A base episode payment is established by the Medicare program through federal regulation. The base episode payment can be adjusted based on each patient's health including clinical condition, functional abilities, and service needs, as well as for the applicable geographic wage index, low utilization, patient transfers, and other factors. The services covered by the episode payment include all disciplines of care in addition to medical supplies.

We bill a portion of reimbursement from each Medicare episode near the start of each episode, and the resulting cash payment is typically received before all services are rendered. As we provide home health services to our patients on a scheduled basis over the episode of care in a manner that approximates a pro rata pattern, revenue for the episode of care is recorded over an average length of treatment period using a calendar day prorating method. The amount of revenue recognized for episodes of care which are incomplete at period end is based on the pro rata number of days in the episode which have been completed as of the period end date. As of December 31, 2018 and December 31, 2017, the difference between the cash

received from Medicare for a request for anticipated payment on episodes in progress and the associated estimated revenue was not material and was recorded in *Other current liabilities* in our consolidated balance sheets.

We are subject to certain Medicare regulations affecting outlier revenue if our patient's care was unusually costly. Regulations require a cap on all outlier revenue at 10% of total Medicare revenue received by each provider during a cost reporting year. Management has reviewed the potential cap. Adjustments to the transaction price for the outlier cap were not material as of December 31, 2018 and December 31, 2017.

For episodic-based rates that are paid by other insurance carriers, including Medicare Advantage, we recognize revenue in a similar manner as discussed above for Medicare revenues. However, these rates can vary based upon the negotiated terms. For non-episodic-based revenue, revenue is recorded on an accrual basis based upon the date of service at amounts equal to our estimated per-visit transaction price. Price concessions, including contractual allowances for the differences between our standard rates and the applicable contracted rates, as well as estimated uncollectible amounts from patients, are recorded as decreases to the transaction price.

Hospice

Medicare revenues for hospice are recognized and recorded on an accrual basis using the input method based on the number of days a patient has been on service at amounts equal to an estimated daily or hourly payment rate. The performance obligation is the rendering of services to the patient during each day that they are on hospice care. The payment rate is dependent on whether a patient is receiving routine home care, general inpatient care, continuous home care or respite care. Adjustments to Medicare revenues are recorded based on an inability to obtain appropriate billing documentation or authorizations acceptable to the payor or other reasons unrelated to credit risk. Hospice companies are subject to two specific payment limit caps under the Medicare program. One limit relates to inpatient care days that exceed 20% of the total days of hospice care provided for the year. The second limit relates to an aggregate Medicare reimbursement cap calculated by the MAC. Adjustments to the transaction price for these caps were not material as of December 31, 2018 and December 31, 2017.

For non-Medicare hospice revenues, we record gross revenue on an accrual basis based upon the date of service at amounts equal to our estimated per day transaction price. Price concessions, including contractual adjustments for the difference between our standard rates and the amounts estimated to be realizable from patients and third parties for services provided, are recorded as decreases to the transaction price and thus reduce our *Net operating revenues*.

Cash and Cash Equivalents—

Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. Carrying values of *Cash and cash equivalents* approximate fair value due to the short-term nature of these instruments.

We maintain amounts on deposit with various financial institutions, which may, at times, exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and we have not experienced any losses on such deposits.

Marketable Securities—

Effective January 1, 2018, in connection with the adoption of ASU 2016-01, we record all marketable securities with readily determinable fair values and for which we do not exercise significant influence at fair value and record the change in fair value for the reporting period in our consolidated statements of operations.

Prior to January 1, 2018, we recorded all marketable securities with readily determinable fair values and for which we did not exercise significant influence as available-for-sale securities. We carried the available-for-sale securities at fair value and reported unrealized holding gains or losses, net of income taxes, in *Accumulated other comprehensive loss*, which is a separate component of shareholders' equity. We recognized realized gains and losses in our consolidated statements of operations using the specific identification method. Unrealized losses were charged against earnings when a decline in fair value was determined to be other than temporary. Management reviewed several factors to determine whether a loss was other than temporary, such as the length of time a security is in an unrealized loss position, the extent to which fair value is less than

cost, the financial condition and near term prospects of the issuer, industry, or geographic area and our ability and intent to hold the security for a period of time sufficient to allow for any anticipated recovery in fair value.

Accounts Receivable—

We report accounts receivable from services rendered at their estimated transaction price which takes into account price concessions from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, workers' compensation programs, employers, and patients. Our accounts receivable are concentrated by type of payor. The concentration of patient service accounts receivable by payor class, as a percentage of total patient service accounts receivable, is as follows:

	As of December 31,	
	2018	2017
Medicare	73.2%	75.1%
Managed care and other discount plans, including Medicare Advantage	19.3%	17.4%
Medicaid	2.8%	2.4%
Other third-party payors	2.7%	2.9%
Workers' compensation	1.1%	1.3%
Patients	0.9%	0.9%
Total	100.0%	100.0%

While revenues and accounts receivable from the Medicare program are significant to our operations, we do not believe there are significant credit risks associated with this government agency. We do not believe there are any other significant concentrations of revenues from any particular payor that would subject us to any significant credit risks in the collection of our accounts receivable.

Accounts requiring collection efforts are reviewed via system-generated work queues that automatically stage (based on age and size of outstanding balance) accounts requiring collection efforts for patient account representatives. Collection efforts include contacting the applicable party (both in writing and by telephone), providing information (both financial and clinical) to allow for payment or to overturn payor decisions to deny payment, and arranging payment plans with self-pay patients, among other techniques. When we determine all in-house efforts have been exhausted or it is a more prudent use of resources, accounts may be turned over to a collection agency.

The collection of outstanding receivables from Medicare, managed care payors, other third-party payors, and patients is our primary source of cash and is critical to our operating performance. While it is our policy to verify insurance prior to a patient being admitted, there are various exceptions that can occur. Such exceptions include instances where we are (1) unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid, and it takes several days, weeks, or months before qualification for such benefits is confirmed or denied, and (3) the patient is transferred to our hospital from an acute care hospital without having access to a credit card, cash, or check to pay the applicable patient responsibility amounts (i.e., deductibles and co-payments).

Our primary collection risks relate to patient responsibility amounts and claims reviews conducted by MACs or other contractors. Patient responsibility amounts include accounts for which the patient was the primary payor or the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient co-payment amounts remain outstanding. Changes in the economy, such as increased unemployment rates or periods of recession, can further exacerbate our ability to collect patient responsibility amounts.

If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. Changes in general economic conditions, business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable, financial position, results of operations, and cash flows.

Property and Equipment—

We report land, buildings, improvements, vehicles, and equipment at cost, net of accumulated depreciation and amortization and any asset impairments. We report assets under capital lease obligations at the lower of fair value or the present value of the aggregate future minimum lease payments at the beginning of the lease term. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Useful lives are generally as follows:

	Years
Buildings	10 to 30
Leasehold improvements	2 to 15
Vehicles	5
Furniture, fixtures, and equipment	3 to 10
Assets under capital lease obligations:	
Real estate	15 to 25
Vehicles	3
Equipment	3 to 5

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and betterments that increase the estimated useful life of an asset. We capitalize pre-acquisition costs when they are directly identifiable with a specific property, the costs would be capitalizable if the property were already acquired, and acquisition of the property is probable. We capitalize interest expense on major construction and development projects while in progress.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balances are removed from the respective accounts, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of operations. However, if the sale, retirement, or disposal involves a discontinued operation, the resulting net amount, less any proceeds, is included in the results of discontinued operations.

We account for operating leases by recognizing rents, including any rent holidays, on a straight-line basis over the term of the lease.

Goodwill and Other Intangible Assets—

We are required to test our goodwill and indefinite-lived intangible asset for impairment at least annually, absent some triggering event that would accelerate an impairment assessment. Absent any impairment indicators, we perform this impairment testing as of October 1st of each year. We recognize an impairment charge for any amount by which the carrying amount of the asset exceeds its implied fair value. We present an impairment charge as a separate line item within income from continuing operations in the consolidated statements of operations, unless the impairment is associated with a discontinued operation. In that case, we include the impairment charge, on a net-of-tax basis, within the results of discontinued operations.

We assess qualitative factors in our inpatient rehabilitation and home health and hospice reporting units to determine whether it is necessary to perform the first step of the two-step quantitative impairment test. If, based on this qualitative assessment, we were to believe we must proceed to Step 1, we would determine the fair value of our reporting units using generally accepted valuation techniques including the income approach and the market approach. The income approach includes the use of each reporting unit's discounted projected operating results and cash flows. This approach includes many assumptions related to pricing and volume, operating expenses, capital expenditures, discount factors, tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. We reconcile the estimated fair value of our reporting units to our market capitalization. When we dispose of a hospital or home health or hospice agency, goodwill is allocated to the gain or loss on disposition using the relative fair value methodology.

We assess qualitative factors related to our indefinite-lived intangible asset to determine whether it is necessary to perform the first step of the two-step quantitative impairment test. If, based on this qualitative assessment, we were to believe we must proceed to Step 1, we would determine the fair value of our indefinite-lived intangible asset using generally accepted valuation techniques including the relief-from-royalty method. This method is a form of the income approach in which value is equated to a series of cash flows and discounted at a risk-adjusted rate. It is based on a hypothetical royalty, calculated as a percentage of forecasted revenue, that we would otherwise be willing to pay to use the asset, assuming it were not already owned. This approach includes assumptions related to pricing and volume, as well as a royalty rate a hypothetical third party would be willing to pay for use of the asset. When making our royalty rate assumption, we consider rates paid in arms-length licensing transactions for assets comparable to our asset.

We amortize the cost of intangible assets with finite useful lives over their respective estimated useful lives to their estimated residual value. As of December 31, 2018, none of our finite useful lived intangible assets has an estimated residual value. We also review these assets for impairment whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount.

The range of estimated useful lives and the amortization basis for our intangible assets, excluding goodwill, are generally as follows:

	Estimated Useful Life and Amortization Basis
Certificates of need	10 to 30 years using straight-line basis
Licenses	10 to 20 years using straight-line basis
Noncompete agreements	1 to 18 years using straight-line basis
Trade names:	
Encompass	indefinite-lived asset
All other	1 to 20 years using straight-line basis
Internal-use software	3 to 7 years using straight-line basis
Market access assets	20 years using accelerated basis

We capitalize the costs of obtaining or developing internal-use software, including external direct costs of material and services and directly related payroll costs. Amortization begins when the internal-use software is ready for its intended use. Costs incurred during the preliminary project and post-implementation stages, as well as maintenance and training costs, are expensed as incurred.

Our market access assets are valued using discounted cash flows under the income approach. The value of the market access assets is attributable to our ability to gain access to and penetrate an acquired facility's historical market patient base. To determine this value, we first develop a debt-free net cash flow forecast under various patient volume scenarios. The debt-free net cash flow is then discounted back to present value using a discount factor, which includes an adjustment for company-specific risk. As noted in the above table, we amortize these assets over 20 years using an accelerated basis that reflects the pattern in which we believe the economic benefits of the market access will be consumed.

Impairment of Long-Lived Assets and Other Intangible Assets—

We assess the recoverability of long-lived assets (excluding goodwill and our indefinite-lived asset) and identifiable acquired intangible assets with finite useful lives, whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount. We measure the recoverability of assets to be held and used by a comparison of the carrying amount of the asset to the expected net future cash flows to be generated by that asset, or, for identifiable intangibles with finite useful lives, by determining whether the amortization of the intangible asset balance over its remaining life can be recovered through undiscounted future cash flows. The amount of impairment of identifiable intangible assets with finite useful lives, if any, to be recognized is measured based on projected discounted future cash flows. We measure the amount of impairment of other long-lived assets (excluding goodwill) as the amount by which the carrying value of the asset exceeds the fair market value of the asset, which is generally determined based on projected discounted future cash flows or appraised

values. We classify long-lived assets to be disposed of other than by sale as held and used until they are disposed. We report long-lived assets to be disposed of by sale as held for sale and recognize those assets in the balance sheet at the lower of carrying amount or fair value less cost to sell, and we cease depreciation.

Investments in and Advances to Nonconsolidated Affiliates—

Investments in entities we do not control but in which we have the ability to exercise significant influence over the operating and financial policies of the investee are accounted for under the equity method. Equity method investments are recorded at original cost and adjusted periodically to recognize our proportionate share of the investees' net income or losses after the date of investment, additional contributions made, dividends or distributions received, and impairment losses resulting from adjustments to net realizable value. We record equity method losses in excess of the carrying amount of an investment when we guarantee obligations or we are otherwise committed to provide further financial support to the affiliate.

We use the cost method to account for equity investments for which the equity securities do not have readily determinable fair values and for which we do not have the ability to exercise significant influence. Under the cost method of accounting, private equity investments are carried at cost and are adjusted only for other-than-temporary declines in fair value, additional investments, or distributions deemed to be a return of capital.

Management periodically assesses the recoverability of our equity method and cost method investments and equity method goodwill for impairment. We consider all available information, including the recoverability of the investment, the earnings and near-term prospects of the affiliate, factors related to the industry, conditions of the affiliate, and our ability, if any, to influence the management of the affiliate. We assess fair value based on valuation methodologies, as appropriate, including discounted cash flows, estimates of sales proceeds, and external appraisals, as appropriate. If an investment or equity method goodwill is considered to be impaired and the decline in value is other than temporary, we record an appropriate write-down.

Financing Costs—

We amortize financing costs using the effective interest method over the expected life of the related debt. Excluding financing costs related to our revolving line of credit (which is included in *Other long-term assets*), financing costs are presented as a direct deduction from the face amount of the financings. The related expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

We accrete discounts and amortize premiums using the effective interest method over the expected life of the related debt, and we report discounts or premiums as a direct deduction from, or addition to, the face amount of the financing. The related income or expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

Fair Value Measurements—

Fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions market participants would use in pricing an asset or liability.

The basis for these assumptions establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- *Level 1* – Observable inputs such as quoted prices in active markets;
- *Level 2* – Inputs, other than quoted prices in active markets, that are observable either directly or indirectly; and
- *Level 3* – Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future cash flows to a single present amount based on market expectations (including present value techniques, option-pricing models, and lattice models).

Our financial instruments consist mainly of cash and cash equivalents, restricted cash, restricted marketable securities, accounts receivable, accounts payable, letters of credit, and long-term debt. The carrying amounts of cash and cash equivalents, restricted cash, accounts receivable, and accounts payable approximate fair value because of the short-term maturity of these instruments. The fair value of our letters of credit is deemed to be the amount of payment guaranteed on our behalf by third-party financial institutions. We determine the fair value of our long-term debt using quoted market prices, when available, or discounted cash flows based on various factors, including maturity schedules, call features, and current market rates.

On a recurring basis, we are required to measure our restricted marketable securities at fair value. The fair values of our restricted marketable securities are determined based on quoted market prices in active markets or quoted prices, dealer quotations, or alternative pricing sources supported by observable inputs in markets that are not considered to be active.

On a nonrecurring basis, we are required to measure property and equipment, goodwill, other intangible assets, investments in nonconsolidated affiliates, and assets and liabilities of discontinued operations at fair value. Generally, assets are recorded at fair value on a nonrecurring basis as a result of impairment charges or similar adjustments made to the carrying value of the applicable assets. The fair value of our property and equipment is determined using discounted cash flows and significant unobservable inputs, unless there is an offer to purchase such assets, which could be the basis for determining fair value. The fair value of our intangible assets, excluding goodwill, is determined using discounted cash flows and significant unobservable inputs. The fair value of our investments in nonconsolidated affiliates is determined using quoted prices in private markets, discounted cash flows or earnings, or market multiples derived from a set of comparables. The fair value of our assets and liabilities of discontinued operations is determined using discounted cash flows and significant unobservable inputs unless there is an offer to purchase such assets and liabilities, which would be the basis for determining fair value. The fair value of our goodwill is determined using discounted projected operating results and cash flows, which involve significant unobservable inputs.

See also the "Redeemable Noncontrolling Interests" section of this note.

Noncontrolling Interests in Consolidated Affiliates—

The consolidated financial statements include all assets, liabilities, revenues, and expenses of less-than-100%-owned affiliates we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities. We record adjustments to noncontrolling interests for the allocable portion of income or loss to which the noncontrolling interests holders are entitled based upon their portion of the subsidiaries they own. Distributions to holders of noncontrolling interests are adjusted to the respective noncontrolling interests holders' balance.

Redeemable Noncontrolling Interests—

Certain of our joint venture agreements contain provisions that allow our partners to require us to purchase their interests in the joint venture at fair value at certain points in the future. Likewise, certain members of the home health and hospice management team hold similar put rights regarding their interests in our home health and hospice business, as discussed in Note 11, *Redeemable Noncontrolling Interests*. Because these noncontrolling interests provide for redemption features that are not solely within our control, we classify them as *Redeemable noncontrolling interests* outside of permanent equity in our consolidated balance sheets. At the end of each reporting period, we compare the carrying value of the *Redeemable noncontrolling interests* to their estimated redemption value. If the estimated redemption value is greater than the current

carrying value, the carrying value is adjusted to the estimated redemption value, with the adjustments recorded through equity in the line item *Capital in excess of par value.*

The fair value of the *Redeemable noncontrolling interests* related to our home health segment is determined using the product of a 12-month specified performance measure and a specified median market price multiple based on a basket of public health companies and publicly disclosed home health acquisitions with a value of $400 million or more. The fair value of our *Redeemable noncontrolling interests* in our joint venture hospitals is determined primarily using the income approach. The income approach includes the use of the hospital's projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the applicable hospitals, or *Level 3* inputs. The projected operating results use management's best estimates of economic and market conditions over the forecasted periods including assumptions for pricing and volume, operating expenses, and capital expenditures.

Share-Based Payments—

Encompass Health has shareholder-approved stock-based compensation plans that provide for the granting of stock-based compensation to certain employees and directors. All share-based payments to employees, excluding stock appreciation rights ("SARs"), are recognized in the financial statements based on their estimated grant-date fair value and amortized on a straight-line basis over the applicable requisite service period. Share-based payments to employees in the form of SARs are recognized in the financial statements based on their current fair value and expensed ratably over the applicable service period.

Litigation Reserves—

We accrue for loss contingencies associated with outstanding litigation for which management has determined it is probable a loss contingency exists and the amount of loss can be reasonably estimated. If the accrued amount associated with a loss contingency is greater than $5.0 million, we also accrue estimated future legal fees associated with the loss contingency. This requires management to estimate the amount of legal fees that will be incurred in the defense of the litigation. These estimates are based on our expectations of the scope, length to complete, and complexity of the claims. In the future, additional adjustments may be recorded as the scope, length to complete, or complexity of outstanding litigation changes.

Advertising Costs—

We expense costs of print, radio, television, and other advertisements as incurred. Advertising expenses, primarily included in *Other operating expenses* within the accompanying consolidated statements of operations, were $6.7 million, $6.3 million, and $7.5 million in each of the years ended December 31, 2018, 2017, and 2016, respectively.

Income Taxes—

We provide for income taxes using the asset and liability method. This approach recognizes the amount of income taxes payable or refundable for the current year, as well as deferred tax assets and liabilities for the future tax consequence of events recognized in the consolidated financial statements and income tax returns. Deferred income tax assets and liabilities are adjusted to recognize the effects of changes in tax laws or enacted tax rates.

A valuation allowance is required when it is more likely than not some portion of the deferred tax assets will not be realized. Realization is dependent on generating sufficient future taxable income in the applicable tax jurisdiction. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences, our forecast of taxable income in future periods by jurisdiction, our ability to sustain a core level of earnings, and the availability of prudent tax planning strategies are important considerations in our assessment.

We evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. We review these tax uncertainties in light of changing facts and circumstances, such as the progress of tax audits, and adjust them accordingly.

We have used the with-and-without method to determine when we will recognize excess tax benefits from stock-based compensation. Under this method in 2016, we recognized these excess tax benefits only after we fully realized the tax benefits of net operating losses.

Encompass Health and its corporate subsidiaries file a consolidated federal income tax return. Some subsidiaries consolidated for financial reporting purposes are not part of the consolidated group for federal income tax purposes and file separate federal income tax returns. State income tax returns are filed on a separate, combined, or consolidated basis in accordance with relevant state laws and regulations. Partnerships, limited liability companies, and other pass-through entities we consolidate or account for using the equity method of accounting file separate federal and state income tax returns. We include the allocable portion of each pass-through entity's income or loss in our federal income tax return. We allocate the remaining income or loss of each pass-through entity to the other partners or members who are responsible for their portion of the taxes.

Assets and Liabilities in and Results of Discontinued Operations—

Effective January 1, 2015, in connection with a new standard issued by the FASB, we changed our criteria for determining which disposals are presented as discontinued operations. Historically, any component that had been disposed of or was classified as held for sale qualified for discontinued operations reporting unless there was significant continuing involvement with the disposed component or continuing cash flows. In contrast, we now report the disposal of the component, or group of components, as discontinued operations only when it represents a strategic shift that has, or will have, a major effect on our operations and financial results. As a result, the sale or disposal of a single Encompass Health facility or location no longer qualifies as a discontinued operation. This accounting change was made prospectively. No new components were recognized as discontinued operations since this guidance became effective.

In the period a component of an entity has been disposed of or classified as held for sale, we reclassify the results of operations for current and prior periods into a single caption titled *(Loss) income from discontinued operations, net of tax*. In addition, we classify the assets and liabilities of those components as current and noncurrent assets and liabilities within *Prepaid expenses and other current assets*, *Other long-term assets*, *Other current liabilities*, and *Other long-term liabilities* in our consolidated balance sheets. We also classify cash flows related to discontinued operations as one line item within each category of cash flows in our consolidated statements of cash flows.

Earnings per Common Share—

The calculation of earnings per common share is based on the weighted-average number of our common shares outstanding during the applicable period. The calculation for diluted earnings per common share recognizes the effect of all potential dilutive common shares, including warrants, that were outstanding during the respective periods, unless their impact would be antidilutive. The calculation of earnings per common share also considers the effect of participating securities. Stock-based compensation awards that contain nonforfeitable rights to dividends and dividend equivalents, such as our restricted stock units, are considered participating securities and are included in the computation of earnings per common share pursuant to the two-class method. In applying the two-class method, earnings are allocated to both common stock shares and participating securities based on their respective weighted-average shares outstanding for the period.

We used the if-converted method to include our convertible senior subordinated notes in our computation of diluted earnings per share. All other potential dilutive shares, including warrants, are included in our weighted-average diluted share count using the treasury stock method.

Treasury Stock—

Shares of common stock repurchased by us are recorded at cost as treasury stock. When shares are reissued, we use an average cost method to determine cost. The difference between the cost of the shares and the re-issuance price is added to or deducted from *Capital in excess of par value*. We account for the retirement of treasury stock as a reduction of retained earnings. However, due to our *Accumulated deficit*, the retirement of treasury stock is currently recorded as a reduction of *Capital in excess of par value*.

Comprehensive Income—

Comprehensive income is comprised of *Net income* and changes in unrealized gains or losses on available-for-sale securities and is included in the consolidated statements of comprehensive income.

Recent Adopted Accounting Pronouncements—

In May 2014, the FASB issued ASU 2014-09, "Revenue from Contracts with Customers" and has subsequently issued supplemental and/or clarifying ASUs (collectively "ASC 606"). ASC 606 outlines a five-step framework that supersedes the principles for recognizing revenue and eliminates industry-specific guidance. In addition, ASC 606 revises current disclosure requirements in an effort to help financial statement users better understand the nature, amount, timing, and uncertainty of revenue that is recognized. We adopted ASC 606 on January 1, 2018 using the full retrospective model. The primary impact of adopting under ASC 606 is that all amounts we previously presented as *Provision for doubtful accounts* are now considered an implicit price concession in determining *Net operating revenues*. Such concessions reduce the transaction price and therefore *Net operating revenues*, as shown below. Adopting ASC 606 on January 1, 2018 using the full retrospective transition method had the following impact to our previously reported consolidated statements of operations (in millions):

	For the Year Ended December 31, 2017			For the Year Ended December 31, 2016		
	As Reported	Adjustment for ASC 606	Recasted	As Reported	Adjustment for ASC 606	Recasted
Net operating revenues	$ 3,971.4	$ (57.5)	$ 3,913.9	$ 3,707.2	$ (64.6)	$ 3,642.6
Provision for doubtful accounts	$ 52.4	$ (52.4)	$ —	$ 61.2	$ (61.2)	$ —
Other operating expenses	$ 536.7	$ (5.1)	$ 531.6	$ 492.1	$ (3.4)	$ 488.7

In addition, the adoption of ASC 606 resulted in increased disclosure, including qualitative and quantitative disclosures about the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. See the "Net Operating Revenues" and "Accounts Receivable" section of this note. Except for the adjustments discussed above, the adoption of ASC 606 did not have a material impact on our consolidated financial statements.

In January 2016, the FASB issued ASU No. 2016-01, "Financial Instruments - Overall (Topic 825): Recognition and Measurement of Financial Assets and Financial Liabilities." This standard revises the classification and measurement of investments in certain equity investments and the presentation of certain fair value changes for certain financial liabilities measured at fair value. This revised standard requires the change in fair value of many equity investments to be recognized in *Net income*. This revised standard requires a modified retrospective application with a cumulative effect adjustment recognized in retained earnings as of the date of adoption and was effective for our interim and annual periods beginning January 1, 2018. Beginning in the first quarter of 2018, we recognized mark-to-market gains and losses associated with our marketable securities through *Net income* instead of *Accumulated other comprehensive income*. The adoption of this guidance resulted in an immaterial impact to our consolidated financial statements. See the "Marketable Securities" section of this note.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230), Classification of Certain Cash Receipts and Cash Payments," to reduce diversity in practice in how certain transactions are classified in the statement of cash flows. In addition, the standard clarifies when cash receipts and cash payments have aspects of more than one class of cash flows and cannot be separated, classification will depend on the predominant source or use. The new guidance requires retrospective application and was effective for our annual reporting period beginning January 1, 2018, including interim periods within that reporting period. The clarification that debt prepayment premiums or debt extinguishment costs should be classified as financing activities resulted in an immaterial increase in certain prior period operating cash inflows and a corresponding increase in financing cash outflows.

In November 2016, the FASB issued ASU 2016-18, "Statement of Cash Flows (Topic 230), Restricted Cash," to clarify how entities should present restricted cash and restricted cash equivalents in the statement of cash flows. The new guidance requires amounts generally described as restricted cash and restricted cash equivalents be included with *Cash and cash equivalents* when reconciling the total beginning and ending amounts for the periods shown on the statement of cash flows. The new guidance requires retrospective application and is effective for our annual reporting period beginning January 1, 2018, including interim periods within that reporting period. The adoption of this guidance resulted in an immaterial decrease to previously reported *Net Cash used in investing activities* and a corresponding increase to previously reported *Increase in cash and cash equivalents* (which is now captioned *Increase in cash, cash equivalents, and restricted cash*, pursuant to the adoption of this guidance). In addition, as noted above, we added a reconciliation of cash, cash equivalents, and restricted cash to the consolidated statements of cash flows.

Recent Accounting Pronouncements Not Yet Adopted—

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)," and has subsequently issued supplemental and/or clarifying ASUs (collectively "ASC 842"), in order to increase transparency and comparability by recognizing lease assets and liabilities on the balance sheet and disclosing key information about leasing arrangements. Under ASC 842, lessees will recognize a right-of-use asset and a corresponding lease liability for all leases with a term longer than 12 months. The liability will be equal to the present value of future minimum lease payments and the corresponding asset may be subject to adjustment, such as for the impact of straight-line rent. For income statement purposes, the FASB retained a dual model, requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense while finance leases will result in an expense pattern similar to current capital leases. Classification will be based on criteria that are similar to those applied in current lease accounting. ASC 842 will be effective for us beginning on January 1, 2019. We will adopt ASC 842 on January 1, 2019 using the modified retrospective transition approach and will recognize any cumulative-effect adjustment to the opening balance of *Capital in excess of par value* in that period. We will apply the transition provisions using the effective date as our date of initial application. Therefore, financial information will not be updated and the disclosures required under ASC 842 will not be provided for dates and periods before January 1, 2019. ASC 842 provides optional practical expedients in transition. We expect to elect the 'package of practical expedients', which permits us not to reassess under ASC 842 our prior conclusions about lease identification, lease classification and initial direct costs, and the practical expedient to not reassess certain land easements. We do not expect to elect the use-of-hindsight practical expedient during the transition to ASC 842.

We have substantially completed our assessment of the impact ASC 842 may have on our consolidated financial statements by validating our current portfolio of leases, including a review of historical accounting policies and practices to identify potential differences in applying the new guidance. In addition, the adoption of ASC 842 will result in increased disclosure, including qualitative and quantitative disclosures about the nature, amount, timing and uncertainty of cash flows arising from leases. We have also received, tested, and implemented the necessary updates to our leasing software to be ready for adoption. Based on our current assessment, we estimate the adoption of ASC 842 will result in an increase of approximately $330 million to $370 million in assets and liabilities to our consolidated balance sheet, with no significant change to our consolidated statements of operations or cash flows. ASC 842 also provides practical expedients for an entity's ongoing accounting. We currently expect to elect the short-term lease recognition exemption for all leases that qualify and the practical expedient to not separate lease and non-lease components for all of our leases. See Note 6, *Property and Equipment*, for disclosure related to our operating leases.

In June 2016, the FASB issued ASU 2016-13, "Financial Instruments – Credit Losses (Topic 326)," which provides guidance for accounting for credit losses on financial instruments. The new guidance introduces an approach based on expected losses to estimate credit losses on certain types of financial instruments and modifies the impairment model for available-for-sale debt securities. The new guidance is effective for us beginning January 1, 2020, including interim periods within that reporting period. Early adoption is permitted beginning January 1, 2019. We continue to review the requirements of this standard and any potential impact it may have on our consolidated financial statements.

In August 2018, the FASB issued ASU 2018-15, "Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract." The update helps entities evaluate the accounting for fees paid by a customer in a cloud computing arrangement (hosting arrangement), by providing guidance in determining when the arrangement includes a software license. It requires entities to account for such costs consistent with the guidance on capitalizing costs associated with developing or obtaining internal-use software. The new guidance is effective for us beginning January 1, 2020, including interim periods within that reporting period. Early adoption is permitted. We continue to review the requirements of this standard and any potential impact it may have on our consolidated financial statements.

We do not believe any other recently issued, but not yet effective, accounting standards will have a material effect on our consolidated financial position, results of operations, or cash flows.

Revision of Previously Issued Financial Statements—

During the preparation of our December 31, 2018 financial statements, an error was identified in the accounting for deferred tax assets related to fair value adjustments to redeemable noncontrolling interests. Because the discharge of the redeemable noncontrolling interest, either through the purchase of shares or the sale of the home health and hospice segment, would not result in a tax deduction or tax loss reported in the income tax return, the GAAP to tax basis difference does not meet the definition of a temporary difference. Accordingly, a deferred tax asset and corresponding increase to capital in excess of par value should not have been recognized in prior periods. In addition, the overstatement of deferred tax assets resulted in a $14.8 million overstatement of our *Provision for income tax expense* in 2017 due to the revaluation of our deferred tax assets and liabilities in connection with the 2017 Tax Cuts and Jobs Act (the "Tax Act"). We assessed the materiality of the errors in deferred tax assets and related balances and concluded they were not material to any previously issued financial statements or disclosures. However, we have revised our prior period financial statements to reflect the correction of the errors, as disclosed in the tables below. See Note 19, "*Quarterly Data (Unaudited)*," for the impact of this revision on our unaudited quarterly results.

The impact on our consolidated financial statements are as follows:

Consolidated Balance Sheet

As of December 31, 2017	As Reported	Adjustment	As Revised
		(In Millions)	
Deferred income tax assets	$ 63.6	$ (29.2)	$ 34.4
Total assets	4,893.7	(29.2)	4,864.5
Capital in excess of par value	2,791.4	(44.0)	2,747.4
Accumulated deficit	(1,191.0)	14.8	(1,176.2)
Total Encompass Health shareholders' equity	1,181.7	(29.2)	1,152.5
Total shareholders' equity	1,424.6	(29.2)	1,395.4
Total liabilities and shareholders' equity	4,893.7	(29.2)	4,864.5

Consolidated Statement of Operations

For the Year Ended December 31, 2017	As Reported	Adjustment	As Revised
		(In Millions, Except Per Share Data)	
Provision for income tax expense	$ 160.6	$ (14.8)	$ 145.8
Income from continuing operations	335.8	14.8	350.6
Net income	335.4	14.8	350.2
Net income attributable to Encompass Health	256.3	14.8	271.1
Basic earnings per share attributable to Encompass Health common shareholders	2.73	0.15	2.88
Diluted earnings per share attributable to Encompass Health common shareholders	2.69	0.15	2.84

Consolidated Statement of Comprehensive Income

For the Year Ended December 31, 2017	As Reported	Adjustment	As Revised
		(In Millions)	
Net income	$ 335.4	$ 14.8	$ 350.2
Comprehensive income	335.3	14.8	350.1
Comprehensive income attributable to Encompass Health	256.2	14.8	271.0

Consolidated Statement of Shareholders' Equity

	As Reported	Adjustment	As Revised
For the Year Ended December 31, 2017		(In Millions)	
Fair value adjustments to redeemable noncontrolling interests	$ (41.0)	$ (26.0)	$ (67.0)
Capital in excess of par value	2,791.4	(44.0)	2,747.4
Accumulated deficit	(1,191.0)	14.8	(1,176.2)
Total shareholders' equity	1,424.6	(29.2)	1,395.4
For the Year Ended December 31, 2016			
Fair value adjustments to redeemable noncontrolling interests	$ (6.7)	$ (4.2)	$ (10.9)
Capital in excess of par value	2,799.1	(18.1)	2,781.0
Total shareholders' equity	928.7	(18.1)	910.6
For the Year Ended December 31, 2015			
Capital in excess of par value	$ 2,834.9	$ (13.9)	$ 2,821.0
Total shareholders' equity	779.3	(13.9)	765.4

Consolidated Statement of Cash Flows

	As Reported	Adjustment	As Revised
For the Year Ended December 31, 2017		(In Millions)	
Net income	$ 335.4	$ 14.8	$ 350.2
Deferred tax expense	75.6	(14.8)	60.8

The impact of the revision has been reflected throughout the financial statements, including the applicable footnotes, as appropriate.

2. Business Combinations:

2018 Acquisitions

Inpatient Rehabilitation

During 2018, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In September 2018, we acquired approximately 62% of a 29-bed inpatient rehabilitation unit, including a 60-bed certificate of need, in Murrells Inlet, South Carolina through a joint venture with Tidelands Health. The acquisition was funded through contributions of funds to be utilized by the consolidated joint venture to build a 46-bed de novo inpatient rehabilitation satellite location.

- In October 2018, we acquired approximately 50% of the 68-bed inpatient rehabilitation unit in Winston-Salem, North Carolina, through a joint venture with Novant Health Inc. This acquisition was funded through a contribution of a 68-bed de novo inpatient rehabilitation hospital to the consolidated joint venture.

- In November 2018, we acquired approximately 68% of an 17-bed inpatient rehabilitation unit in Littleton, Colorado through a joint venture with Portercare Adventist Health System. The acquisition was funded through the contribution of our existing inpatient rehabilitation hospital in Littleton, Colorado to the consolidated joint venture.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from its respective date of acquisition. Assets acquired were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: an income approach using primarily discounted cash flow techniques for the noncompete intangible asset; an income approach utilizing the relief from royalty method for the trade name intangible asset; and an income approach utilizing the excess earnings method for the certificate of need intangible asset. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in this market. None of the goodwill recorded as a result from these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired at the acquisition date were as follows (in millions):

Property and equipment	$	0.1
Identifiable intangible assets:		
Noncompete agreements (useful lives of 2 to 3 years)		1.4
Trade names (useful lives of 20 years)		2.3
Certificates of need (useful lives of 20 years)		12.5
Goodwill		23.2
Total assets acquired		39.5
Total liabilities assumed		(0.2)
Net assets acquired	$	39.3

Information regarding the net cash paid for the inpatient rehabilitation acquisitions during 2018 is as follows (in millions):

Fair value of assets acquired	$	16.3
Goodwill		23.2
Fair value of liabilities assumed		(0.2)
Fair value of noncontrolling interest owned by joint venture partner		(39.3)
Net cash paid for acquisition	$	—

Home Health and Hospice

Camellia Acquisition

On May 1, 2018, we completed the previously announced acquisition of privately owned Camellia Healthcare and affiliated entities ("Camellia"). The Camellia portfolio consists of hospice, home health and private duty locations in Mississippi, Alabama, Louisiana and Tennessee. The acquisition leverages our home health and hospice operating platform across key certificate of need states and strengthens our geographic presence in the Southeastern United States. We funded the cash purchase price of the acquisition with cash on hand and borrowings under our revolving credit facility.

We accounted for this transaction under the acquisition method of accounting and reported the results of operations of Camellia from its date of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: replacement cost and continued use methods for property and equipment; an income approach using primarily discounted cash flow techniques for the noncompete and certain license intangible assets; an income approach utilizing the relief-from-royalty method for the trade name intangible asset; and an income approach utilizing the excess earnings method for the certificate of need and certain

license intangible assets. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. For all other assets and liabilities, the fair value was assumed to represent carrying value due to their short maturities. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. All goodwill recorded as a result from this transaction is deductible for federal income tax purposes. The goodwill reflects our expectations of favorable growth opportunities in the home health and hospice markets based on positive demographic trends.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Cash and cash equivalents	$	1.3
Prepaid expenses and other current assets		0.3
Property and equipment, net		0.6
Identifiable intangible assets:		
Noncompete agreements (useful lives of 5 years)		0.5
Trade name (useful life of 1 year)		1.4
Certificates of need (useful lives of 10 years)		16.6
Licenses (useful lives of 10 years)		21.6
Goodwill		96.1
Total assets acquired		138.4
Liabilities assumed:		
Accounts payable		1.7
Accrued payroll		4.0
Total liabilities assumed		5.7
Net assets acquired	$	132.7

Information regarding the net cash paid for Camellia is as follows (in millions):

Fair value of assets acquired, net of $1.3 million of cash acquired	$	41.0
Goodwill		96.1
Fair value of liabilities assumed		(5.7)
Net cash paid for acquisition	$	131.4

Other Home Health and Hospice Acquisitions

During 2018, we completed the following home health acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in the applicable geographic areas. Each acquisition was funded using cash on hand.

- In January 2018, we acquired the assets of one hospice location from Golden Age Hospice, Inc. in Oklahoma City, Oklahoma.
- In June 2018, we acquired the assets of one hospice location from Medical Services of America in Las Vegas, Nevada.
- In November 2018, we acquired the assets of one home health and one hospice location from Tenet Hospital Limited in Birmingham, Alabama and El Paso, Texas. We also acquired 75% of the assets of a home health location in Talladega, Alabama through a joint venture with Tenet Hospital Limited.

- In December 2018, we acquired 75% of the assets of a hospice location in Talladega, Alabama through a joint venture with Tenet Hospital Limited.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired locations from their respective dates of acquisition. Assets acquired were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using an income approach. The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to utilize the acquired locations' mobile workforce and established relationships within each community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. All goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired at the acquisition date were as follows (in millions):

Total current assets	$	0.1
Identifiable intangible assets:		
Noncompete agreements (useful lives of 5 years)		0.2
Certificates of need (useful lives of 10 years)		2.5
Licenses (useful lives of 10 years)		1.5
Goodwill		8.9
Total assets acquired	$	13.2
Total liabilities assumed		(0.1)
Net assets acquired	$	13.1

Information regarding the net cash paid for the other home health and hospice acquisitions during each period presented is as follows (in millions):

Fair value of assets acquired	$	4.3
Goodwill		8.9
Fair value of liabilities assumed		(0.1)
Fair value of noncontrolling interest owned by joint venture partner		(0.6)
Net cash paid for acquisitions	$	12.5

Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned acquisitions from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2017 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2018		
Inpatient Rehabilitation	$ 9.1	$ (1.6)
Camellia	50.0	(0.9)
All Other Home Health and Hospice	3.5	(0.3)
Combined entity: Supplemental pro forma from 01/01/2018-12/31/2018 (unaudited)	4,337.4	300.0
Combined entity: Supplemental pro forma from 01/01/2017-12/31/2017 (unaudited)	4,039.9	289.0

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2017 period.

2017 Acquisitions

Inpatient Rehabilitation

During 2017, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In April 2017, we acquired 80% of the 33-bed inpatient rehabilitation unit of Memorial Hospital at Gulfport in Gulfport, Mississippi, through a joint venture with Memorial Hospital at Gulfport. This acquisition was funded on March 31, 2017 using cash on hand.
- In April 2017, we also acquired approximately 80% of the inpatient rehabilitation unit of Mount Carmel West in Columbus, Ohio, through a joint venture with Mount Carmel Health System. This acquisition was funded through a contribution of a 60-bed de novo inpatient rehabilitation hospital to the consolidated joint venture.
- In July 2017, we acquired 50% of the inpatient rehabilitation unit at Jackson-Madison County General Hospital through a joint venture with West Tennessee Healthcare. The acquisition was funded through a contribution of our existing inpatient rehabilitation hospital in Martin, Tennessee to the consolidated joint venture.
- In September 2017, we acquired 75% of Heritage Valley Beaver Hospital's inpatient rehabilitation unit in Beaver, Pennsylvania, through a joint venture with Heritage Valley Health System, Inc. The acquisition was funded through the exchange of 25% of our existing inpatient rehabilitation hospital in Sewickley, Pennsylvania.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from their respective dates of acquisition. Assets acquired were recorded at their estimated fair values as of the respective acquisition dates. The fair values of the identifiable intangible assets were based on valuations using the income approach. The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. None of the goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired at the acquisition date were as follows (in millions):

Property and equipment	$	0.1
Identifiable intangible assets:		
Noncompete agreements (useful lives of 2 to 3 years)		0.6
Trade name (useful life of 20 years)		0.5
Certificate of need (useful life of 20 years)		9.8
Goodwill		24.0
Total assets acquired	$	35.0

Information regarding the net cash paid for the inpatient rehabilitation acquisitions during 2017 is as follows (in millions):

Fair value of assets acquired	$	11.0
Goodwill		24.0
Fair value of noncontrolling interest owned by joint venture partner		(24.1)
Net cash paid for acquisition	$	10.9

Home Health and Hospice

During 2017, we completed the following home health acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in the applicable geographic areas. Each acquisition was funded using cash on hand.

- In February 2017, we acquired the assets of Celtic Healthcare of Maryland, Inc., a home health provider with locations in Owings Mill, Maryland and Rockville, Maryland.
- In February 2017, we also acquired the assets of two home health locations from Community Health Services, Inc., located in Owensboro, Kentucky and Elizabethtown, Kentucky.
- In May 2017, we acquired the assets of two home health locations from Bio Care Home Health Services, Inc. and Kinsman Enterprises, Inc., located in Irving, Texas and Longview, Texas.
- In July 2017, we acquired the assets of four home health locations from VNA Healthtrends, located in Bourbonnais, Illinois; Des Plaines, Illinois; Schererville, Indiana; and Tempe, Arizona.
- In August 2017, we acquired the assets of two home health locations from VNA Healthtrends, located in Canton, Ohio and Forsyth, Illinois.
- In October 2017, we acquired the assets of a home health location from Ware Visiting Nurses Services, Inc. located in Savannah, Georgia; and
- In October 2017, we also acquired the assets of a home health location from Pickens County Health Care Authority located in Carrollton, Alabama.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired locations from their respective dates of acquisition. Assets acquired or liabilities assumed were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using the cost and income approaches. The cost approach is based on amounts that would be required to replace the asset (i.e., replacement cost). The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill

reflects our expectations of our ability to utilize the acquired locations' mobile workforce and established relationships within each community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. All of the goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Total current assets	$ 0.1
Identifiable intangible asset:	
Noncompete agreements (useful lives of 5 years)	0.8
Trade name (useful life of 1 year)	0.1
Certificates of need (useful lives of 10 years)	1.8
Licenses (useful lives of 10 years)	4.0
Goodwill	21.4
Total assets acquired	28.2
Total liabilities assumed	(0.3)
Net assets acquired	$ 27.9

Information regarding the net cash paid for the home health acquisitions during 2017 is as follows (in millions):

Fair value of assets acquired	$ 6.8
Goodwill	21.4
Fair value of liabilities assumed	(0.3)
Net cash paid for acquisitions	$ 27.9

Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned acquisitions from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2016 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2017	$ 32.9	$ (6.3)
Combined entity: Supplemental pro forma from 01/01/2017-12/31/2017 (unaudited)	3,996.1	260.3
Combined entity: Supplemental pro forma from 01/01/2016-12/31/2016 (unaudited)	3,771.5	254.8

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2016 reporting period.

2016 Acquisitions

Inpatient Rehabilitation

During 2016, we completed the following inpatient rehabilitation hospital acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas. Each acquisition was funded through a contribution to the respective consolidated joint venture.

- In February 2016, we acquired 50% of the inpatient rehabilitation hospital at CHI St. Vincent Hot Springs, a 20-bed inpatient rehabilitation hospital in Hot Springs, Arkansas, through a joint venture with St. Vincent Community Health Services, Inc.
- In August 2016, we acquired 50% of the inpatient rehabilitation hospital at St. Joseph Regional Health Center, a 19-bed inpatient rehabilitation hospital in Bryan, Texas, through a joint venture with St. Joseph Health System.
- In August 2016, we also acquired 51% of the inpatient rehabilitation hospital at The Bernsen Rehabilitation Center at St. John, a 24-bed inpatient rehabilitation hospital in Broken Arrow, Oklahoma, through a joint venture with St. John Health System.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from their respective dates of acquisition. Assets acquired and liabilities assumed, if any, were recorded at their estimated fair values as of the respective acquisition dates. The fair values of the identifiable intangible assets were based on valuations using the income approach. The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. None of the goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired at the acquisition date were as follows (in millions):

Property and equipment	$	5.3
Identifiable intangible assets:		
Noncompete agreements (useful lives of 1 to 3 years)		0.4
Trade names (useful lives of 20 years)		1.0
Goodwill		9.4
Total assets acquired	$	16.1

Information regarding the net cash paid for all inpatient rehabilitation acquisitions during 2016 is as follows (in millions):

Fair value of assets acquired	$	6.7
Goodwill		9.4
Fair value of noncontrolling interest owned by joint venture partner		(16.1)
Net cash paid for acquisition	$	—

See also Note 8, *Investments in and Advances to Nonconsolidated Affiliates*.

Home Health and Hospice

During 2016, we completed the following home health and hospice acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in the applicable geographic areas. Each acquisition was funded using cash on hand.

- In May 2016, we acquired Home Health Agency of Georgia, LLC, a home health and hospice provider with two home health locations and two hospice locations in the Greater Atlanta area.
- In July 2016, we acquired Advantage Health Inc., a home health provider with one location in Yuma, Arizona.

- In September 2016, we acquired three hospice agencies from Sotto International, Inc. located in Texarkana, Arkansas; Magnolia, Arkansas; and Texarkana, Texas.
- In October 2016, we acquired two home health agencies from Summit Home Health Care, Inc. located in Cheyenne, Wyoming and Laramie, Wyoming.
- In October 2016, we also acquired LightHouse Health Care, Inc., a home health provider with one location in Springfield, Virginia.
- In November 2016, we acquired Gulf City Home Care, Inc., a home health provider with one location in Sarasota, Florida.
- In November 2016, we also acquired Honor Hospice, LLC, a hospice provider with one location in Wheat Ridge, Colorado.

We accounted for all of these transactions under the acquisition method of accounting and reported the results of operations of the acquired locations from their respective dates of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using the cost and income approaches. The cost approach is based on amounts that would be required to replace the asset (i.e., replacement cost). The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to utilize the acquired locations' mobile workforce and established relationships within each community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. All goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Identifiable intangible asset:		
Noncompete agreements (useful lives of 5 years)	$	1.1
Trade names (useful lives of 1 year)		0.7
Certificate of needs (useful lives of 10 years)		1.9
Licenses (useful lives of 10 years)		3.4
Goodwill		41.4
Total assets acquired		48.5
Total liabilities assumed		(0.4)
Net assets acquired	$	48.1

Information regarding the net cash paid for home health and hospice acquisitions during 2016 is as follows (in millions):

Fair value of assets acquired	$	7.1
Goodwill		41.4
Fair value of liabilities assumed		(0.4)
Net cash paid for acquisitions	$	48.1

Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned inpatient rehabilitation hospitals and home health and hospice agencies from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2015 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2016	$ 27.4	$ (2.2)
Combined entity: Supplemental pro forma from 1/01/2016-12/31/2016 (unaudited)	3,745.6	252.2
Combined entity: Supplemental pro forma from 1/01/2015-12/31/2015 (unaudited)	3,217.1	187.3

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2015 reporting period.

3. Variable Interest Entities:

As of December 31, 2018 and December 31, 2017, we consolidated eight and ten, respectively, limited partnership-like entities that are variable interest entities ("VIEs") and of which we are the primary beneficiary. Our ownership percentages in these entities range from 50.0% to 75.0% as of December 31, 2018. Through partnership and management agreements with or governing each of these entities, we manage all of these entities and handle all day-to-day operating decisions. Accordingly, we have the decision making power over the activities that most significantly impact the economic performance of our VIEs and an obligation to absorb losses or receive benefits from the VIE that could potentially be significant to the VIE. These decisions and significant activities include, but are not limited to, marketing efforts, oversight of patient admissions, medical training, nurse and therapist scheduling, provision of healthcare services, billing, collections and creation and maintenance of medical records. The terms of the agreements governing each of our VIEs prohibit us from using the assets of each VIE to satisfy the obligations of other entities.

The carrying amounts and classifications of the consolidated VIEs' assets and liabilities, which are included in our consolidated balance sheet, are as follows (in millions):

	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 0.3	$ 1.2
Accounts receivable	31.0	32.6
Other current assets	4.9	5.6
Total current assets	36.2	39.4
Property and equipment, net	111.5	142.8
Goodwill	15.9	73.5
Intangible assets, net	4.3	7.7
Deferred income tax assets	0.6	0.7
Other long-term assets	29.0	—
Total assets	$ 197.5	$ 264.1
Liabilities		
Current liabilities:		
Current portion of long-term debt	$ 0.6	$ 1.8
Accounts payable	5.2	6.5
Accrued payroll	7.0	7.1
Accrued interest payable	—	0.2
Other current liabilities	38.0	8.6
Total current liabilities	50.8	24.2
Long-term debt, net of current portion	—	28.3
Total liabilities	$ 50.8	$ 52.5

4. Cash and Marketable Securities:

The components of our investments as of December 31, 2018 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 69.2	$ 64.3	$ —	$ 133.5
Marketable securities	—	—	62.0	62.0
Total	$ 69.2	$ 64.3	$ 62.0	$ 195.5

The components of our investments as of December 31, 2017 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 54.4	$ 62.4	$ —	$ 116.8
Marketable securities	—	—	62.0	62.0
Total	$ 54.4	$ 62.4	$ 62.0	$ 178.8

Restricted Cash—

As of December 31, 2018 and 2017, *Restricted cash* consisted of the following (in millions):

	As of December 31,	
	2018	2017
Current:		
Affiliate cash	$ 16.4	$ 18.1
Self-insured captive funds	42.6	44.3
	59.0	62.4
Noncurrent:		
Self-insured captive funds	5.3	—
Total restricted cash	$ 64.3	$ 62.4

Affiliate cash represents cash accounts maintained by joint ventures in which we participate where one or more of our external partners requested, and we agreed, that the joint venture's cash not be commingled with other corporate cash accounts and be used only to fund the operations of those joint ventures. Self-insured captive funds represent cash held at our wholly owned insurance captive, HCS, Ltd., as discussed in Note 10, *Self-Insured Risks*. These funds are committed to pay third-party administrators for claims incurred and are restricted by insurance regulations and requirements. These funds cannot be used for purposes outside HCS without the permission of the Cayman Islands Monetary Authority.

The classification of restricted cash held by HCS as current or noncurrent depends on the classification of the corresponding claims liability.

Marketable Securities—

Restricted marketable securities at both balance sheet dates represent restricted assets held at HCS. HCS insures a substantial portion of Encompass Health's professional liability, workers' compensation, and other insurance claims. These funds are committed for payment of claims incurred, and the classification of these marketable securities as current or noncurrent depends on the classification of the corresponding claims liability. As of December 31, 2018 and 2017, $62.0 million and $44.2 million, respectively, of restricted marketable securities are included in *Other long-term assets* in our consolidated balance sheets. As of December 31, 2018, $1.7 million of unrealized net losses were recognized in our consolidated statement of operations during 2018 on marketable securities were still held at the reporting date.

A summary of our restricted marketable securities as of December 31, 2017, as required for equity securities prior to ASU No. 2016-01, is as follows (in millions):

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Marketable securities	$ 64.0	$ 0.3	$ (2.3)	$ 62.0

Cost in the above table includes adjustments made to the cost basis of our equity securities for other-than-temporary impairments. During the years ended December 31, 2017, and 2016, we did not record any impairment charges related to our restricted marketable securities.

Investing information related to our restricted marketable securities is as follows (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Proceeds from sales of restricted marketable securities	$ 11.4	$ 4.0	$ —
Gross realized losses	$ (0.6)	$ —	$ —

Our portfolio of marketable securities is comprised of investments in mutual funds that hold investments in a variety of industries and geographies. As discussed in Note 1, *Summary of Significant Accounting Policies*, "Marketable Securities," and prior to ASU No. 2016-01, when our portfolio included marketable securities with unrealized losses that are not deemed to be other-than-temporarily impaired, we examined the severity and duration of the impairments in relation to the cost of the individual investments. We also considered the industry and geography in which each investment is held and the near-term prospects for a recovery in each.

5. Accounts Receivable:

Accounts receivable consists of the following (in millions):

	As of December 31,	
	2018	2017
Current:		
Patient accounts receivable	$ 459.9	$ 459.5
Other accounts receivable	7.8	12.6
	467.7	472.1
Noncurrent patient accounts receivable	155.5	129.1
Accounts receivable	$ 623.2	$ 601.2

Because the resolution of claims that are part of Medicare audit programs can take in excess of three years, we review the patient receivables that are part of this adjudication process to determine their appropriate classification as either current or noncurrent. Amounts considered noncurrent are included in *Other long-term assets* in our consolidated balance sheet.

6. Property and Equipment:

Property and equipment consists of the following (in millions):

	As of December 31,	
	2018	2017
Land	$ 142.4	$ 125.4
Buildings	1,875.2	1,712.4
Leasehold improvements	147.5	138.1
Vehicles	24.6	16.2
Furniture, fixtures, and equipment	441.6	461.5
	2,631.3	2,453.6
Less: Accumulated depreciation and amortization	(1,147.0)	(1,097.8)
	1,484.3	1,355.8
Construction in progress	150.5	161.3
Property and equipment, net	$ 1,634.8	$ 1,517.1

As of December 31, 2018, approximately 70% of our consolidated *Property and equipment, net* held by Encompass Health Corporation and its guarantor subsidiaries was pledged to the lenders under our credit agreement. See Note 9, *Long-term Debt*, and Note 20, *Condensed Consolidating Financial Information.*

In February 2016, we entered into a development/lease agreement with CR HQ, LLC (the "Developer") to construct our new home office in Birmingham, Alabama. Under the terms of this agreement, the Developer is responsible for all costs of constructing the new facility 'shell' which is being leased to us for an initial term of 15 years with four, five-year renewal options. The lease commenced in April of 2018. We were responsible for the costs associated with improvements to the interior of the building. Due to the nature and extent of the tenant improvements we made to the new home office and certain provisions of the development/lease agreement, we were deemed to be the accounting owner of the new home office during the construction period. Construction commenced in the second quarter of 2016. As of December 31, 2018 and 2017, *Property and equipment, net* includes $55.0 million and $49.8 million, respectively, for the construction costs incurred by the Developer, and *Long-term debt, net of current portion* includes a corresponding financing obligation liability of $54.8 million and $49.5 million, respectively. The remaining corresponding financing obligation liability of $0.2 million and $0.3 million as of December 31, 2018 and 2017 is included in the *Current portion of long-term debt*. The amounts recorded for construction costs and the corresponding liability are noncash activities for purposes of our consolidated statement of cash flows. See Note 9, *Long-term Debt.*

Information related to fully depreciated assets and assets under capital lease obligations is as follows (in millions):

	As of December 31,	
	2018	2017
Fully depreciated assets	$ 311.7	$ 318.6
Assets under capital lease obligations:		
Buildings	$ 329.6	$ 329.6
Vehicles	21.1	13.0
Equipment	0.3	0.3
	351.0	342.9
Less: Accumulated amortization	(126.9)	(104.6)
Assets under capital lease obligations, net	$ 224.1	$ 238.3

The amount of depreciation expense, amortization expense relating to assets under capital lease obligations, interest capitalized, and rent expense under operating leases is as follows (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Depreciation expense	$ 124.2	$ 111.8	$ 102.3
Amortization expense	$ 24.1	$ 22.7	$ 21.8
Interest capitalized	$ 6.0	$ 3.7	$ 2.0
Rent expense:			
Minimum rent payments	$ 69.8	$ 66.5	$ 62.6
Contingent and other rents	24.9	24.1	29.4
Other	9.1	8.9	4.0
Total rent expense	$ 103.8	$ 99.5	$ 96.0

Leases

We lease certain land, buildings, and equipment under noncancelable operating leases generally expiring at various dates through 2037. We also lease certain buildings and equipment under capital leases generally expiring at various dates through 2037. Operating leases generally have 1- to 20-year terms, with one or more renewal options, with terms to be negotiated at the time of renewal. Various facility leases include provisions for rent escalation to recognize increased operating costs or require us to pay certain maintenance and utility costs. Contingent rents are included in rent expense in the year incurred.

Some facilities are subleased to other parties. Rental income from subleases approximated $3.0 million, $2.9 million, and $4.1 million for the years ended December 31, 2018, 2017, and 2016, respectively. Total expected future minimum rentals under these noncancelable subleases approximated $2.6 million as of December 31, 2018.

Certain leases contain annual escalation clauses based on changes in the Consumer Price Index while others have fixed escalation terms. The excess of cumulative rent expense (recognized on a straight-line basis) over cumulative rent payments made on leases with fixed escalation terms is recognized as straight-line rental accrual and is included in *Other long-term liabilities* in the accompanying consolidated balance sheets, as follows (in millions):

	As of December 31,	
	2018	2017
Straight-line rental accrual	$ 12.1	$ 11.2

Future minimum lease payments at December 31, 2018, for those leases having an initial or remaining noncancelable lease term in excess of one year, are as follows (in millions):

Year Ending December 31,	Operating Leases	Capital Lease Obligations	Total
2019	$ 71.4	$ 36.2	$ 107.6
2020	65.8	32.3	98.1
2021	54.3	30.3	84.6
2022	41.0	28.7	69.7
2023	35.3	28.0	63.3
2024 and thereafter	148.2	299.7	447.9
	$ 416.0	455.2	$ 871.2
Less: Interest portion		(191.4)	
Obligations under capital leases		$ 263.8	

In addition to the above, and as discussed in Note 9, *Long-term Debt*, "Other Notes Payable," we have three sale/leaseback transactions involving real estate accounted for as financings. Future minimum payments, two of which are accounted for as interest, under these obligations are $7.5 million in year one, $7.5 million in year two, $7.6 million in year three, $7.5 million in year four, $6.8 million in year five, and $82.2 million thereafter.

7. Goodwill and Other Intangible Assets:

The following table shows changes in the carrying amount of *Goodwill* for the years ended December 31, 2018, 2017, and 2016 (in millions):

	Inpatient Rehabilitation	Home Health and Hospice	Consolidated
Goodwill as of December 31, 2015	$ 1,133.1	$ 757.0	$ 1,890.1
Acquisitions	8.9	42.5	51.4
Divestiture of pediatric home health services	—	(14.3)	(14.3)
Goodwill as of December 31, 2016	1,142.0	785.2	1,927.2
Acquisitions	24.0	21.4	45.4
Goodwill as of December 31, 2017	1,166.0	806.6	1,972.6
Acquisitions	23.2	105.0	128.2
Goodwill as of December 31, 2018	$ 1,189.2	$ 911.6	$ 2,100.8

Goodwill increased in 2016 as a result of our acquisitions of inpatient and home health and hospice operations offset by the divestiture of our pediatric home health assets to Thrive Skilled Pediatric Care in November 2016 for approximately $21 million. We recorded a $3.3 million gain as part of *Other operating expenses* in our consolidated statements of operations during the year ended December 31, 2016. *Goodwill* increased in 2017 as a result of our acquisitions of inpatient and home health operations. *Goodwill* increased in 2018 as a result of our acquisitions of Camellia and other inpatient and home health and hospice operations. See Note 2, *Business Combinations*.

We performed impairment reviews as of October 1, 2018, 2017, and 2016 and concluded no *Goodwill* impairment existed. As of December 31, 2018, we had no accumulated impairment losses related to *Goodwill*.

The following table provides information regarding our other intangible assets (in millions):

	Gross Carrying Amount	Accumulated Amortization	Net
Certificates of need:			
2018	$ 148.3	$ (28.2)	$ 120.1
2017	113.7	(19.5)	94.2
Licenses:			
2018	$ 169.1	$ (82.2)	$ 86.9
2017	146.0	(71.6)	74.4
Noncompete agreements:			
2018	$ 65.6	$ (58.6)	$ 7.0
2017	63.5	(55.4)	8.1
Trade name - Encompass:			
2018	$ 135.2	$ —	$ 135.2
2017	135.2	—	135.2
Trade names - all other:			
2018	$ 38.9	$ (19.4)	$ 19.5
2017	35.1	(16.4)	18.7
Internal-use software:			
2018	$ 161.3	$ (89.3)	$ 72.0
2017	201.6	(132.3)	69.3
Market access assets:			
2018	$ 13.2	$ (10.5)	$ 2.7
2017	13.2	(10.0)	3.2
Total intangible assets:			
2018	$ 731.6	$ (288.2)	$ 443.4
2017	708.3	(305.2)	403.1

Amortization expense for other intangible assets is as follows (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Amortization expense	$ 51.4	$ 49.3	$ 48.5

Total estimated amortization expense for our other intangible assets for the next five years is as follows (in millions):

Year Ending December 31,	Estimated Amortization Expense
2019	$ 56.9
2020	43.3
2021	35.7
2022	29.6
2023	27.0

8. Investments in and Advances to Nonconsolidated Affiliates:

Investments in and advances to nonconsolidated affiliates as of December 31, 2018 represents our investment in five partially owned subsidiaries, of which four are general or limited partnerships, limited liability companies, or joint ventures in which Encompass Health or one of its subsidiaries is a general or limited partner, managing member, member, or venturer, as applicable. We do not control these affiliates but have the ability to exercise significant influence over the operating and financial policies of certain of these affiliates. Our ownership percentages in these affiliates range from approximately 19% to 60%. We account for these investments using the cost and equity methods of accounting. Our investments, which are included in *Other long-term assets* in our consolidated balance sheets, consist of the following (in millions):

	As of December 31,	
	2018	2017
Equity method investments:		
Capital contributions	$ 0.9	$ 0.9
Cumulative share of income	114.0	105.3
Cumulative share of distributions	(102.7)	(94.5)
	12.2	11.7
Cost method investments:		
Capital contributions, net of distributions and impairments	—	0.2
Total investments in and advances to nonconsolidated affiliates	$ 12.2	$ 11.9

The following summarizes the combined assets, liabilities, and equity and the combined results of operations of our equity method affiliates (on a 100% basis, in millions):

	As of December 31,	
	2018	2017
Assets—		
Current	$ 9.9	$ 10.1
Noncurrent	17.8	18.3
Total assets	$ 27.7	$ 28.4
Liabilities and equity—		
Current liabilities	$ 1.4	$ 2.7
Noncurrent liabilities	0.1	0.2
Partners' capital and shareholders' equity—		
Encompass Health	12.2	11.7
Outside partners	14.0	13.8
Total liabilities and equity	$ 27.7	$ 28.4

Condensed statements of operations (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Net operating revenues	$ 42.6	$ 40.9	$ 44.8
Operating expenses	(25.6)	(24.1)	(24.3)
Income from continuing operations, net of tax	17.1	17.0	20.5
Net income	17.1	17.0	20.5

9. Long-term Debt:

Our long-term debt outstanding consists of the following (in millions):

	As of December 31,	
	2018	2017
Credit Agreement—		
Advances under revolving credit facility	$ 30.0	$ 95.0
Term loan facilities	280.1	294.7
Bonds payable—		
5.125% Senior Notes due 2023	296.6	295.9
5.75% Senior Notes due 2024	1,194.7	1,193.9
5.75% Senior Notes due 2025	345.0	344.4
Other notes payable	104.2	82.3
Capital lease obligations	263.8	271.5
	2,514.4	2,577.7
Less: Current portion	(35.8)	(32.3)
Long-term debt, net of current portion	$ 2,478.6	$ 2,545.4

The following chart shows scheduled principal payments due on long-term debt for the next five years and thereafter (in millions):

Year Ending December 31,	Face Amount	Net Amount
2019	$ 36.5	$ 36.5
2020	33.0	33.0
2021	28.4	28.4
2022	291.9	290.7
2023	313.4	310.1
Thereafter	1,826.2	1,815.7
Total	$ 2,529.4	$ 2,514.4

As a result of the 2017 and 2016 redemptions discussed below, we recorded a $10.7 million, and $7.4 million *Loss on early extinguishment of debt* in 2017 and 2016, respectively. There were no redemptions resulting in a *Loss on early extinguishment of debt* during 2018.

Senior Secured Credit Agreement—

Credit Agreement

In September 2017, we amended our existing credit agreement, previously amended on July 29, 2015 (the "Credit Agreement"). The Credit Agreement provided for a $300 million term loan commitment and a $700 million revolving credit facility, with a $260 million letter of credit subfacility and a swingline loan subfacility, all of which mature in September 2022. Outstanding term loan borrowings are payable in equal consecutive quarterly installments, commencing on December 31, 2017, of 1.25% of the aggregate principal amount of the term loans outstanding as of December 31, 2017, with the remainder due at maturity. We have the right at any time to prepay, in whole or in part, any borrowing under the term loan facilities.

Amounts drawn on the term loan facilities and the revolving credit facility bear interest at a rate per annum of, at our option, (1) LIBOR or (2) the higher of (a) Barclays Bank PLC's ("Barclays") prime rate and (b) the federal funds rate plus 0.5%, in each case, plus, in each case, an applicable margin that varies depending upon our leverage ratio. We are also subject to a commitment fee of 0.375% per annum on the daily amount of the unutilized commitments under the term loan facilities and revolving credit facility. The current interest rate on borrowings under the Credit Agreement is LIBOR plus 1.50%.

The Credit Agreement contains affirmative and negative covenants and default and acceleration provisions, including a minimum interest coverage ratio and a maximum leverage ratio that change over time. Under one such negative covenant, we are restricted from paying common stock dividends, prepaying certain senior notes, making certain investments, and repurchasing preferred and common equity unless (1) we are not in default under the terms of the Credit Agreement and (2) our senior secured leverage ratio, as defined in the Credit Agreement, does not exceed 2x. In the event the senior secured leverage ratio exceeds 2x, these payments are subject to a limit of $200 million plus an amount equal to a portion of available excess cash flows each fiscal year. Our obligations under the Credit Agreement are secured by the current and future personal property of the Company and its subsidiary guarantors. The maximum leverage ratio in the financial covenants is 4.50x through September 2019 and 4.25x from then until maturity.

As of December 31, 2018 and 2017, $30 million and $95 million were drawn under the revolving credit facility with an interest rate of 3.9% and 3.1%, respectively. Amounts drawn as of December 31, 2018 and 2017 exclude $37.4 million and $35.4 million, respectively, utilized under the letter of credit subfacility, which were being used in the ordinary course of business to secure workers' compensation and other insurance coverages and for general corporate purposes. Currently, there are no undrawn term loan commitments under the Credit Agreement. The 2017 amendment to our existing credit agreement included a net repayment of approximately $110 million to our existing term loan facility.

2016 Credit Agreement

In June and July 2015, we amended our existing credit agreement (the "2016 Credit Agreement"). The 2016 Credit Agreement provided for $500 million of term loan commitments and a $600 million revolving credit facility, with a $260 million letter of credit subfacility and a swingline loan subfacility, all of which would have matured in July 2020. Outstanding term loan borrowings were payable in equal consecutive quarterly installments, commencing on March 31, 2016, of 1.25% of the aggregate principal amount of the term loans outstanding as of December 31, 2015, with the remainder due at maturity. The 2016 Credit Agreement contained the same affirmative and negative covenants and default and acceleration provisions as the Credit Agreement, except for the senior secured leverage ratio couldn't exceed 1.75x under the negative covenant described above and the maximum leverage ratio was 4.50x through June 2017 and 4.25x from then until maturity.

Bonds Payable—

Nonconvertible Notes

The Company's 2023 Notes, 2024 Notes, and 2025 Notes (collectively, the "Senior Notes") were issued pursuant to an indenture (the "Base Indenture") dated as of December 1, 2009 between us and The Bank of Nova Scotia Trust Company of New York, as trustee (the "Original Trustee"), as supplemented by each Senior Notes respective supplemental indenture (together with the Base Indenture, the "Indenture"), among us, the Subsidiary Guarantors (as defined in the Indenture), and the Original Trustee. The Original Trustee notified us of its intention to discontinue its corporate trust operations and, accordingly, to resign upon the appointment of a successor trustee. Effective July 29, 2013, Wells Fargo Bank, National Association, was

appointed as successor trustee under the Indenture.

Pursuant to the terms of the Indenture, the Senior Notes are jointly and severally guaranteed on a senior, unsecured basis by all of our existing and future subsidiaries that guarantee borrowings under our Credit Agreement and other capital markets debt (see Note 20, *Condensed Consolidating Financial Information*). The Senior Notes are senior, unsecured obligations of Encompass Health and rank equally with our other senior indebtedness, senior to any of our subordinated indebtedness, and effectively junior to our secured indebtedness to the extent of the value of the collateral securing such indebtedness.

Upon the occurrence of a change in control (as defined in the Indenture), each holder of the Senior Notes may require us to repurchase all or a portion of the notes in cash at a price equal to 101% of the principal amount of the Senior Notes to be repurchased, plus accrued and unpaid interest.

The Senior Notes contain covenants and default and acceleration provisions, that, among other things, limit our and certain of our subsidiaries' ability to (1) incur additional debt, (2) make certain restricted payments, (3) consummate specified asset sales, (4) incur liens, and (5) merge or consolidate with another person.

2023 Notes

In March 2015, we issued $300 million of 5.125% Senior Notes due 2023 ("the 2023 Notes") at par, which resulted in approximately $295 million in net proceeds from the public offering. The 2023 Notes mature on March 15, 2023 and bear interest at a per annum rate of 5.125%. Inclusive of financing costs, the effective interest rate on the 2023 Notes is 5.4%. Interest on the 2023 Notes is payable semiannually in arrears on March 15 and September 15, beginning on September 15, 2015.

We may redeem the 2023 Notes, in whole or in part, at any time on or after March 15, 2018 at the redemption prices set forth below:

Period	Redemption Price*
2018	103.844%
2019	102.563%
2020	101.281%
2021 and thereafter	100.000%

* Expressed in percentage of principal amount

2024 Notes

In September 2012, we completed a public offering of $275 million aggregate principal amount of the 5.75% Senior Notes due 2024 ("the 2024 Notes") at par. In September 2014, we issued an additional $175 million of the 2024 Notes at a price of 103.625% of the principal amount, in January 2015, we issued an additional $400 million of the 2024 Notes at a price of 102% of the principal amount, and in August 2015, we issued an additional $350 million of our 2024 Notes at a price of 100.5% of the principal amount. The 2024 Notes mature on November 1, 2024 and bear interest at a per annum rate of 5.75%. Inclusive of premiums and financing costs, the effective interest rate on the 2024 Notes is 5.8%. Interest is payable semiannually in arrears on May 1 and November 1 of each year.

We may redeem the 2024 Notes, in whole or in part, at any time on or after November 1, 2017, at the redemption prices set forth below:

Period	Redemption Price*
2018	101.917%
2019	100.958%
2020 and thereafter	100.000%

* Expressed in percentage of principal amount

2025 Notes

In September 2015, we issued $350 million of 5.75% Senior Notes due 2025 ("the 2025 Notes") at par. The 2025 Notes mature on September 15, 2025 and bear interest at a per annum rate of 5.75%. Inclusive of financing costs, the effective interest rate on the 2025 Notes is 6.0%. Interest on the 2025 Notes is payable semiannually in arrears on March 15 and September 15, beginning on March 15, 2016.

We may redeem the 2025 Notes, in whole or in part, at any time on or after September 15, 2020, at the redemption prices set forth below:

Period	Redemption Price*
2020	102.875%
2021	101.917%
2022	100.958%
2023 and thereafter	100.000%

* Expressed in percentage of principal amount

Former 2022 Notes

In March and May 2016, we redeemed $50.0 million of the outstanding principal amount of our former senior notes due 2022 ("the Former 2022 Notes"). Pursuant to the terms of the Former 2022 Notes, these optional redemptions were made at a price of 103.875%, which resulted in a total cash outlay of approximately $104 million. We used cash on hand and capacity under our revolving credit facility to fund these redemptions.

In September 2016, we redeemed the remaining outstanding principal amount of $76 million of the Former 2022 Notes. Pursuant to the terms of these notes, these optional redemptions were made at a price of 102.583%, which resulted in a total cash outlay of approximately $78 million. We used cash on hand and capacity under our revolving credit facility to fund this redemption. The Former 2022 Notes would have matured on September 15, 2022. Inclusive of premiums and financing costs, the effective interest rate on the Former 2022 Notes was 7.9%. Interest was payable semiannually in arrears on March 15 and September 15 of each year.

Convertible Notes

Former Convertible Senior Subordinated Notes Due 2043

In November 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 (the "Former Convertible Notes") for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock. Our Former Convertible Notes were issued pursuant to an indenture dated November 18, 2013 (the " Former Convertible Notes Indenture") between us and Wells Fargo Bank, National Association, as trustee and conversion agent.

In May 2017, we provided notice of our intent to exercise our early redemption option on the $320 million outstanding principal amount of the Former Convertible Notes. Pursuant to the Former Convertible Notes Indenture, the holders had the right to convert their Former Convertible Notes into shares of our common stock at a conversion rate of 27.2221 shares per $1,000 principal amount of Former Convertible Notes, which rate was increased by the make-whole premium. Holders of $319.4 million in principal of these Former Convertible Notes chose to convert their notes to shares of our common stock resulting in the issuance of 8.9 million shares from treasury stock, including 0.2 million shares due to the make-whole premium. Approximately 8.6 million of these shares were included in *Diluted earnings per share attributable to Encompass Health common shareholders* as of March 31, 2017. We redeemed the remaining $0.6 million in principal at par in cash. The redemption and all conversions occurred in the second quarter of 2017. The Former Convertible Notes would have matured on December 1, 2043. Inclusive of discounts and financing costs, the effective interest rate on the Former Convertible Notes was 6.0%. Interest was payable semiannually in arrears in cash on June 1 and December 1 of each year.

Other Notes Payable—

Our notes payable consist of the following (in millions):

	As of December 31,		
	2018	2017	Interest Rates
Sale/leaseback transactions involving real estate accounted for as financings	$ 82.8	$ 77.7	7.5% to 11.2%
Construction of a new hospital	14.6	4.4	LIBOR + 2.5%; 4.8% to 5.0% and 3.9% as of December 31, 2018 and 2017, respectively
Other	6.8	0.2	4.3% to 6.8%
Other notes payable	$ 104.2	$ 82.3	

See also Note 6, *Property and Equipment*.

Capital Lease Obligations—

We engage in a significant number of leasing transactions including real estate and other equipment utilized in operations. Leases meeting certain accounting criteria have been recorded as an asset and liability at the lower of fair value or the net present value of the aggregate future minimum lease payments at the inception of the lease. Interest rates used in computing the net present value of the lease payments generally ranged from 2% to 11% based on our incremental borrowing rate at the inception of the lease. Our leasing transactions include arrangements for vehicles with major finance companies who retain ownership in the equipment during the term of the lease and with a variety of both small and large real estate owners.

10. Self-Insured Risks:

We insure a substantial portion of our professional liability, general liability, and workers' compensation risks through a self-insured retention program ("SIR") underwritten by our consolidated wholly owned offshore captive insurance subsidiary, HCS, Ltd., which we fund via regularly scheduled premium payments. HCS is an insurance company licensed by the Cayman Island Monetary Authority. We use HCS to fund our first layer of insurance coverage up to approximately $30 million for annual aggregate losses associated with general and professional liability risks. Workers' compensation exposures are capped on a per claim basis. Risks in excess of specified limits per claim and in excess of our aggregate SIR amount are covered by unrelated commercial carriers.

The following table presents the changes in our self-insurance reserves for the years ended December 31, 2018, 2017, and 2016 (in millions):

	2018	2017	2016
Balance at beginning of period, gross	$ 171.0	$ 171.4	$ 142.1
Less: Reinsurance receivables	(39.9)	(41.4)	(26.6)
Balance at beginning of period, net	131.1	130.0	115.5
Increase for the provision of current year claims	47.1	44.7	43.5
Decrease for the provision of prior year claims	(8.7)	(3.0)	(0.1)
Expenses related to discontinued operations	(0.2)	(0.5)	(0.4)
Payments related to current year claims	(7.0)	(5.0)	(5.0)
Payments related to prior year claims	(27.0)	(35.1)	(23.5)
Balance at end of period, net	135.3	131.1	130.0
Add: Reinsurance receivables	25.6	39.9	41.4
Balance at end of period, gross	$ 160.9	$ 171.0	$ 171.4

As of December 31, 2018 and 2017, $41.3 million and $60.9 million, respectively, of these reserves are included in *Other current liabilities* in our consolidated balance sheets.

Provisions for these risks are based primarily upon actuarially determined estimates. These reserves represent the unpaid portion of the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. The changes to the estimated ultimate loss amounts are included in current operating results.

The reserves for these self-insured risks cover approximately 1,000 individual claims at December 31, 2018 and 2017, and estimates for potential unreported claims. The time period required to resolve these claims can vary depending upon the jurisdiction, the nature, and the form of resolution of the claims. The estimation of the timing of payments beyond a year can vary significantly. Although considerable variability is inherent in reserve estimates, management believes the reserves for losses and loss expenses are adequate; however, there can be no assurance the ultimate liability will not exceed management's estimates.

11. Redeemable Noncontrolling Interests:

The following is a summary of the activity related to our *Redeemable noncontrolling interests* (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Balance at beginning of period	$ 220.9	$ 138.3	$ 121.1
Net income attributable to noncontrolling interests	13.9	17.9	14.1
Distributions declared	(8.6)	(4.6)	(7.8)
Contribution to joint venture	9.6	2.3	—
Purchase of redeemable noncontrolling interests	(65.1)	—	—
Change in fair value	91.0	67.0	10.9
Balance at end of period	$ 261.7	$ 220.9	$ 138.3

The following table reconciles the net income attributable to nonredeemable *Noncontrolling interests*, as recorded in the shareholders' equity section of the consolidated balance sheets, and the net income attributable to *Redeemable noncontrolling interests*, as recorded in the mezzanine section of the consolidated balance sheets, to the *Net income attributable to noncontrolling interests* presented in the consolidated statements of operations (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Net income attributable to nonredeemable noncontrolling interests	$ 69.2	$ 61.2	$ 56.4
Net income attributable to redeemable noncontrolling interests	13.9	17.9	14.1
Net income attributable to noncontrolling interests	$ 83.1	$ 79.1	$ 70.5

On December 31, 2014, we acquired 83.3% of our home health and hospice business when we purchased EHHI Holdings, Inc. ("EHHI"). In the acquisition, we acquired all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to Encompass Health Home Health Holdings, Inc. ("Holdings"), a subsidiary of Encompass Health and an indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. Those sellers were members of EHHI management, and they contributed a portion of their shares of common stock of EHHI, valued at approximately $64 million on the acquisition date, in exchange for approximately 16.7% of the outstanding shares of common stock of Holdings. At any time after December 31, 2017, each management investor has the right (but not the obligation) to have his or her shares of Holdings stock repurchased by Encompass Health for a cash purchase price per share equal to the fair value. Specifically, up to one-third of each management investor's shares of Holdings stock may be sold prior to December 31, 2018; two-thirds of each management investor's shares of Holdings stock may be sold prior to December 31, 2019; and all of each management investor's shares of Holdings stock may be sold thereafter. At any time after December 31, 2019, Encompass Health will have the right (but not the obligation) to repurchase all or any portion of the shares of Holdings stock owned by one or more management investors for a cash purchase price per share equal to the fair value. In February 2018, each management investor exercised the right to sell one-third of his or her shares of Holdings stock to Encompass Health, representing approximately 5.6% of the outstanding shares of the common stock of Holdings. On February 21, 2018, Encompass Health settled the acquisition of those shares upon payment of approximately $65 million in cash. As of December 31, 2018, the value of those outstanding shares of Holdings was approximately $223 million. See also Note 12, *Fair Value Measurements*.

12. Fair Value Measurements:

Our financial assets and liabilities that are measured at fair value on a recurring basis are as follows (in millions):

		Fair Value Measurements at Reporting Date Using			
As of December 31, 2018	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Valuation Technique [1]
Other long-term assets:					
Restricted marketable securities	$ 62.0	$ 6.4	$ 55.6	$ —	M
Redeemable noncontrolling interests	261.7	—	—	261.7	I
As of December 31, 2017					
Prepaid expenses and other current assets:					
Current portion of restricted marketable securities	$ 17.8	$ —	$ 17.8	$ —	M
Other long-term assets:					
Restricted marketable securities	44.2	—	44.2	—	M
Redeemable noncontrolling interests	220.9	—	—	220.9	I

[1] The three valuation techniques are: market approach (M), cost approach (C), and income approach (I).

In addition to assets and liabilities recorded at fair value on a recurring basis, we are also required to record assets and liabilities at fair value on a nonrecurring basis. Generally, assets are recorded at fair value on a nonrecurring basis as a result of impairment charges or similar adjustments made to the carrying value of the applicable assets. During the years ended December 31, 2018, 2017, and 2016, we did not record any gains or losses related to our nonfinancial assets and liabilities that are recognized or disclosed at fair value in the financial statements on a nonrecurring basis as part of our continuing operations.

As discussed in Note 1, *Summary of Significant Accounting Policies*, "Fair Value Measurements," the carrying value equals fair value for our financial instruments that are not included in the table below and are classified as current in our consolidated balance sheets. The carrying amounts and estimated fair values for our other financial instruments are presented in the following table (in millions):

	As of December 31, 2018		As of December 31, 2017	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Long-term debt:				
Advances under revolving credit facility	$ 30.0	$ 30.0	$ 95.0	$ 95.0
Term loan facilities	280.1	281.3	294.7	296.3
5.125% Senior Notes due 2023	296.6	298.5	295.9	306.8
5.75% Senior Notes due 2024	1,194.7	1,200.0	1,193.9	1,228.5
5.75% Senior Notes due 2025	345.0	339.5	344.4	364.9
Other notes payable	104.2	104.2	82.3	82.3
Financial commitments:				
Letters of credit	—	37.4	—	35.4

Fair values for our long-term debt and financial commitments are determined using inputs, including quoted prices in nonactive markets, that are observable either directly or indirectly, or *Level 2* inputs within the fair value hierarchy. See Note 1, *Summary of Significant Accounting Policies*, "Fair Value Measurements" and "Redeemable Noncontrolling Interests."

13. Share-Based Payments:

The Company has awarded employee stock-based compensation in the form of stock options, SARs, and restricted stock awards ("RSAs") under the terms of share-based incentive plans designed to align employee and executive interests to those of its stockholders. All employee stock-based compensation awarded between January 1, 2015 and May 8, 2016 was issued under the Amended and Restated 2008 Equity Incentive Plan (the "2008 Plan"), a stockholder-approved plan that reserved and provided for the grant of up to nine million shares of common stock. This plan allowed the grants of nonqualified stock options, incentive stock options, restricted stock, SARs, performance shares, performance share units, dividend equivalents, restricted stock units ("RSUs"), and/or other stock-based awards. No additional stock-based compensation was or will be issued from the 2008 Plan.

In May 2016, our stockholders approved the 2016 Omnibus Performance Incentive Plan, which reserves and provides for the grant of up to 14,000,000 shares of common stock. All employee stock-based compensation awarded after May 8, 2016 was issued under this plan. This plan allows for the same types of equity grants as the 2008 Plan.

Stock Options—

Under our share-based incentive plans, officers and employees are given the right to purchase shares of Encompass Health common stock at a fixed grant price determined on the day the options are granted. The terms and conditions of the options, including exercise prices and the periods in which options are exercisable, are generally at the discretion of the compensation and human capital committee of our board of directors. However, no options are exercisable beyond ten years from the date of grant. Granted options vest over the awards' requisite service periods, which are generally three years.

The fair values of the options granted during the years ended December 31, 2018, 2017, and 2016 have been estimated at the grant date using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	For the Year Ended December 31,		
	2018	2017	2016
Expected volatility	29.2%	30.5%	37.2%
Risk-free interest rate	2.7%	2.1%	1.6%
Expected life (years)	7.1	7.7	7.5
Dividend yield	2.2%	2.2%	2.1%

The Black-Scholes option-pricing model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, the Black-Scholes option-pricing model requires the input of highly subjective assumptions, including the expected stock price volatility. We estimate our expected term through an analysis of actual, historical post-vesting exercise, cancellation, and expiration behavior by our employees and projected post-vesting activity of outstanding options. We calculate volatility based on the historical volatility of our common stock over the period commensurate with the expected term of the options. The risk-free interest rate is the implied daily yield currently available on U.S. Treasury issues with a remaining term closely approximating the expected term used as the input to the Black-Scholes option-pricing model. We estimated our dividend yield based on our annual dividend rate and our stock price on the dividend payment dates. Under the Black-Scholes option-pricing model, the weighted-average grant date fair value per share of employee stock options granted during the years ended December 31, 2018, 2017, and 2016 was $14.57, $11.55, and $11.55, respectively.

A summary of our stock option activity and related information is as follows:

	Shares (In Thousands)	Weighted-Average Exercise Price per Share	Weighted-Average Remaining Life (Years)	Aggregate Intrinsic Value (In Millions)
Outstanding, December 31, 2017	557	$ 30.53		
Granted	95	53.79		
Exercised	(115)	27.79		
Forfeitures	—	—		
Expirations	—	—		
Outstanding, December 31, 2018	537	35.22	5.9	$ 14.2
Exercisable, December 31, 2018	317	27.65	4.1	10.8

We recognized approximately $1.1 million, $0.8 million, and $1.6 million of compensation expense related to our stock options for the years ended December 31, 2018, 2017, and 2016, respectively. As of December 31, 2018, there was $1.6 million of unrecognized compensation cost related to unvested stock options. This cost is expected to be recognized over a weighted-average period of 21 months. The total intrinsic value of options exercised during the years ended December 31, 2018, 2017, and 2016 was $5.2 million, $29.0 million, and $9.1 million, respectively.

Stock Appreciation Rights—

In conjunction with the EHHI acquisition, we granted SARs based on Encompass Health Home Health Holdings, Inc. ("Holdings") common stock to certain members of EHHI management at closing on December 31, 2014. Under a separate plan, we granted 122,976 SARs that vest based on continued employment and an additional maximum number of 129,124 SARs that vest based on continued employment and the extent of the attainment of a specified 2017 performance measure. The maximum number of performance SARs was achieved. In general terms, half of the SARs of each type will vest on December 31, 2018 with the remainder vesting on December 31, 2019. The SARs that ultimately vest will expire on the tenth

anniversary of the grant date or within a specified period following any earlier termination of employment. Upon exercise, each SAR must be settled for cash in the amount by which the per share fair value of Holdings' common stock on the exercise date exceeds the per share fair value on the grant date. The fair value of Holdings' common stock is determined using the product of the trailing 12-month specified performance measure for Holdings and a specified median market price multiple based on a basket of public home health companies and publicly disclosed home health acquisitions with a value of $400 million or more.

The fair value of the SARs granted in conjunction with the EHHI acquisition has been estimated using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	As of December 31,	
	2018	2017
Expected volatility	27.1%	28.7%
Risk-free interest rate	2.6%	1.9%
Expected life (years)	1.3	2.1
Dividend yield	—%	—%

We did not include a dividend payment as part of our pricing model because Holdings currently does not pay dividends on its common stock. Under the Black-Scholes option-pricing model, the weighted-average fair value per share of SARs granted in conjunction with the EHHI acquisition was $419.28 and $199.41 as of December 31, 2018 and 2017, respectively. As of December 31, 2018, the fair value of the SARs is approximately $87 million, of which approximately $48 million is included in *Other current liabilities* and approximately $39 million is included in *Other long-term liabilities* in the consolidated balance sheet.

We recognized approximately $56.2 million, $26.0 million, and $5.8 million of compensation expense related to our SARs for the years ended December 31, 2018, 2017 and 2016, respectively. As of December 31, 2018, there was $9.7 million of unrecognized compensation cost related to unvested SARs. This cost is expected to be recognized over a weighted-average period of 12 months. The remaining unrecognized compensation expense for our SARs may vary each reporting period based on changes in both operational performance and the specified median market multiple. As of December 31, 2018, 231,092 SARs were outstanding.

Restricted Stock—

The RSAs granted in 2018, 2017, and 2016 included service-based awards and performance-based awards (that also included a service requirement). These awards generally vest over a three-year requisite service period. For RSAs with a service and/or performance requirement, the fair value of the RSA is determined by the closing price of our common stock on the grant date.

A summary of our issued restricted stock awards is as follows (share information in thousands):

	Shares	Weighted-Average Grant Date Fair Value
Nonvested shares at December 31, 2017	673	$ 40.90
Granted	687	37.61
Vested	(439)	42.60
Forfeited	(14)	40.00
Nonvested shares at December 31, 2018	907	37.61

The weighted-average grant-date fair value of restricted stock granted during the years ended December 31, 2017 and 2016 was $42.85 and $33.56 per share, respectively. We recognized approximately $27.1 million, $19.6 million, and $18.7 million of compensation expense related to our restricted stock awards for the years ended December 31, 2018, 2017, and 2016,

respectively. As of December 31, 2018, there was $29.9 million of unrecognized compensation expense related to unvested restricted stock. This cost is expected to be recognized over a weighted-average period of 20 months. The remaining unrecognized compensation expense for the performance-based awards may vary each reporting period based on changes in the expected achievement of performance measures. The total fair value of shares vested during the years ended December 31, 2018, 2017, and 2016 was $22.1 million, $17.7 million, and $24.3 million, respectively. We accrue dividends on outstanding RSAs which are paid upon vesting.

Nonemployee Stock-Based Compensation Plans—

During the years ended December 31, 2018, 2017, and 2016, we provided incentives to our nonemployee members of our board of directors through the issuance of RSUs out of our share-based incentive plans. RSUs are fully vested when awarded and receive dividend equivalents in the form of additional RSUs upon the payment of a cash dividend on our common stock. During the years ended December 31, 2018, 2017, and 2016, we issued 24,771, 27,594, and 32,031 RSUs, respectively, with a fair value of $62.88, $47.30, and $40.75, respectively, per unit. We recognized approximately $1.6 million, $1.3 million, and $1.3 million, respectively, of compensation expense upon their issuance in 2018, 2017, and 2016. There was no unrecognized compensation related to unvested shares as of December 31, 2018. During the years ended 2018, 2017, and 2016, we issued an additional 8,045, 9,968, and 10,248, respectively, of RSUs as dividend equivalents. As of December 31, 2018, 504,512 RSUs were outstanding.

14. Employee Benefit Plans:

Substantially all Encompass Health hospital employees are eligible to enroll in Encompass Health-sponsored healthcare plans, including coverage for medical and dental benefits. Our primary healthcare plans are national plans administered by third-party administrators. We are self-insured for these plans. During 2018, 2017, and 2016, costs associated with these plans, net of amounts paid by employees, approximated $134.9 million, $120.8 million, and $119.0 million, respectively.

The Encompass Health Retirement Investment Plan is a qualified 401(k) savings plan. The plan allows eligible employees to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. Encompass Health's employer matching contribution is 50% of the first 6% of each participant's elective deferrals. All contributions to the plan are in the form of cash. Employees who are at least 21 years of age are eligible to participate in the plan. Employer contributions vest 100% after three years of service. Participants are always fully vested in their own contributions.

Employer contributions to the Encompass Health Retirement Investment Plan approximated $19.8 million, $18.2 million, and $16.6 million in 2018, 2017, and 2016, respectively. In 2018, 2017, and 2016, approximately $2.4 million, $1.4 million, and $0.6 million, respectively, from the plan's forfeiture account were used to fund the matching contributions in accordance with the terms of the plan.

Senior Management Bonus Program—

We maintain a Senior Management Bonus Program to reward senior management for performance based on a combination of corporate or regional goals and individual goals. The corporate and regional goals are approved on an annual basis by our board of directors as part of our routine budgeting and financial planning process. The individual goals, which are weighted according to importance, are determined between each participant and his or her immediate supervisor. The program applies to persons who join the Company in, or are promoted to, senior management positions. In 2019, we expect to pay approximately $20.4 million under the program for the year ended December 31, 2018. In March 2018 and February 2017, we paid $14.7 million and $11.2 million, respectively, under the program for the years ended December 31, 2017 and 2016.

15. Income Taxes:

On December 22, 2017, the US enacted the 2017 Tax Cuts and Jobs Act (the "Tax Act"). The Tax Act, which is commonly referred to as "US tax reform," significantly changes US corporate income tax laws by, among other things, reducing the US corporate income tax rate from 35% to 21% starting in 2018. As a result, we recorded a net benefit of $13.6 million during the fourth quarter of 2017. This amount, which is included in *Provision for income tax expense* in the

consolidated statement of operations, consists of three components: (i) a $5.8 million credit resulting from the remeasurement of our net federal deferred tax assets based on the new lower corporate income tax rate, (ii) a $13.8 million credit resulting from the remeasurement of our net state deferred tax assets as a result of the decreased federal benefit implicit in the new lower corporate income tax rate, and (iii) a $5.8 million charge resulting from the remeasurement of our net valuation allowances for state NOLs as a result of the decreased federal benefit implicit in the new lower corporate income tax rate. In addition, we adopted the Tax Act's provisions allowing for 100% bonus depreciation on qualifying assets placed in service after September 27, 2017, which resulted in additional bonus depreciation deductions of $8.8 million in the fourth quarter of 2017. Certain amounts related to the impact of the Tax Act have been revised due to a correction of an error in our deferred tax assets. See Note 1, *Summary of Significant Accounting Policies*, "Revision of Previously Issued Financial Statements," for additional information on this revision.

The significant components of the *Provision for income tax expense* related to continuing operations are as follows (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Current:			
Federal	$ 103.8	$ 72.2	$ 16.1
State and other	24.2	12.8	14.9
Total current expense	128.0	85.0	31.0
Deferred:			
Federal	(13.7)	58.4	130.5
State and other	4.6	2.4	2.4
Total deferred expense	(9.1)	60.8	132.9
Total income tax expense related to continuing operations	$ 118.9	$ 145.8	$ 163.9

A reconciliation of differences between the federal income tax at statutory rates and our actual income tax expense on our income from continuing operations, which include federal, state, and other income taxes, is presented below:

	For the Year Ended December 31,		
	2018	2017	2016
Tax expense at statutory rate	21.0 %	35.0 %	35.0 %
Increase (decrease) in tax rate resulting from:			
State and other income taxes, net of federal tax benefit	4.5 %	3.5 %	3.8 %
(Decrease) increase in valuation allowance	(0.4)%	0.4 %	0.1 %
Nondeductible government, class action, and related settlements	2.7 %	— %	— %
Noncontrolling interests	(3.2)%	(4.6)%	(4.4)%
Share-based windfall tax benefits	(0.4)%	(1.8)%	— %
Tax Act	— %	(2.8)%	— %
Other, net	(0.1)%	(0.3)%	(0.5)%
Income tax expense	24.1 %	29.4 %	34.0 %

The *Provision for income tax expense* in 2018 was greater than the federal statutory rate primarily due to: (1) state and other income tax expense and (2) nondeductible settlements offset by (3) the impact of noncontrolling interests. See Note 1, *Summary of Significant Accounting Policies*, "Income Taxes," for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in this discussion. The *Provision for income tax expense* in 2017 was less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests, (2) the

impact of the Tax Act and (3) share-based windfall tax benefits offset by (4) state and other income tax expense. The *Provision for income tax expense* in 2016 was less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests offset by (2) state and other income tax expense.

Deferred income taxes recognize the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and amounts used for income tax purposes and the impact of available NOLs. The significant components of our deferred tax assets and liabilities are presented in the following table (in millions):

	As of December 31,	
	2018	2017
Deferred income tax assets:		
Net operating loss	$ 66.0	$ 77.3
Property, net	30.8	36.3
Insurance reserve	16.8	19.9
Stock-based compensation	33.0	19.5
Revenue reserves	6.1	14.0
Other accruals	22.5	20.4
Tax credits	4.7	2.8
Other	0.6	0.5
Total deferred income tax assets	180.5	190.7
Less: Valuation allowance	(33.7)	(35.8)
Net deferred income tax assets	146.8	154.9
Deferred income tax liabilities:		
Deferred revenue	—	(28.9)
Intangibles	(88.5)	(80.0)
Carrying value of partnerships	(15.2)	(11.4)
Other	(0.2)	(0.2)
Total deferred income tax liabilities	(103.9)	(120.5)
Net deferred income tax assets	$ 42.9	$ 34.4

We have state NOLs of $66.0 million that expire in various amounts at varying times through 2031. For the years ended December 31, 2018, 2017, and 2016, the net changes in our valuation allowance were $2.1 million, ($7.9) million, and ($0.3) million, respectively. The decrease in our valuation allowance in 2018 related primarily to expirations of state net operating losses. The increase in our valuation allowance in 2017 related primarily to the impact of remeasuring our state NOL deferred tax assets and their corresponding valuation allowances pursuant to the Tax Act. The increase in our valuation allowance in 2016 related primarily to the valuation of our tax credits.

As of December 31, 2018, we have a remaining valuation allowance of $33.7 million. This valuation allowance remains recorded due to uncertainties regarding our ability to utilize a portion of our state NOLs and other credits before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence including management's estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable. It is possible we may be required to increase or decrease our valuation allowance at some future time if our forecast of future earnings varies from actual results on a consolidated basis or in the applicable state tax jurisdictions, or if the timing of future tax deductions or credit utilizations differs from our expectations.

During the third quarter of 2016, we filed a non-automatic tax accounting method change related to billings denied under pre-payment claims reviews conducted by certain of our Medicare Administrative Contractors. In March 2017, the IRS approved our request resulting in additional cash tax benefits of approximately $51.3 million through December 31, 2017. These benefits are expected to reverse as pre-payment claims denials are settled and collected. This change did not have a

material impact on our effective tax rate. The Tax Act included revisions to Internal Revenue Code §451 that may eliminate this deferral of revenue for tax purposes. We are currently evaluating this provision of the Tax Act and its future impact on the method change we received in March 2017.

As of January 1, 2016, total remaining gross unrecognized tax benefits were $2.9 million, all of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits did not change significantly during 2016. Total remaining gross unrecognized tax benefits were $2.8 million as of December 31, 2016, all of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits decreased $2.5 million during 2017, primarily related to the favorable settlement of a federal interest claim. Total remaining gross unrecognized tax benefits were $0.3 million as of December 31, 2017, all of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits did not change significantly during 2018. Total remaining gross unrecognized tax benefits were $0.9 million as of December 31, 2018, all of which would affect our effective tax rate if recognized.

A reconciliation of the beginning and ending liability for unrecognized tax benefits is as follows (in millions):

	Gross Unrecognized Income Tax Benefits	Accrued Interest and Penalties
January 1, 2016	$ 2.9	$ —
Gross amount of increases in unrecognized tax benefits related to prior periods	0.3	—
Gross amount of decreases in unrecognized tax benefits related to prior periods	(0.4)	—
Gross amount of increases in unrecognized tax benefits related to current period	0.1	—
Gross amount of decreases in unrecognized tax benefits related to current period	(0.1)	—
December 31, 2016	2.8	—
Gross amount of decreases in unrecognized tax benefits related to prior periods	(0.4)	—
Decreases in unrecognized tax benefits relating to settlements with taxing authorities	(2.1)	—
December 31, 2017	0.3	—
Gross amount of increases in unrecognized tax benefits related to prior periods	0.8	0.1
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(0.2)	—
December 31, 2018	$ 0.9	$ 0.1

Our continuing practice is to recognize interest and penalties related to income tax matters in income tax expense. Interest recorded as part of our income tax provision during 2018, 2017, and 2016 was not material. Accrued interest income related to income taxes as of December 31, 2018 and 2017 was not material.

In December 2016, we signed an agreement with the IRS to participate in their Compliance Assurance Process ("CAP") for the 2017 tax year. CAP is a program in which we and the IRS endeavor to agree on the treatment of significant tax positions prior to the filing of our federal income tax returns. We renewed this agreement in January 2018 for the 2018 tax year and in December 2018 for the 2019 tax year. As a result of these agreements, the IRS is currently examining the 2017, 2018 and 2019 tax years. In May 2018, the IRS issued a no-change Revenue Agent's Report effectively closing our 2016 tax year audit. The statute of limitations has expired or we have settled federal income tax examinations with the IRS for all tax years through 2016. Our state income tax returns are also periodically examined by various regulatory taxing authorities. We are currently under audit by one state for tax years ranging from 2013 through 2015.

For the tax years that remain open under the applicable statutes of limitations, amounts related to unrecognized tax benefits have been considered by management in its estimate of our potential net recovery of prior years' income taxes. Based on discussions with taxing authorities, we anticipate $0.5 million of our unrecognized tax benefits will be released within the next 12 months.

See also Note 1, *Summary of Significant Accounting Policies*, "Recent Accounting Pronouncements."

16. Earnings per Common Share:

The following table sets forth the computation of basic and diluted earnings per common share (in millions, except per share amounts):

	For the Year Ended December 31,		
	2018	2017	2016
Basic:			
Numerator:			
Income from continuing operations[*]	$ 374.3	$ 350.6	$ 318.1
Less: Net income attributable to noncontrolling interests included in continuing operations	(83.1)	(79.1)	(70.5)
Less: Income allocated to participating securities[*]	(0.9)	(0.9)	(0.8)
Income from continuing operations attributable to Encompass Health common shareholders[*]	290.3	270.6	246.8
Income (loss) from discontinued operations, net of tax, attributable to Encompass Health common shareholders	1.1	(0.4)	—
Net income attributable to Encompass Health common shareholders[*]	$ 291.4	$ 270.2	$ 246.8
Denominator:			
Basic weighted average common shares outstanding	97.9	93.7	89.1
Basic earnings per share attributable to Encompass Health common shareholders:[*]			
Continuing operations	$ 2.97	$ 2.88	$ 2.77
Discontinued operations	0.01	—	—
Net income	$ 2.98	$ 2.88	$ 2.77
Diluted:			
Numerator:			
Income from continuing operations[*]	$ 374.3	$ 350.6	$ 318.1
Less: Net income attributable to noncontrolling interests included in continuing operations	(83.1)	(79.1)	(70.5)
Add: Interest on convertible debt, net of tax	—	4.6	9.7
Add: Loss on extinguishment of convertible debt, net of tax	—	6.2	—
Income from continuing operations attributable to Encompass Health common shareholders[*]	291.2	282.3	257.3
Income (loss) from discontinued operations, net of tax, attributable to Encompass Health common shareholders	1.1	(0.4)	—
Net income attributable to Encompass Health common shareholders[*]	$ 292.3	$ 281.9	$ 257.3
Denominator:			
Diluted weighted average common shares outstanding	99.8	99.3	99.5
Diluted earnings per share attributable to Encompass Health common shareholders:[*]			
Continuing operations	$ 2.92	$ 2.84	$ 2.59
Discontinued operations	0.01	—	—
Net income	$ 2.93	$ 2.84	$ 2.59

[*] 2017 amounts have been revised to correct an error in our deferred tax assets as discussed in Note 1, *Summary of Significant Accounting Policies*, "Revision of Previously Issued Financial Statements."

The following table sets forth the reconciliation between basic weighted average common shares outstanding and diluted weighted average common shares outstanding (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Basic weighted average common shares outstanding	97.9	93.7	89.1
Convertible senior subordinated notes	—	4.0	8.5
Restricted stock awards, dilutive stock options, and restricted stock units	1.9	1.6	1.9
Diluted weighted average common shares outstanding	99.8	99.3	99.5

There were no antidilutive options to purchase shares of common stock outstanding as of December 31, 2018. Options to purchase approximately 0.2 million shares of common stock were outstanding as of December 31, 2017, but were not included in the computation of diluted weighted-average shares because to do so would have been antidilutive.

In February 2014, our board of directors approved an increase in our common stock repurchase authorization from $200 million to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. On July 24, 2018, the Company's board approved resetting the aggregate common stock repurchase authorization to $250 million. During 2017 and 2016, we repurchased 0.9 million, and 1.7 million shares of our common stock in the open market for $38.1 million, and $65.6 million, respectively. There were no repurchases of our common stock during 2018.

In July 2015, our board of directors approved an increase in the quarterly cash dividend and declared a dividend of $0.23 per share. The cash dividend of $0.23 per common share was declared and paid each quarter through July 2016. In July 2016, our board of directors approved an increase in the quarterly cash dividend on our common stock and declared a dividend of $0.24 per share. The cash dividend of $0.24 per common share was declared and paid each quarter through July 2017. In July 2017, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.25 per share. The cash dividend of $0.25 per common share was declared and paid in each quarter through July 2018. In July 2018, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.27 per share. The cash dividend of $0.27 per common share was declared in July 2018 and October 2018 and paid in October 2018 and January 2019, respectively. As of December 31, 2018 and 2017, accrued common stock dividends of $28.4 million and $25.4 million were included in *Other current liabilities* in our consolidated balance sheet. Future dividend payments are subject to declaration by our board of directors.

On September 30, 2009, we issued 5.0 million shares of common stock and 8.2 million common stock warrants in full satisfaction of our obligation to do so under the January 2007 comprehensive settlement of the consolidated securities action brought against us by our stockholders and bondholders. Prior to their expiration on January 17, 2017, the warrants were exercisable at a price of $41.40 per share by means of a cash or a cashless exercise at the option of the holder. The warrants were not assumed exercised for dilutive shares outstanding because they were antidilutive in 2016.

The following table summarizes information relating to these warrants and their activity through their expiration date (number of warrants in millions):

	Number of Warrants	Weighted Average Exercise Price
Common stock warrants outstanding as of December 31, 2016	8.2	$ 41.40
Cashless exercise	(6.5)	41.40
Cash exercise	(0.6)	41.40
Expired	(1.1)	41.40
Common stock warrants outstanding as of January 17, 2017	—	

The above exercises resulted in the issuance of 0.7 million shares of common stock in January 2017. Cash exercises resulted in gross proceeds of $26.7 million in January 2017.

See also Note 9, *Long-term Debt.*

17. Contingencies and Other Commitments:

We operate in a highly regulated industry in which healthcare providers are routinely subject to litigation. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. The resolution of any such lawsuits, claims, or legal and regulatory proceedings could materially and adversely affect our financial position, results of operations, and cash flows in a given period.

Nichols Litigation—

We have been named as a defendant in a lawsuit filed March 28, 2003 by several individual stockholders in the Circuit Court of Jefferson County, Alabama, captioned *Nichols v. HealthSouth Corp.* The plaintiffs allege that we, some of our former officers, and our former investment bank engaged in a scheme to overstate and misrepresent our earnings and financial position. The plaintiffs are seeking compensatory and punitive damages. This case was stayed in the Circuit Court on August 8, 2005. The plaintiffs filed an amended complaint on November 9, 2010 to which we responded with a motion to dismiss filed on December 22, 2010. During a hearing on February 24, 2012, plaintiffs' counsel indicated his intent to dismiss certain claims against us. Instead, on March 9, 2012, the plaintiffs amended their complaint to include additional securities fraud claims against Encompass Health and add several former officers to the lawsuit. On September 12, 2012, the plaintiffs further amended their complaint to request certification as a class action. One of those named officers has repeatedly attempted to remove the case to federal district court, most recently on December 11, 2012. We filed our latest motion to remand the case back to state court on January 10, 2013. On September 27, 2013, the federal court remanded the case back to state court. On November 25, 2014, the plaintiffs filed another amended complaint to assert new allegations relating to the time period of 1997 to 2002. On December 10, 2014, we filed a motion to dismiss on the grounds the plaintiffs lack standing because their claims are derivative in nature, and the claims are time-barred by the statute of limitations. On May 26, 2016, the court granted our motion to dismiss. The plaintiffs appealed the dismissal of the case to the Supreme Court of Alabama on June 28, 2016. On March 23, 2018, the supreme court reversed the trial court's dismissal, holding that the plaintiffs' claims were not derivative or time-barred, and remanded the case for further proceedings. On April 6, 2018, we filed an application for rehearing with the Alabama Supreme Court.

We intend to vigorously defending ourselves in this case. Based on the stage of litigation, review of the current facts and circumstances as we understand them, the nature of the underlying claim, the results of the proceedings to date, and the nature and scope of the defense we continue to mount, we do not believe an adverse judgment or settlement is probable in this matter, and it is also not possible to estimate an amount of loss, if any, or range of possible loss that might result from an adverse judgment or settlement of this case.

Other Litigation—

One of our hospital subsidiaries was named as a defendant in a lawsuit filed August 12, 2013 by an individual in the Circuit Court of Etowah County, Alabama, captioned *Honts v. HealthSouth Rehabilitation Hospital of Gadsden, LLC*. The plaintiff alleged that her mother, who died more than three months after being discharged from our hospital, received an unprescribed opiate medication at the hospital. We deny the patient received any such medication, accounted for all the opiates at the hospital and argued the plaintiff established no causal liability between the actions of our staff and her mother's death. The plaintiff sought recovery for punitive damages. On May 18, 2016, the jury in this case returned a verdict in favor of the plaintiff for $20.0 million. On June 17, 2016, we filed a renewed motion for judgment as a matter of law or, in the alternative, a motion for new trial or, in the further alternative, a motion seeking reduction of the damages awarded (collectively, the "post-judgment motions"). The trial court denied the post-judgment motions. We appealed the verdict as well as the rulings on the post-judgment motions to the Supreme Court of Alabama on October 12, 2016. On September 28, 2018, the supreme court reversed the trial court's judgment and remanded the case for a new trial. On October 12, 2018, the plaintiff filed an application for rehearing with the supreme court, and we filed a brief in opposition to the rehearing application on October 25, 2018.

As a result of the original judgment, we recorded a net charge of $5.7 million to *Other operating expenses* in our consolidated statements of operations for the year ended December 31, 2016. As of June 30, 2018, we maintained a liability of $20.1 million in *Accrued expenses and other current liabilities* in our condensed consolidated balance sheet with a corresponding receivable of $15.5 million in *Other current assets* for the portion of the liability we would expect to be covered through our excess insurance coverages. The portion of this liability that would be a covered claim through our captive insurance subsidiary, HCS, Ltd. is $6.0 million.

As a result of the Alabama Supreme Court's reversal, we reduced the associated liability, and no longer maintain an insurance receivable in our consolidated balance sheet because we do not believe the liability exceeds the retention level. As of December 31, 2018, we maintained a liability included in *Other current liabilities* in our consolidated balance sheet in connection with this matter. We continue to believe in the merits of our defenses and counterarguments, and we intend to vigorously defend ourselves in the re-trial of this case.

Governmental Inquiries and Investigations—

On March 4, 2013, we received document subpoenas from an office of the HHS-OIG addressed to four of our hospitals. Those subpoenas also requested complete copies of medical records for 100 patients treated at each of those hospitals between September 2008 and June 2012. The investigation is being conducted by the United States Department of Justice (the "DOJ"). On April 24, 2014, we received document subpoenas relating to an additional seven of our hospitals. The new subpoenas reference substantially similar investigation subject matter as the original subpoenas and request materials from the period January 2008 through December 2013. Two of the four hospitals addressed in the original set of subpoenas have received supplemental subpoenas to cover this new time period. The most recent subpoenas do not include requests for specific patient files. However, in February 2015, DOJ requested the voluntary production of the medical records of an additional 70 patients, some of whom were treated in hospitals not subject to the subpoenas, and we provided these records. We have not received any subsequent requests for medical records from DOJ.

All of the subpoenas were in connection with an investigation of alleged improper or fraudulent claims submitted to Medicare and Medicaid and requested documents and materials relating to practices, procedures, protocols and policies, of certain pre- and post-admissions activities at these hospitals including, among other things, marketing functions, pre-admission screening, post-admission physician evaluations, patient assessment instruments, individualized patient plans of care, and compliance with the Medicare 60% rule. Under the Medicare rule commonly referred to as the "60% rule," an inpatient rehabilitation hospital must treat 60% or more of its patients from at least one of a specified list of medical conditions in order to be reimbursed at the inpatient rehabilitation hospital payment rates, rather than at the lower acute care hospital payment rates.

We have been cooperating fully with DOJ in connection with this investigation. Based on recent discussions with the government as well as the burdens and distractions associated with continuing the investigation and the likely costs of future litigation, we now estimate a settlement value of $48 million and have accrued a loss contingency in that amount which is included in *Other current liabilities* in our consolidated balance sheet. Discussions are ongoing, and until they are concluded, there can be no certainty about the nature, timing or likelihood of a settlement.

Other Matters—

The False Claims Act allows private citizens, called "relators," to institute civil proceedings on behalf of the United States alleging violations of the False Claims Act. These lawsuits, also known as "whistleblower" or "*qui tam*" actions, can involve significant monetary damages, fines, attorneys' fees and the award of bounties to the relators who successfully prosecute or bring these suits to the government. *Qui tam* cases are sealed at the time of filing, which means knowledge of the information contained in the complaint typically is limited to the relator, the federal government, and the presiding court. The defendant in a *qui tam* action may remain unaware of the existence of a sealed complaint for years. While the complaint is under seal, the government reviews the merits of the case and may conduct a broad investigation and seek discovery from the defendant and other parties before deciding whether to intervene in the case and take the lead on litigating the claims. The court lifts the seal when the government makes its decision on whether to intervene. If the government decides not to intervene, the relator may elect to continue to pursue the lawsuit individually on behalf of the government. It is possible that *qui tam* lawsuits have been filed against us, which suits remain under seal, or that we are unaware of such filings or precluded by existing law or court order from discussing or disclosing the filing of such suits. We may be subject to liability under one or more undisclosed *qui tam* cases brought pursuant to the False Claims Act.

It is our obligation as a participant in Medicare and other federal healthcare programs to routinely conduct audits and reviews of the accuracy of our billing systems and other regulatory compliance matters. As a result of these reviews, we have made, and will continue to make, disclosures to the HHS-OIG and CMS relating to amounts we suspect represent over-payments from these programs, whether due to inaccurate billing or otherwise. Some of these disclosures have resulted in, or may result in, Encompass Health refunding amounts to Medicare or other federal healthcare programs.

Other Commitments—

We are a party to service and other contracts in connection with conducting our business. Minimum amounts due under these agreements are $45.9 million in 2019, $44.0 million in 2020, $28.1 million in 2021, $9.5 million in 2022, $7.6 million in 2023, and $6.5 million thereafter. These contracts primarily relate to software licensing and support.

18. Segment Reporting:

Our internal financial reporting and management structure is focused on the major types of services provided by Encompass Health. We manage our operations using two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. These reportable operating segments are consistent with information used by our chief executive officer, who is our chief operating decision maker, to assess performance and allocate resources. The following is a brief description of our reportable segments:

- *Inpatient Rehabilitation* - Our national network of inpatient rehabilitation hospitals stretches across 32 states and Puerto Rico, with a concentration of hospitals in the eastern half of the United States and Texas. As of December 31, 2018, we operate 130 inpatient rehabilitation hospitals, including one hospital that operates as a joint venture which we account for using the equity method of accounting. We are the sole owner of 85 of these hospitals. We retain 50.0% to 97.5% ownership in the remaining 45 jointly owned hospitals. In addition, we manage five inpatient rehabilitation units through management contracts. We provide specialized rehabilitative treatment on both an inpatient and outpatient basis. Our inpatient rehabilitation hospitals provide a higher level of rehabilitative care to patients who are recovering from conditions such as stroke and other neurological disorders, cardiac and pulmonary conditions, brain and spinal cord injuries, complex orthopedic conditions, and amputations.

- *Home Health and Hospice* - As of December 31, 2018, we provide home health and hospice services in 278 locations across 30 states with concentrations in the Southeast and Texas. In addition, two of these agencies operate as joint ventures which we account for using the equity method of accounting. We are the sole owner of 270 of these locations We retain 50.0% to 81.0% ownership in the remaining eight jointly owned locations. Our home health services include a comprehensive range of Medicare-certified home nursing services to adult patients in need of care. These services include, among others, skilled nursing, physical, occupational, and speech therapy, medical social work, and home health aide services. Our hospice services include in-home services to terminally

ill patients and their families to address patients' physical needs, including pain control and symptom management, and to provide emotional and spiritual support.

The accounting policies of our reportable segments are the same as those described in Note 1, *Summary of Significant Accounting Policies*. All revenues for our services are generated through external customers. See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues," for the payor composition of our revenues. No corporate overhead is allocated to either of our reportable segments. Our chief operating decision maker evaluates the performance of our segments and allocates resources to them based on adjusted earnings before interest, taxes, depreciation, and amortization ("Segment Adjusted EBITDA").

Selected financial information for our reportable segments is as follows (in millions):

	Inpatient Rehabilitation			Home Health and Hospice		
	For the Year Ended December 31,			For the Year Ended December 31,		
	2018	2017	2016	2018	2017	2016
Net operating revenues	$ 3,346.2	$ 3,141.3	$ 2,964.1	$ 931.1	$ 772.6	$ 678.5
Operating expenses:						
Inpatient rehabilitation:						
Salaries and benefits	1,701.5	1,603.8	1,493.4	—	—	—
Other operating expenses	502.3	462.5	431.5	—	—	—
Supplies	140.6	135.7	128.8	—	—	—
Occupancy costs	63.8	61.9	61.2	—	—	—
Home health and hospice:						
Cost of services sold (excluding depreciation and amortization)	—	—	—	438.4	363.3	333.1
Support and overhead costs	—	—	—	323.5	277.2	237.2
	2,408.2	2,263.9	2,114.9	761.9	640.5	570.3
Other income	(3.6)	(4.1)	(2.9)	(0.5)	—	—
Equity in net income of nonconsolidated affiliates	(7.5)	(7.3)	(9.1)	(1.2)	(0.7)	(0.7)
Noncontrolling interests	77.2	67.6	64.0	8.5	6.9	6.5
Segment Adjusted EBITDA	$ 871.9	$ 821.2	$ 797.2	$ 162.4	$ 125.9	$ 102.4
Capital expenditures	$ 264.6	$ 238.0	$ 198.3	$ 11.6	$ 10.7	$ 8.7

	Inpatient Rehabilitation	Home Health and Hospice	Encompass Health Consolidated
As of December 31, 2018			
Total assets	$ 3,900.9	$ 1,314.6	$ 5,175.0
Investments in and advances to nonconsolidated affiliates	9.5	2.7	12.2
As of December 31, 2017			
Total assets[*]	$ 3,759.9	$ 1,150.5	$ 4,864.5
Investments in and advances to nonconsolidated affiliates	9.3	2.6	11.9

[*] 2017 amounts have been revised to correct an error in our deferred tax assets as discussed in Note 1, *Summary of Significant Accounting Policies*, "Revision of Previously Issued Financial Statements."

Segment reconciliations (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Total segment Adjusted EBITDA	$ 1,034.3	$ 947.1	$ 899.6
General and administrative expenses	(220.2)	(171.7)	(133.4)
Depreciation and amortization	(199.7)	(183.8)	(172.6)
Loss on disposal of assets	(5.7)	(4.6)	(0.7)
Government, class action, and related settlements	(52.0)	—	—
Professional fees—accounting, tax, and legal	—	—	(1.9)
Loss on early extinguishment of debt	—	(10.7)	(7.4)
Interest expense and amortization of debt discounts and fees	(147.3)	(154.4)	(172.1)
Net income attributable to noncontrolling interests	83.1	79.1	70.5
SARs mark-to-market impact on noncontrolling interests	2.6	—	—
Change in fair market value of equity securities	(1.9)	—	—
Tax reform impact on noncontrolling interests	—	(4.6)	—
Income from continuing operations before income tax expense	$ 493.2	$ 496.4	$ 482.0

	As of December 31, 2018	As of December 31, 2017
Total assets for reportable segments*	$ 5,215.5	$ 4,910.4
Reclassification of noncurrent deferred income tax liabilities to net noncurrent deferred income tax assets	(40.5)	(45.9)
Total consolidated assets*	$ 5,175.0	$ 4,864.5

(*) 2017 amounts have been revised to correct an error in our deferred tax assets as discussed in Note 1, *Summary of Significant Accounting Policies*, "Revision of Previously Issued Financial Statements."

Additional detail regarding the revenues of our operating segments by service line follows (in millions):

	For the Year Ended December 31,		
	2018	2017	2016
Inpatient rehabilitation:			
Inpatient	$ 3,247.9	$ 3,039.3	$ 2,853.9
Outpatient and other	98.3	102.0	110.2
Total inpatient rehabilitation	3,346.2	3,141.3	2,964.1
Home health and hospice:			
Home health	814.6	702.4	630.8
Hospice	116.5	70.2	47.7
Total home health and hospice	931.1	772.6	678.5
Total net operating revenues	$ 4,277.3	$ 3,913.9	$ 3,642.6

19. Quarterly Data (Unaudited):

	2018				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 1,046.0	$ 1,067.7	$ 1,067.6	$ 1,096.0	$ 4,277.3
Operating earnings [a]	150.0	157.3	154.5	93.4	555.2
Provision for income tax expense	30.0	29.3	30.2	29.4	118.9
Income from continuing operations	105.7	113.0	109.4	46.2	374.3
(Loss) income from discontinued operations, net of tax	(0.5)	0.2	(0.1)	1.5	1.1
Net income	105.2	113.2	109.3	47.7	375.4
Less: Net income attributable to noncontrolling interests	(21.4)	(21.4)	(20.7)	(19.6)	(83.1)
Net income attributable to Encompass Health	$ 83.8	$ 91.8	$ 88.6	$ 28.1	$ 292.3
Earnings per common share:					
Basic earnings per share attributable to Encompass Health common shareholders: [b]					
Continuing operations	$ 0.86	$ 0.93	$ 0.90	$ 0.27	$ 2.97
Discontinued operations	(0.01)	—	—	0.02	0.01
Net income	$ 0.85	$ 0.93	$ 0.90	$ 0.29	$ 2.98
Diluted earnings per share attributable to Encompass Health common shareholders: [b]					
Continuing operations	$ 0.85	$ 0.92	$ 0.89	$ 0.26	$ 2.92
Discontinued operations	(0.01)	—	—	0.02	0.01
Net income	$ 0.84	$ 0.92	$ 0.89	$ 0.28	$ 2.93

[a] We define operating earnings as income from continuing operations attributable to Encompass Health before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; and (4) income tax expense.

[b] Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

	2017				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 957.1	$ 966.4	$ 981.6	$ 1,008.8	$ 3,913.9
Operating earnings [a]	147.1	141.3	145.2	144.7	578.3
Provision for income tax expense [b]	39.7	28.6	43.1	34.4	145.8
Income from continuing operations [b]	84.7	79.2	85.2	101.5	350.6
(Loss) income from discontinued operations, net of tax	(0.3)	0.2	(0.1)	(0.2)	(0.4)
Net income [b]	84.4	79.4	85.1	101.3	350.2
Less: Net income attributable to noncontrolling interests	(17.6)	(16.4)	(19.2)	(25.9)	(79.1)
Net income attributable to Encompass Health [b]	$ 66.8	$ 63.0	$ 65.9	$ 75.4	$ 271.1
Earnings per common share:					
Basic earnings per share attributable to Encompass Health common shareholders: [b] [c]					
Continuing operations	$ 0.75	$ 0.70	$ 0.67	$ 0.77	$ 2.88
Discontinued operations	—	—	—	—	—
Net income	$ 0.75	$ 0.70	$ 0.67	$ 0.77	$ 2.88
Diluted earnings per share attributable to Encompass Health common shareholders: [b] [c] [d]					
Continuing operations	$ 0.70	$ 0.70	$ 0.67	$ 0.76	$ 2.84
Discontinued operations	—	—	—	—	—
Net income	$ 0.70	$ 0.70	$ 0.67	$ 0.76	$ 2.84

[a] We define operating earnings as income from continuing operations attributable to Encompass Health before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; and (4) income tax expense.

[b] During the preparation of our December 31, 2018 financial statements, an error was identified in the accounting for deferred tax assets as described further in Note 1, *Summary of Significant Accounting Policies*, "Revision of Previously Issued Financial Statements." The financial results included in the table above reflects the revision of our quarterly results for the three months and year ended December 31, 2017 to reflect the $14.8 million reduction in our *Provision for income tax expense* as shown in the table below. The revision of unaudited financial statements for the quarter and year-to-date periods ended March 31, June 30, and September 30, 2018 related to the statement of shareholders' equity, will be affected in connection with the filing of our 2019 Form 10-Qs.

For the Three Months Ended December 31, 2017	As Reported	Adjustment	As Revised
	(In Millions, Except Per Share Data)		
Provision for income tax expense	$ 49.2	$ (14.8)	$ 34.4
Income from continuing operations	86.7	14.8	101.5
Net income	86.5	14.8	101.3
Net income attributable to Encompass Health	60.6	14.8	75.4
Basic earnings per share attributable to Encompass Health common shareholders	0.62	0.15	0.77
Diluted earnings per share attributable to Encompass Health common shareholders	0.61	0.15	0.76

[c] Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

(d) For the second quarter of 2017, adding back the loss on extinguishment of convertible debt, net of tax to our *Income from continuing operations attributable to Encompass Health common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. Therefore, basic and diluted earnings per common share are the same for the three months ended June 30, 2017.

20. Condensed Consolidating Financial Information:

The accompanying condensed consolidating financial information has been prepared and presented pursuant to SEC Regulation S-X, Rule 3-10, "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered." Each of the subsidiary guarantors is 100% owned by Encompass Health, and all guarantees are full and unconditional and joint and several, subject to certain customary conditions for release. Encompass Health's investments in its consolidated subsidiaries, as well as guarantor subsidiaries' investments in nonguarantor subsidiaries and nonguarantor subsidiaries' investments in guarantor subsidiaries, are presented under the equity method of accounting with the related investment presented within the line items *Intercompany receivable* and *Intercompany payable* in the accompanying condensed consolidating balance sheets.

The terms of our credit agreement allow us to declare and pay cash dividends on our common stock so long as: (1) we are not in default under our credit agreement and (2) our senior secured leverage ratio (as defined in our credit agreement) remains less than or equal to 2x. The terms of our senior note indenture allow us to declare and pay cash dividends on our common stock so long as (1) we are not in default, (2) the consolidated coverage ratio (as defined in the indenture) exceeds 2x or we are otherwise allowed under the indenture to incur debt, and (3) we have capacity under the indenture's restricted payments covenant to declare and pay dividends. See Note 9, *Long-term Debt*.

Periodically, certain wholly owned subsidiaries of Encompass Health make dividends or distributions of available cash and/or intercompany receivable balances to their parents. In addition, Encompass Health makes contributions to certain wholly owned subsidiaries. When made, these dividends, distributions, and contributions impact the *Intercompany receivable*, *Intercompany payable*, and *Encompass Health shareholders' equity* line items in the accompanying condensed consolidating balance sheet but have no impact on the consolidated financial statements of Encompass Health Corporation.

During the preparation of our December 31, 2018 financial statements, an error was identified in our deferred tax assets as discussed in Note 1, *Summary of Significant Accounting Policies*, "Revision of Previously Issued Financial Statements." We have revised our supplemental guarantor condensed consolidating statements of operations for the year ended December 31, 2017, and condensed consolidating balance sheet as of December 31, 2017, to reflect the impact of such revision. The errors did not impact the total cash flows from operating, investing, or financing activities in the condensed consolidating statement of cash flows. The impact on our condensed consolidating financial statements is as follows:

	Condensed Consolidating Statement of Operations For the Year Ended December 31, 2017		
	As Reported	Adjustment	As Revised
Encompass Health Corporation		(In Millions)	
Provision for income tax expense	$ (90.2)	$ (14.8)	$ (105.0)
Income from continuing operations	256.7	14.8	271.5
Net income	256.3	14.8	271.1
Net income attributable to Encompass Health	256.3	14.8	271.1
Comprehensive income	256.2	14.8	271.0
Comprehensive income attributable to Encompass Health	256.2	14.8	271.0

	Condensed Consolidating Balance Sheet As of December 31, 2017		
	As Reported	Adjustment	As Revised
Encompass Health Corporation		(In Millions)	
Deferred income tax assets	$ 97.4	$ (29.2)	$ 68.2
Total assets	3,681.2	(29.2)	3,652.0
Encompass Health shareholders' equity	1,181.7	(29.2)	1,152.5
Total shareholders' equity	1,181.7	(29.2)	1,152.5
Total liabilities and shareholders' equity	3,681.2	(29.2)	3,652.0

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2018				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
			(In Millions)		
Net operating revenues	$ 21.0	$ 2,325.6	$ 2,061.0	$ (130.3)	$ 4,277.3
Operating expenses:					
Salaries and benefits	49.5	1,120.0	1,205.9	(21.4)	2,354.0
Other operating expenses	37.9	340.7	256.3	(49.8)	585.1
Occupancy costs	1.9	95.5	39.7	(59.1)	78.0
Supplies	—	94.7	64.0	—	158.7
General and administrative expenses	161.0	—	59.2	—	220.2
Depreciation and amortization	14.3	106.0	79.4	—	199.7
Government, class action, and related settlements	52.0	—	—	—	52.0
Total operating expenses	316.6	1,756.9	1,704.5	(130.3)	3,647.7
Interest expense and amortization of debt discounts and fees	124.2	20.6	27.7	(25.2)	147.3
Other income	(22.4)	(1.0)	(4.0)	25.2	(2.2)
Equity in net income of nonconsolidated affiliates	—	(7.5)	(1.2)	—	(8.7)
Equity in net income of consolidated affiliates	(465.0)	(65.8)	—	530.8	—
Management fees	(153.1)	112.7	40.4	—	—
Income from continuing operations before income tax (benefit) expense	220.7	509.7	293.6	(530.8)	493.2
Provision for income tax (benefit) expense	(70.5)	136.4	53.0	—	118.9
Income from continuing operations	291.2	373.3	240.6	(530.8)	374.3
Income from discontinued operations, net of tax	1.1	—	—	—	1.1
Net income	292.3	373.3	240.6	(530.8)	375.4
Less: Net income attributable to noncontrolling interests	—	—	(83.1)	—	(83.1)
Net income attributable to Encompass Health	$ 292.3	$ 373.3	$ 157.5	$ (530.8)	$ 292.3
Comprehensive income	$ 292.3	$ 373.3	$ 240.6	$ (530.8)	$ 375.4
Comprehensive income attributable to Encompass Health	$ 292.3	$ 373.3	$ 157.5	$ (530.8)	$ 292.3

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2017				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
			(In Millions)		
Net operating revenues	$ 21.3	$ 2,228.0	$ 1,790.7	$ (126.1)	$ 3,913.9
Operating expenses:					
Salaries and benefits	34.7	1,077.4	1,063.5	(21.0)	2,154.6
Other operating expenses	32.8	321.8	225.6	(48.6)	531.6
Occupancy costs	1.9	93.4	34.7	(56.5)	73.5
Supplies	—	93.2	56.1	—	149.3
General and administrative expenses	143.7	—	28.0	—	171.7
Depreciation and amortization	8.8	103.4	71.6	—	183.8
Total operating expenses	221.9	1,689.2	1,479.5	(126.1)	3,264.5
Loss on early extinguishment of debt	10.7	—	—	—	10.7
Interest expense and amortization of debt discounts and fees	130.5	21.1	23.8	(21.0)	154.4
Other (income) loss	(21.7)	0.2	(3.6)	21.0	(4.1)
Equity in net income of nonconsolidated affiliates	—	(7.3)	(0.7)	—	(8.0)
Equity in net income of consolidated affiliates	(341.6)	(40.3)	—	381.9	—
Management fees	(145.0)	108.3	36.7	—	—
Income from continuing operations before income tax (benefit) expense	166.5	456.8	255.0	(381.9)	496.4
Provision for income tax (benefit) expense	(105.0)	182.3	68.5	—	145.8
Income from continuing operations	271.5	274.5	186.5	(381.9)	350.6
Loss from discontinued operations, net of tax	(0.4)	—	—	—	(0.4)
Net income	271.1	274.5	186.5	(381.9)	350.2
Less: Net income attributable to noncontrolling interests	—	—	(79.1)	—	(79.1)
Net income attributable to Encompass Health	$ 271.1	$ 274.5	$ 107.4	$ (381.9)	$ 271.1
Comprehensive income	$ 271.0	$ 274.5	$ 186.5	$ (381.9)	$ 350.1
Comprehensive income attributable to Encompass Health	$ 271.0	$ 274.5	$ 107.4	$ (381.9)	$ 271.0

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2016				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
			(In Millions)		
Net operating revenues	$ 20.1	$ 2,129.9	$ 1,610.5	$ (117.9)	$ 3,642.6
Operating expenses:					
Salaries and benefits	45.5	1,006.1	952.6	(18.3)	1,985.9
Other operating expenses	27.4	309.8	199.7	(46.3)	490.6
Occupancy costs	2.9	89.8	31.9	(53.3)	71.3
Supplies	—	89.9	50.1	—	140.0
General and administrative expenses	126.7	—	6.7	—	133.4
Depreciation and amortization	9.4	102.8	60.4	—	172.6
Total operating expenses	211.9	1,598.4	1,301.4	(117.9)	2,993.8
Loss on early extinguishment of debt	7.4	—	—	—	7.4
Interest expense and amortization of debt discounts and fees	147.3	21.6	23.1	(19.9)	172.1
Other income	(19.6)	(0.4)	(2.8)	19.9	(2.9)
Equity in net income of nonconsolidated affiliates	—	(9.0)	(0.8)	—	(9.8)
Equity in net income of consolidated affiliates	(347.2)	(41.2)	—	388.4	—
Management fees	(136.2)	103.1	33.1	—	—
Income from continuing operations before income tax (benefit) expense	156.5	457.4	256.5	(388.4)	482.0
Provision for income tax (benefit) expense	(91.1)	182.6	72.4	—	163.9
Income from continuing operations	247.6	274.8	184.1	(388.4)	318.1
Income from discontinued operations, net of tax	—	—	—	—	—
Net income	247.6	274.8	184.1	(388.4)	318.1
Less: Net income attributable to noncontrolling interests	—	—	(70.5)	—	(70.5)
Net income attributable to Encompass Health	$ 247.6	$ 274.8	$ 113.6	$ (388.4)	$ 247.6
Comprehensive income	$ 247.6	$ 274.8	$ 184.1	$ (388.4)	$ 318.1
Comprehensive income attributable to Encompass Health	$ 247.6	$ 274.8	$ 113.6	$ (388.4)	$ 247.6

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2018				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
			(In Millions)		
Assets					
Current assets:					
Cash and cash equivalents	$ 41.5	$ 2.9	$ 24.8	$ —	$ 69.2
Restricted cash	—	—	59.0	—	59.0
Accounts receivable, net	—	268.1	199.6	—	467.7
Prepaid expenses and other current assets	36.3	17.5	31.2	(18.8)	66.2
Total current assets	77.8	288.5	314.6	(18.8)	662.1
Property and equipment, net	123.9	1,015.3	495.6	—	1,634.8
Goodwill	—	854.6	1,246.2	—	2,100.8
Intangible assets, net	21.4	94.6	327.4	—	443.4
Deferred income tax assets	47.9	28.9	—	(33.9)	42.9
Other long-term assets	47.9	101.3	141.8	—	291.0
Intercompany notes receivable	535.3	—	—	(535.3)	—
Intercompany receivable and investments in consolidated affiliates	2,904.4	515.7	—	(3,420.1)	—
Total assets	$ 3,758.6	$ 2,898.9	$ 2,525.6	$ (4,008.1)	$ 5,175.0
Liabilities and Shareholders' Equity					
Current liabilities:					
Current portion of long-term debt	$ 35.0	$ 6.8	$ 11.5	$ (17.5)	$ 35.8
Accounts payable	8.9	46.1	35.0	—	90.0
Accrued payroll	35.0	68.5	84.9	—	188.4
Accrued interest payable	22.3	2.2	0.2	(0.3)	24.4
Other current liabilities	154.5	4.8	175.6	(1.0)	333.9
Total current liabilities	255.7	128.4	307.2	(18.8)	672.5
Long-term debt, net of current portion	2,188.7	235.2	54.7	—	2,478.6
Intercompany notes payable	—	—	535.3	(535.3)	—
Self-insured risks	16.1	—	103.5	—	119.6
Other long-term liabilities	21.4	17.1	80.9	(33.8)	85.6
Intercompany payable	—	—	44.7	(44.7)	—
	2,481.9	380.7	1,126.3	(632.6)	3,356.3
Commitments and contingencies					
Redeemable noncontrolling interests	—	—	261.7	—	261.7
Shareholders' equity:					
Encompass Health shareholders' equity	1,276.7	2,518.2	857.3	(3,375.5)	1,276.7
Noncontrolling interests	—	—	280.3	—	280.3
Total shareholders' equity	1,276.7	2,518.2	1,137.6	(3,375.5)	1,557.0
Total liabilities and shareholders' equity	$ 3,758.6	$ 2,898.9	$ 2,525.6	$ (4,008.1)	$ 5,175.0

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2017				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
			(In Millions)		
Assets					
Current assets:					
Cash and cash equivalents	$ 34.3	$ 2.9	$ 17.2	$ —	$ 54.4
Restricted cash	—	—	62.4	—	62.4
Accounts receivable, net	—	285.2	186.9	—	472.1
Prepaid expenses and other current assets	61.4	21.7	48.7	(18.5)	113.3
Total current assets	95.7	309.8	315.2	(18.5)	702.2
Property and equipment, net	101.8	991.5	423.8	—	1,517.1
Goodwill	—	854.6	1,118.0	—	1,972.6
Intangible assets, net	11.8	105.1	286.2	—	403.1
Deferred income tax assets	68.2	8.4	—	(42.2)	34.4
Other long-term assets	49.2	100.5	85.4	—	235.1
Intercompany notes receivable	486.2	—	—	(486.2)	—
Intercompany receivable and investments in consolidated affiliates	2,839.1	311.3	—	(3,150.4)	—
Total assets	$ 3,652.0	$ 2,681.2	$ 2,228.6	$ (3,697.3)	$ 4,864.5
Liabilities and Shareholders' Equity					
Current liabilities:					
Current portion of long-term debt	$ 32.8	$ 7.4	$ 9.6	$ (17.5)	$ 32.3
Accounts payable	10.4	43.5	24.5	—	78.4
Accrued payroll	36.1	63.8	72.2	—	172.1
Accrued interest payable	21.9	2.6	0.2	—	24.7
Other current liabilities	108.8	15.6	86.6	(1.0)	210.0
Total current liabilities	210.0	132.9	193.1	(18.5)	517.5
Long-term debt, net of current portion	2,258.5	242.2	44.7	—	2,545.4
Intercompany notes payable	—	—	486.2	(486.2)	—
Self-insured risks	9.6	—	100.5	—	110.1
Other long-term liabilities	21.4	17.8	78.1	(42.1)	75.2
Intercompany payable	—	—	144.8	(144.8)	—
	2,499.5	392.9	1,047.4	(691.6)	3,248.2
Commitments and contingencies					
Redeemable noncontrolling interests	—	—	220.9	—	220.9
Shareholders' equity:					
Encompass Health shareholders' equity	1,152.5	2,288.3	717.4	(3,005.7)	1,152.5
Noncontrolling interests	—	—	242.9	—	242.9
Total shareholders' equity	1,152.5	2,288.3	960.3	(3,005.7)	1,395.4
Total liabilities and shareholders' equity	$ 3,652.0	$ 2,681.2	$ 2,228.6	$ (3,697.3)	$ 4,864.5

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2018				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
			(In Millions)		
Net cash (used in) provided by operating activities	$ (10.6)	$ 417.8	$ 355.2	$ —	$ 762.4
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	(131.4)	—	(12.5)	—	(143.9)
Purchases of property and equipment	(34.1)	(133.0)	(87.4)	—	(254.5)
Additions to capitalized software costs	(14.1)	(0.1)	(1.8)	—	(16.0)
Proceeds from disposal of assets	—	—	0.4	—	0.4
Proceeds from sale of restricted investments	—	—	11.6	—	11.6
Purchases of restricted investments	—	—	(13.3)	—	(13.3)
Proceeds from repayment of intercompany note receivable	87.0	—	—	(87.0)	—
Other	(8.5)	2.8	(3.1)	—	(8.8)
Net cash used in investing activities	(101.1)	(130.3)	(106.1)	(87.0)	(424.5)
Cash flows from financing activities:					
Principal payments on debt, including pre-payments	(17.6)	—	(3.0)	—	(20.6)
Principal borrowings on notes	—	—	13.2	—	13.2
Principal payments on intercompany note payable	—	—	(87.0)	87.0	—
Borrowings on revolving credit facility	325.0	—	—	—	325.0
Payments on revolving credit facility	(390.0)	—	—	—	(390.0)
Principal payments under capital lease obligations	—	(7.6)	(10.3)	—	(17.9)
Dividends paid on common stock	(100.7)	—	(0.1)	—	(100.8)
Purchase of equity interests in consolidated affiliates	(65.1)	—	—	—	(65.1)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(75.4)	—	(75.4)
Taxes paid on behalf of employees for shares withheld	(7.4)	—	(0.9)	—	(8.3)
Contributions from consolidated affiliates	—	—	12.6	—	12.6
Other	3.0	—	3.1	—	6.1
Change in intercompany advances	371.7	(279.9)	(91.8)	—	—
Net cash provided by (used in) financing activities	118.9	(287.5)	(239.6)	87.0	(321.2)
Increase in cash, cash equivalents, and restricted cash	7.2	—	9.5	—	16.7
Cash, cash equivalents, and restricted cash at beginning of year	34.3	2.9	79.6	—	116.8
Cash, cash equivalents, and restricted cash at end of year	$ 41.5	$ 2.9	$ 89.1	$ —	$ 133.5
Reconciliation of Cash, Cash Equivalents, and Restricted Cash					
Cash and cash equivalents at beginning of period	$ 34.3	$ 2.9	$ 17.2	$ —	$ 54.4
Restricted cash at beginning of period	—	—	62.4	—	62.4
Cash, cash equivalents, and restricted cash at beginning of period	$ 34.3	$ 2.9	$ 79.6	$ —	$ 116.8
Cash and cash equivalents at end of period	$ 41.5	$ 2.9	$ 24.8	$ —	$ 69.2
Restricted cash at end of period	—	—	59.0	—	59.0
Restricted cash included in other long-term assets at end of period	—	—	5.3	—	5.3
Cash, cash equivalents, and restricted cash at end of period	$ 41.5	$ 2.9	$ 89.1	$ —	$ 133.5
Supplemental schedule of noncash financing activity:					
Intercompany note activity	$ (136.8)	$ —	$ 136.8	$ —	$ —

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2017				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
			(In Millions)		
Net cash provided by operating activities	$ 28.7	$ 381.3	$ 248.3	$ —	$ 658.3
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	(10.9)	—	(27.9)	—	(38.8)
Purchases of property and equipment	(39.4)	(106.1)	(80.3)	—	(225.8)
Additions to capitalized software costs	(16.3)	(0.2)	(2.7)	—	(19.2)
Proceeds from disposal of assets	—	11.7	0.6	—	12.3
Proceeds from sale of restricted investments	—	—	4.2	—	4.2
Purchases of restricted investments	—	—	(8.5)	—	(8.5)
Proceeds from repayment of intercompany note receivable	51.0	—	—	(51.0)	—
Other	(3.7)	—	(3.5)	—	(7.2)
Net cash used in investing activities	(19.3)	(94.6)	(118.1)	(51.0)	(283.0)
Cash flows from financing activities:					
Principal payments on debt, including pre-payments	(126.9)	—	(3.0)	—	(129.9)
Principal payments on intercompany notes payable	—	—	(51.0)	51.0	—
Borrowings on revolving credit facility	273.3	—	—	—	273.3
Payments on revolving credit facility	(330.3)	—	—	—	(330.3)
Principal payments under capital lease obligations	—	(6.8)	(8.5)	—	(15.3)
Repurchases of common stock, including fees and expenses	(38.1)	—	—	—	(38.1)
Dividends paid on common stock	(91.5)	—	—	—	(91.5)
Proceeds from exercising stock warrants	26.6	—	—	—	26.6
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(51.9)	—	(51.9)
Taxes paid on behalf of employees for shares withheld	(19.5)	—	(0.3)	—	(19.8)
Contributions from consolidated affiliates	—	—	20.8	—	20.8
Other	(3.1)	—	(0.7)	—	(3.8)
Change in intercompany advances	313.8	(278.6)	(35.2)	—	—
Net cash provided by (used in) financing activities	4.3	(285.4)	(129.8)	51.0	(359.9)
Increase in cash, cash equivalents, and restricted cash	13.7	1.3	0.4	—	15.4
Cash, cash equivalents, and restricted cash at beginning of year	20.6	1.6	79.2	—	101.4
Cash, cash equivalents, and restricted cash at end of year	$ 34.3	$ 2.9	$ 79.6	$ —	$ 116.8
Reconciliation of Cash, Cash Equivalents, and Restricted Cash					
Cash and cash equivalents at beginning of period	$ 20.6	$ 1.6	$ 18.3	$ —	$ 40.5
Restricted cash at beginning of period	—	—	60.9	—	60.9
Cash, cash equivalents, and restricted cash at beginning of period	$ 20.6	$ 1.6	$ 79.2	$ —	$ 101.4
Cash and cash equivalents at end of period	$ 34.3	$ 2.9	$ 17.2	$ —	$ 54.4
Restricted cash at end of period	—	—	62.4	—	62.4
Cash, cash equivalents, and restricted cash at end of period	$ 34.3	$ 2.9	$ 79.6	$ —	$ 116.8
Supplemental schedule of noncash financing activities:					
Intercompany note activity	$ (8.8)	$ —	$ 8.8	$ —	$ —
Conversion of convertible debt	$ 319.4	$ —	$ —	$ —	$ 319.4

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2016				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
			(In Millions)		
Net cash provided by operating activities	$ 60.3	$ 327.4	$ 252.5	$ —	$ 640.2
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	—	—	(48.1)	—	(48.1)
Purchases of property and equipment	(21.8)	(77.4)	(78.5)	—	(177.7)
Additions to capitalized software costs	(22.8)	(0.2)	(2.2)	—	(25.2)
Proceeds from disposal of assets	—	0.7	23.2	—	23.9
Proceeds from sale of restricted investments	—	—	0.1	—	0.1
Purchases of restricted investments	—	—	(1.3)	—	(1.3)
Funding of intercompany note receivable	(22.5)	—	—	22.5	—
Proceeds from repayment of intercompany note receivable	52.0	—	—	(52.0)	—
Other	(3.7)	(0.2)	2.2	—	(1.7)
Net cash provided by investing activities of discontinued operations	0.1	—	—	—	0.1
Net cash used in investing activities	(18.7)	(77.1)	(104.6)	(29.5)	(229.9)
Cash flows from financing activities:					
Principal payments on debt, including pre-payments	(198.5)	(1.3)	(2.3)	—	(202.1)
Principal borrowings on intercompany notes payable	—	—	22.5	(22.5)	—
Principal payments on intercompany notes payable	—	—	(52.0)	52.0	—
Borrowings on revolving credit facility	335.0	—	—	—	335.0
Payments on revolving credit facility	(313.0)	—	—	—	(313.0)
Principal payments under capital lease obligations	(0.1)	(5.9)	(7.3)	—	(13.3)
Repurchases of common stock, including fees and expenses	(65.6)	—	—	—	(65.6)
Dividends paid on common stock	(83.8)	—	—	—	(83.8)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(64.9)	—	(64.9)
Taxes paid on behalf of employees for shares withheld	(11.6)	—	—	—	(11.6)
Contributions from consolidated affiliates	—	—	3.5	—	3.5
Other	1.1	—	(1.7)	—	(0.6)
Change in intercompany advances	274.3	(242.7)	(31.6)	—	—
Net cash used in financing activities	(62.2)	(249.9)	(133.8)	29.5	(416.4)
(Decrease) increase in cash, cash equivalents, and restricted cash	(20.6)	0.4	14.1	—	(6.1)
Cash, cash equivalents, and restricted cash at beginning of year	41.2	1.2	65.1	—	107.5
Cash, cash equivalents, and restricted cash at end of year	$ 20.6	$ 1.6	$ 79.2	$ —	$ 101.4
Reconciliation of Cash, Cash Equivalents, and Restricted Cash					
Cash and cash equivalents at beginning of period	$ 41.2	$ 1.2	$ 19.2	$ —	$ 61.6
Restricted cash at beginning of period	—	—	45.9	—	45.9
Cash, cash equivalents, and restricted cash at beginning of period	$ 41.2	$ 1.2	$ 65.1	$ —	$ 107.5
Cash and cash equivalents at end of period	$ 20.6	$ 1.6	$ 18.3	$ —	$ 40.5
Restricted cash at end of period	—	—	60.9	—	60.9
Cash, cash equivalents, and restricted cash at end of period	$ 20.6	$ 1.6	$ 79.2	$ —	$ 101.4
Supplemental schedule of noncash financing activities:					
Intercompany note activity	$ (11.7)	$ —	$ 11.7	$ —	$ —

EXHIBIT LIST

Effective as of January 1, 2018, we changed our name to Encompass Health Corporation. By operation of law, any reference to "HealthSouth" in these exhibits should be read as "Encompass Health" as set forth in the Exhibit List below.

No.	Description
2.1	Stock Purchase Agreement, dated as of November 23, 2014, by and among EHHI Holdings, Inc., the sellers party thereto, Encompass Health Corporation, Encompass Health Home Health Corporation, and the sellers' representative named therein (incorporated by reference to Exhibit 2.1 to Encompass Health's Annual Report on Form 10-K filed on March 2, 2015).#
3.1.1	Amended and Restated Certificate of Incorporation of Encompass Health Corporation, effective as of January 1, 2018 (incorporated by reference to Exhibit 3.1 to Encompass Health's Current Report on Form 8-K filed on October 25, 2017).
3.1.2	Certificate of Designations of 6.50% Series A Convertible Perpetual Preferred Stock, as filed with the Secretary of State of the State of Delaware on March 7, 2006 (incorporated by reference to Exhibit 3.1 to Encompass Health's Current Report on Form 8-K filed on March 9, 2006).
3.2	Amended and Restated Bylaws of Encompass Health Corporation, effective as of January 1, 2018 (incorporated by reference to Exhibit 3.2 to Encompass Health's Current Report on Form 8-K filed on October 25, 2017).
4.1.1	Indenture, dated as of December 1, 2009, between Encompass Health Corporation and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to Encompass Health's 5.125% Senior Notes due 2023, 5.75% Senior Notes due 2024, and 5.75% Senior Notes due 2025 (incorporated by reference to Exhibit 4.7.1 to Encompass Health's Annual Report on Form 10-K filed on February 23, 2010).
4.1.2	First Supplemental Indenture, dated December 1, 2009, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.7.2 to Encompass Health's Annual Report on Form 10-K filed on February 23, 2010).
4.1.3	Second Supplemental Indenture, dated as of October 7, 2010, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.2 to Encompass Health's Current Report on Form 8-K filed on October 12, 2010).
4.1.4	Third Supplemental Indenture, dated October 7, 2010, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.3 to Encompass Health's Current Report on Form 8-K filed on October 12, 2010).
4.1.5	Fourth Supplemental Indenture, dated September 11, 2012, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to Encompass Health's 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.2 to Encompass Health's Current Report on Form 8-K filed on September 11, 2012).
4.1.6	Fifth Supplemental Indenture, dated as of March 12, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to Encompass Health's 5.125% Senior Notes due 2023 (incorporated by reference to Exhibit 4.2 to Encompass Health's Current Report on Form 8-K filed on March 12, 2015).
4.1.7	Sixth Supplemental Indenture, dated as of August 7, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to Encompass Health's 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.4 to Encompass Health's Current Report on Form 8-K filed on August 12, 2015).
4.1.8	Seventh Supplemental Indenture, dated as of September 16, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to Encompass Health's 5.75% Senior Notes due 2025 (incorporated by reference to Exhibit 4.2 to Encompass Health's Current Report on Form 8-K filed on September 21, 2015).
10.1.1	Encompass Health Corporation Amended and Restated 2004 Director Incentive Plan (incorporated by reference to Exhibit 10.12.1 to Encompass Health's Annual Report on Form 10-K filed on March 29, 2006).+

10.1.2	Form of Restricted Stock Unit Agreement (Amended and Restated 2004 Director Incentive Plan)(incorporated by reference to Exhibit 10.12.2 to Encompass Health's Annual Report on Form 10-K filed on March 29, 2006).+
10.2	Form of Indemnity Agreement entered into between Encompass Health Corporation and the directors of Encompass Health (incorporated by reference to Exhibit 10.31 to Encompass Health's Annual Report on Form 10-K filed on June 27, 2005).+
10.3	Encompass Health Corporation Fourth Amended and Restated Change in Control Benefits Plan (incorporated by reference to Exhibit 10.1 to Encompass Health's Quarterly Report on Form 10-Q filed on October 31, 2018).+
10.4	Description of the Encompass Health Corporation Senior Management Compensation Recoupment Policy (incorporated by reference to Item 5, "Other Matters," in Encompass Health's Quarterly Report on Form 10-Q filed on November 4, 2009).+
10.5	Description of the Encompass Health Corporation Senior Management Bonus and Long-Term Incentive Plans (incorporated by reference to the section captioned "Executive Compensation – Compensation Discussion and Analysis – Elements of Executive Compensation" in Encompass Health's Definitive Proxy Statement on Schedule 14A filed on March 23, 2018).+
10.6	Description of the annual compensation arrangement for non-employee directors of Encompass Health Corporation (incorporated by reference to the section captioned "Corporate Governance and Board Structure – Compensation of Directors" in Encompass Health's Definitive Proxy Statement on Schedule 14A, filed on March 23, 2018).+
10.7	Encompass Health Corporation Fifth Amended and Restated Executive Severance Plan (incorporated by reference to Exhibit 10.2 to Encompass Health's Quarterly Report on Form 10-Q filed on October 31, 2018).+
10.8	Encompass Health Corporation Nonqualified 401(k) Plan (incorporated by reference to Exhibit 10.1 to Encompass Health's Quarterly Report on Form 10-Q filed on July 29, 2014).+
10.9.1	Encompass Health Corporation Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 4(d) to Encompass Health's Registration Statement on Form S-8 filed on August 2, 2011).+
10.9.2	Form of Non-Qualified Stock Option Agreement (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.10.2 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
10.9.3	Form of Non-Qualified Stock Option Agreement (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.10.3 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
10.9.4	Form of Restricted Stock Unit Award (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.1.5 to Encompass Health's Quarterly Report on Form 10-Q filed on August 4, 2011).+
10.10	Encompass Health Corporation Directors' Deferred Stock Investment Plan (incorporated by reference to Exhibit 10.15 to Encompass Health's Annual Report on Form 10-K filed on February 19, 2013).+
10.11.1	Encompass Health Corporation 2016 Omnibus Performance Incentive Plan (incorporated by reference to Exhibit 10.1.1 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.11.2	Form of Non-Qualified Stock Option Agreement (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed on December 12, 2016).+
10.11.3	Form of Restricted Stock Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.3 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.11.4	Form of Performance Share Unit Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.4 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.11.5	Form of Restricted Stock Unit Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.5 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.12	Amended and Restated Collateral and Guarantee Agreement, dated as of October 26, 2010, among Encompass Health Corporation, its subsidiaries identified herein, and Barclays Bank PLC, as collateral agent (incorporated by reference to Exhibit 10.3 to Encompass Health's Current Report on Form 8-K/A filed on November 23, 2010).

Attachment 33

10.13	Fourth Amended and Restated Credit Agreement, dated as of September 29, 2017, by and among the Encompass Health Corporation, certain of its subsidiaries, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.1 to Encompass Health's Quarterly Report on Form 10-Q filed on October 31, 2017).
10.14	Homecare Homebase, L.L.C. Restated Client Service and License Agreement, dated December 31, 2014, by and between Homecare Homebase, L.L.C. and EHHI Holdings, Inc. (incorporated by reference to Exhibit 10.19 to Encompass Health's Annual Report on Form 10-K filed on March 2, 2015).*
10.15	Rollover Stock Agreement, dated as of November 23, 2014, by and among Encompass Health Corporation, Encompass Health Home Health Holdings, Inc., and the selling stockholders of EHHI Holdings, Inc. named therein (incorporated by reference to Exhibit 2.2 to Encompass Health's Annual Report on Form 10-K filed on March 2, 2015).#
10.16	Stockholders' Agreement relating to Encompass Health Home Health Holdings, Inc., dated as of December 31, 2014, by and among Encompass Health Corporation, Encompass Health Home Health Holdings, Inc., and the selling stockholders of EHHI Holdings, Inc. named therein (incorporated by reference to Exhibit 10.15 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
10.17	Amended and Restated Senior Management Agreement, dated as of November 23, 2014, by and among EHHI Holdings, Inc., April Anthony, Encompass Health Corporation, and solely for purposes of Sections 6(b) and 6(j) thereof, Thoma Cressey Fund VIII, L.P. (incorporated by reference to Exhibit 10.20 to Encompass Health's Annual Report on Form 10-K filed on March 2, 2015).+
10.18	Non-Competition and Non-Solicitation Agreement, effective as of December 31, 2014, by and among April Anthony, Encompass Health Corporation, and Encompass Health Home Health Corporation (incorporated by reference to Exhibit 10.17 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
21.1	Subsidiaries of Encompass Health Corporation.
23.1	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm.
24.1	Power of Attorney (included as part of signature page).
31.1	Certification of Chief Executive Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	Sections of the Encompass Health Corporation Annual Report on Form 10-K for the year ended December 31, 2018, formatted in XBRL (eXtensible Business Reporting Language), submitted in the following files:
	101.INS XBRL Instance Document
	101.SCH XBRL Taxonomy Extension Schema Document
	101.CAL XBRL Taxonomy Extension Calculation Linkbase Document
	101.DEF XBRL Taxonomy Extension Definition Linkbase Document
	101.LAB XBRL Taxonomy Extension Label Linkbase Document
	101.PRE XBRL Taxonomy Extension Presentation Linkbase Document

Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule will be furnished supplementally to the Securities and Exchange Commission upon request.

Attachment 33

+ Management contract or compensatory plan or arrangement.

* Certain portions of this exhibit have been omitted pursuant to a request for confidential treatment. The nonpublic information has been filed separately with the Securities and Exchange Commission pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended.

Financial Viability
The Rehabilitation Institute of Southern Illinois, LLC

The Income Statement for the Applicant entity, The Rehab Institute follows.

	CON Year 1	CON Year 2
Revenue		
Gross Patient Revenue	$ 23,120,900	$ 29,870,300
Contractual Adjustments	7,756,700	10,062,700
Other Deductions from Revenue	702,100	906,300
Deductions from Revenue	8,458,800	10,969,000
Net Patient Revenue	$ 14,662,100	$ 18,901,300
Other Revenue		
Total Revenue	$ 14,662,100	$ 18,901,300
Operating Expenses		
Salaries and Benefits	$ 8,534,800	$ 10,287,100
Supplies	646,400	835,100
Administrative Services	410,600	529,300
Depreciation and Amortization	1,480,600	1,488,600
Other Operating Expenses	3,552,400	3,893,000
Total Operating Expenses	14,624,800	17,033,100
Income from Project Operations	$ 37,300	$ 1,868,200
Taxes	10,200	504,600
Net Income from Project Operations	$ 27,100	$ 1,363,600

Attachment 35
Page 1

Financial Viability
The Rehabilitation Institute of Southern Illinois, LLC

The Balance Statement for the Applicant entity, The Rehab Institute follows.

	CON Year 1	CON Year 2
Cash	$ 1,569,664	$ 4,373,755
Accounts Receivable	3,374,310	3,987,417
Other Current Assets		
Total Current Assets	4,943,974	8,361,172
PP&E	33,021,324	33,101,324
Accumulated Depreciation	(2,718,423)	(4,206,972)
PP&E, net	30,302,900	28,894,351
Other Assets		
TOTAL ASSETS	$ 35,246,875	$ 37,255,524
CURRENT LIABILITIES		
Accounts Payable	239,932	273,664
Accrued Salaries	701,482	845,508
Other Current Liabilities		
TOTAL CURRENT LIABILITIES	941,414	1,119,172
L/T LIABILITIES		
EQUITY		
Partners Equity	34,267,749	34,267,749
Retained Earnings	37,711	1,868,603
NET EQUITY	$ 34,305,460	$ 36,136,352
TOTAL LIAB AND EQUITY	$ 35,246,875	$ 37,255,524

Financial Viability
The Rehabilitation Institute of Southern Illinois, LLC

The Financial Viability Ratios for the Applicant entity, The Rehab Institute follows.

	CON Year 1	CON Year 2
Current Ratio:	**5.25**	**7.47**
Current Assets /	4,943,974	8,361,172
Current Liabilities	941,414	1,119,172
Net Margin Percentage	**0.3%**	**9.9%**
Income b/f Tax /	37,300	1,868,200
Net Patient Revenue	14,662,100	18,901,300
Percent Debt to Capitalization	**N/A**	**N/A**
Note: Licensee has no long term debt		
Projected Debt Service Coverage	**N/A**	**N/A**
Note: Licensee has no long term debt		
Days Cash on Hand	**43.6**	**102.7**
Total Expenses excl Depreciation	13,144,200	15,544,500
Expenses per Day	36,012	42,588
Cushion Ratio	**N/A**	**N/A**
Note: Licensee has no long term debt		

Financial Viability
The Rehabilitation Institute of Southern Illinois, LLC

The assumptions supporting the income statement for The Rehab Institute follows.

Patient Utilization
As explained and supported throughout this application, patient days are projected to reach 12,483 in CON Year 2, the first full fiscal year when the project achieves the target utilization of 85% of average annual occupancy.

Gross Patient Revenues
The Rehab Institute's proposed charges are based upon the expected diagnostic and acuity levels of the patients treated and average charges per patient day experienced by Encompass Health and BJC. Gross patient revenues include patient room, therapeutic, and ancillary service charges. Average charges per patient day are projected to be $2,393 in CON Year 2.

Contractual Allowances
Contractual allowances are the difference between the gross patient charge and anticipated third-party payment rate. Projected contractual allowances are based upon anticipated payor mix and third-party payment rates for the anticipated diagnostic and acuity levels of the patients treated.

Proposed patient payor mix was developed from the service area payor mix and Encompass Health and BJC experience, and is summarized below as follows:

Payor	Payor Mix
Medicare	60.3%
Medicaid	12.5%
BCBS	8.4%
Managed Care	16.4%
Self-Pay/Other (incl. Charity)	2.4%
Total	100.0%

Other Deductions from Revenue
Other Deductions are predominately comprised of self-pay discount, free care, bad debt, charity care, and indigent care write-offs. These deductions are based on The Rehab Institute's anticipated services and payor mix, as well as experiences in other Encompass and BJC facilities.

Expenses
The Rehab Institute's projected expenses are based on historical expenses incurred at other Encompass hospitals and Encompass's vast operations knowledge and experience opening new hospitals in similar markets. Explanations of significant expense assumptions are provided below.

Salaries and Benefits
Clinical nursing staffing levels are based upon Encompass Health and BJC experience and standard hours of care, applied to anticipated patient volumes and patient acuity mix. Nursing staffing levels are sufficient to meet the medical and rehabilitation needs of the patients and to achieve service excellence.

Salaries and benefit expenses are based on projected patient census, staffing mix, area labor market conditions, and Encompass Health and BJC experience in recruiting employees.

Supplies and Drugs
Supplies and drugs expenses are based on The Rehab Institute's projected patient case mix and Encompass and BJC experience. Supplies and drug expenses for the proposed hospital will approximate $67 per patient day in CON Year 2.

Administrative Services
These expenses, estimated to be 2.8% of net patient revenues, represent service fees that will be paid by The Rehab Institute to Encompass Health for administrative support and assistance in areas such as financial, accounting, payroll, management information systems, human resources, insurance, risk management, cash management and other related support services.

Depreciation and Amortization
Depreciation and amortization expenses are based upon The Rehab Institute's project costs depreciated over asset average useful lives using the straight-line method.

Other Operating Expenses
Other operating expenses are comprised of maintenance costs, utilities, contract and directorship fees, ground lease expense, and other services. These expenses are based on projected patient utilization and Encompass Health and BJC experience.

Taxes
Projected income taxes represent estimated federal and state taxes related to projected income. Although income taxes on an LLC are paid at the member level, taxes paid are estimated at an effective rate of 27%.

Encompass Health

9001 Liberty Parkway
Birmingham, AL 35242

encompasshealth.com

May 13, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: The Rehabilitation Institute of Southern Illinois, LLC
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.120(a) Available Funds Certification
Criterion 1120.140A. Reasonableness of Financing Arrangements

Dear Ms. Avery:

In accordance with the verification requirements of 735 ILCS 5/1-109 of the Illinois Code of Civil Procedure, I hereby certify under the penalty of perjury the following:

1. The Rehabilitation Institute of Southern Illinois, LLC Project costs will be funded with $30,998,250, of which Encompass Health Corporation, an Applicant, will fund up to 50% of the Project, in the amount of $15,499,125 from internal cash resources including cash and equivalents and/or available line of credit facilities.

2. Encompass Health, an Applicant, will fund up to 50% of the Project's necessary working capital and operating deficits through the first full fiscal year when the project achieves the target utilization of 85% of average annual occupancy.

3. Encompass Health, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. In 2018, Encompass Health Corporation's operating activities generated $762 Million and as of the end of 2018, the company had $69 Million of unrestricted cash on its balance sheet. In addition, Encompass Health Corporation has at its discretion a $700 Million Revolving Credit Facility, of which approximately $621 Million was available as of February 28, 2019. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed Project. We have sufficient resources to fully fund these expenditures in addition to our other ongoing obligations.

This letter shall also serve as a confirmation of our analysis of the funding options for this Project. Funding the Project through cash and securities is the lowest cost option.

I hereby certify this is true and based upon my personal knowledge and under the penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely yours,

Jennifer Solomon
Director, Corporate Treasury
Encompass Health Corporation

Subscribed and Sworn before to me this 13th day of May, 2019.

Notary Public

[Seal]

LISA CORNETT GOLDEN
MY COMMISSION EXPIRES
OCTOBER 31, 2022
NOTARY PUBLIC
STATE OF ALABAMA

BJC HealthCare

May 13, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: The Rehabilitation Institute of Southern Illinois, LLC
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.120(a) Available Funds Certification
Criterion 1120.140A. Reasonableness of Financing Arrangements

Dear Ms. Avery:

In accordance with the verification requirements of 735 ILCS 5/1-109 of the Illinois Code of Civil Procedure, I hereby certify under the penalty of perjury the following:

1. BJC HealthCare, an Applicant, will fund up to 50% of The Rehabilitation Institute of Southern Illinois, LLC Project costs, up to the amount of $15,499,125, from internal cash resources including cash and equivalents and/or unrestricted board-designated investments.

2. BJC HealthCare, an Applicant, will fund up to 50% of the Project's necessary working capital and operating deficits through the first full fiscal year when the project achieves the target utilization of 85% of average annual occupancy.

3. BJC HealthCare, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. As of December 31, 2018, BJC HealthCare had $4,151.3 Million of cash, cash equivalents, and unrestricted board-designated investments on its balance sheet. These amounts offer more than adequate internal resource funds for the proposed Project costs and necessary working capital.

This letter shall also serve as a confirmation of our analysis of the funding options for this Project. Funding the Project through cash and securities is the lowest cost option.

BJC HealthCare

I hereby certify this is true and based upon my personal knowledge and under the penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely yours,

Christy Moore
Vice President

Sworn and subscribed to before me this 14th day of May, 2019.

Signature of Notary

[Seal]

NOTARY PUBLIC NOTARY SEAL STATE OF MISSOURI

DAPHNE L WILCUT
My Commission Expires
February 21, 2023
St Louis City
Commission #15146250

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	Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. $ (A x C)	Mod. $ (B x E)	
New Construction	403.84		47,749				19,282,746		
Contingency	40.38		47,749				1,928,275		
TOTALS	444.22		47,749				21,211,021		
* Include the percentage (%) of space for circulation									

Projected Operating Costs

The projected operating costs for The Rehab Institute of Southern Illinois in the first full fiscal year when the Project achieves target utilization are as follows:

Factor	CON Year 2
Salaries and Benefits	$ 8,190,300
Benefits	$ 2,096,700
Supplies	$ 835,100
Total Operating Costs	$ 11,122,100
Patient Days	12,483
Cost per Day	$ 891.00

Total Effect of the Project on Capital Costs

The projected capital costs for The Rehab Institute of Southern Illinois in the first full fiscal year when the Project achieves target utilization are as follows:

Factor	CON Year 2
Depreciation	$ 1,488,600
Total Capital Costs	$ 1,488,600
Patient Days	12,483
Cost per Day	$ 119.25

Safety Net Impact Statement
The Rehabilitation Institute of Southern Illinois, LLC

The proposed project is a new entity that will be a 50/50 joint venture between BJC HealthCare and Encompass Health, two national health care organizations. Both of these organizations serve patients in need, regardless of ability to pay; thus, the establishment of a new 40-bed comprehensive physical rehabilitation hospital in Shiloh will have a positive impact on community safety net services.

Notably, BJC is a nonprofit health care organization with 14 hospitals, five service organizations and hundreds of outreach services for residents in the greater St. Louis, southern Illinois and mid-Missouri areas. BJC is the largest provider of charity care, unreimbursed care and community benefit in Missouri, providing $904 million in free or reduced medical care, education of health professionals, medical research funding and community outreach programs. Many of BJC's programs and services benefit the residents of Southern Illinois who travel to St. Louis for health care services provided by BJC and its affiliates.

As one of the largest nonprofit health care integrated delivery organizations in the country, BJC has the clinical excellence, community outreach and education, research and education component through its relationship with Washington University School of Medicine, and financial strength to ensure the success of the proposed project. BJC brings its commitment of improving the health and well-being of the people and communities it serves through leadership, education, innovation, and excellence in medicine to the proposed project, which will of course ultimately positively impact all patients, including charity and Medicaid patients.

No existing safety net services offered by other providers will be impacted by the proposed project.

Project Safety Net Table		
	CON Year 1	**CON Year 2**
Charity Care		
# of Patients		
Inpatient	9	12
Outpatient	-	-
Total	9	12
Cost		
Inpatient	$ 145,780	$ 169,419
Outpatient	-	-
Total	$ 145,780	$ 169,419
Medicaid		
# of Patients		
Inpatient	100	127
Outpatient	-	-
Total	100	127
Net Revenue		
Inpatient	$ 1,552,039	$ 2,008,533
Outpatient	-	-
Total	$ 1,552,039	$ 2,008,533

Attachment 37
Page 1

Charity Care Information
The Rehabilitation Institute of Southern Illinois, LLC

Project Charity Care		
	CON Year 1	**CON Year 2**
Net Patient Revenue	$ 14,662,100	$ 18,901,300
Amount of Charity Care (Charges)	$ 230,463	$ 297,114
Cost of Charity Care	$ 145,780	$ 169,419
Charity Care Cost % of Net Pat Rev	1.0%	0.9%

Attachment 38
Page 1

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

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5	Flood Plain Requirements	117-118
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13	Alternatives to the Project	178
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15	Project Service Utilization	186
16	Unfinished or Shell Space	N/A
17	Assurances for Unfinished/Shell Space	N/A
	Service Specific:	
18	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
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21	Open Heart Surgery	N/A
22	Cardiac Catheterization	N/A
23	In-Center Hemodialysis	N/A
24	Non-Hospital Based Ambulatory Surgery	N/A
25	Selected Organ Transplantation	N/A
26	Kidney Transplantation	N/A
27	Subacute Care Hospital Model	N/A
28	Community-Based Residential Rehabilitation Center	N/A
29	Long Term Acute Care Hospital	N/A
30	Clinical Service Areas Other than Categories of Service	N/A
31	Freestanding Emergency Center Medical Services	N/A
32	Birth Center	N/A
	Financial and Economic Feasibility:	
33	Availability of Funds	214-357
34	Financial Waiver	N/A
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Benesch

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May 16, 2019

VIA FEDEX

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

Re: The Rehabilitation Institute of Southern Illinois - CON Application

Dear Ms. Avery:

Enclosed please find the CON application to establish a 40 Bed Comprehensive Physical Rehabilitation Hospital in Shiloh, Illinois along with the initial application fee in the amount of $2,500.00.

If you have any questions or need any additional information regarding the project, please feel free to contact me via phone at 312-212-4967 or via email at Msilberman@beneschlaw.com You can also contact my colleague Juan Morado Jr., via phone at 312-212-4967 or via email at Jmorado@beneshclaw.com with any questions.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Mark J. Silberman

Enclosures

and their Joint Venture Entity

The Rehabilitation Institute of Southern Illinois, LLC

Propose to Establish a New 40-Bed Comprehensive Physical Rehabilitation Hospital in Shiloh, Illinois (St. Clair County, HSA 11)

Applicant:

The Rehabilitation Institute of Southern Illinois, LLC
A Joint Venture of BJC HealthCare & Encompass Health
2001 Frank Scott Parkway East
Shiloh, Illinois 62269

Authorized Representatives:

Greg Bratcher
Director of Public Policy
BJC HealthCare
4901 Forest Park Avenue
St. Louis, Missouri 63108
(314) 323-1231

Walter Smith
Director, State Regulatory Affairs
Encompass Health
9001 Liberty Parkway
Birmingham, AL 35242
(205) 970-7926

May 17, 2019