POLSINELLI

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

Via Hand Delivery

November 15, 2019

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

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

Dear Ms. Avery:

Polsinelli, as co-counsel with Benesch, submits this letter on behalf of Rehabilitation Institute of Southern Illinois, LLC and the other project Applicants[1] in their proposal to establish a 40-bed inpatient rehabilitation facility in Shiloh, Illinois (the "Rehab Institute"). In this capacity, I am writing to provide additional information subsequent to the Illinois Health Facilities and Services Review Board's (the "HFSRB") September 17, 2019 meeting where the Rehab Institute proposal received four favorable votes, just one vote short of approval.

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

1. Demonstrates there is a Need for 47 Inpatient Rehab Beds in HSA 11.

2. Describes Inpatient Rehabilitation Facilities (IRF) and distinguishes IRF care from Skilled Nursing Facility (SNF) care.

3. Describes how the Rehab Institute is an essential complement to acute care hospital services in the Metro East Region and why the services are needed.

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

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

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

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

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

Table 1 Components of Estimated Demand for Inpatient Rehab Services (HSA11)		
Estimated Demand for Inpatient Rehab Services	**CY18 Admissions**	**Beds Needed at 85% Occupancy**
Current Patients Admitted to Rehab Services		
St. Elizabeth's 16-bed Unit, St. Clair County	400	16
HSA11 Patients Served in Missouri Rehab	635	29
Subtotal, Bed Need for Patients Currently Served	*1,035*	*45*
Plus Gap in Care: Unrealized Need, HSA11 Patients[2]	774	36
***Equals* Total HSA11 Rehab Bed Need**	**1,809**	**81**
Minus Anderson Hospital, Madison County, Approved 34-bed Rehab	816	34
***Equals* Net Bed Need, HSA11**	**993**	**47**
Sources: St. Elizabeth's Hospital Discontinuation Application for Exemption (#E-046-19), Attachment 7, page 39; Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database; and Encompass Health. Note: beds needed at 85% occupancy based on statewide average length of stay of 14.1 days.		

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

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

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

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

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

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

- *Stroke*
- *Brain injury*
- *Neurological conditions*
- *Joint replacement*[6]
- *Orthopedic*
- *Hip fracture*
- *Spinal cord injury*
- *Amputee*

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

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

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

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

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

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

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

Examples of patient goals include:

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

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

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

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

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

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

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[7] 20 ILSC 3960/2

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

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

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

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

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

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

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[9] 77 IAC 1110.350.
[10] 77 IAC 1100.410.

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

5. Correction of Space Plan.

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

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

Sincerely,

Kara Friedman

Kara Friedman

Enclosures

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

Exhibit A
Inpatient Rehabilitation Facility Care versus Skilled Nursing Facility Care

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

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

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

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

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

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

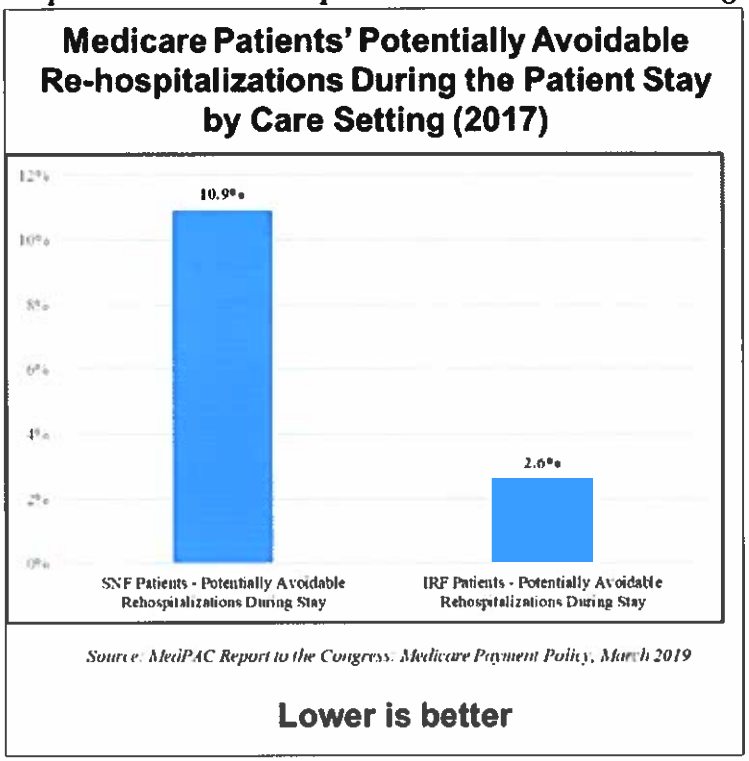
Source: MedPAC, Medicare Payment Policy, March 2018 pages 215, 219, 226, 278, and 280; American Hospital Association

Encompass' Discharge to Community Rate is 79.9%.

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

Figure 2

Rehab Hospitals have lower Hospital Readmissions than Nursing Homes



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit B
Need for the Project

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

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

a. Despite operating at or near fully capacity, St. Elizabeth's Hospital in St. Clair County received HFSRB approval to permanently close its 16-bed rehab unit (Project #E-046-19);

b. Anderson Rehabilitation Hospital ("Anderson") received HFSRB approval (Project #19-026) to expand and relocate northward its inpatient rehab program to serve the fast-growing I-55 corridor in Madison County[16] and areas beyond HSA11; and,

c. As discussed in Exhibit A, Medicare implemented a new payment system effective on October 1, 2019 for Skilled Nursing Facilities ("SNF") that is expected to significantly reduce the amount of therapy (rehab) services nursing homes provide to their patients. This will exacerbate the already existing "gap in care" that many post-acute care patients experience when discharged to a SNF rather than to a rehab facility.

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

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

i. HSA11 residents who currently receive inpatient rehab care, regardless of geographic location of the IRF provider; and

ii. HSA11 residents discharged from a general acute care hospital in need of intensive inpatient rehab care, but for any number of reasons, do not receive intensive rehab care. We refer to these individuals as patients who are experiencing a "gap in care" or who have an unrealized need for inpatient rehab services.

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

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

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

Components of Estimated Demand – CY 2018		
	Patient Admissions	***Beds Needed at 85% Occupancy***
1 Current Patient Admissions at St. Elizabeth's 16-bed Unit	**400**	**16**
2 HSA11 Patients Out-migrating to Missouri for Inpatient Rehab Care	**635**	**29**
3 Gap in Care Based on Rehab-Appropriate DRGs from Acute Care Hospital	**774**	**36**
TOTAL	**1,809**	**81**
Anderson Hospital	**816**	**34**
Net Bed Need	**993**	**47**

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

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

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

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

Details regarding the recent market changes[17] follow.

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

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

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

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

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

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

Table 1
St. Elizabeth's Hospital Inpatient Rehab Program Utilization

Time Period	Beds	Admissions	% Occupancy	Patient Days	ADC	Peak ADC
CY18	16	400	78%	4,575	12.53	16
CY19TD	16	298	83%	3,225	13.27	N/A

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

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

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

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

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

Consider the following:

a. Anderson documented a need for 80 inpatient rehabilitation beds. Anderson utilized a similar approach to the Rehab Institute in its quantitative analysis to determine rehab bed need. Their methodology considered: current utilization of programs; unrealized need or a gap in care for patients in need of rehab but who are unable to receive it; and outmigration of patients to Missouri for rehab care. (*See* Figure 2 on the following page, which is a copy of Anderson's visual presentation to the HFSRB.)

Though Anderson documented a need for 80 rehabilitation beds (which is approximately the same number of beds the Rehab Institute forecasts is needed), Anderson proposed and received approval to build only a 34-bed facility. Anderson rejected a larger hospital because Anderson had competing priorities for the use of funds, not because of the lack of community need for rehab services. (*See* CON #19-026 p. 87, Attachment 13.)

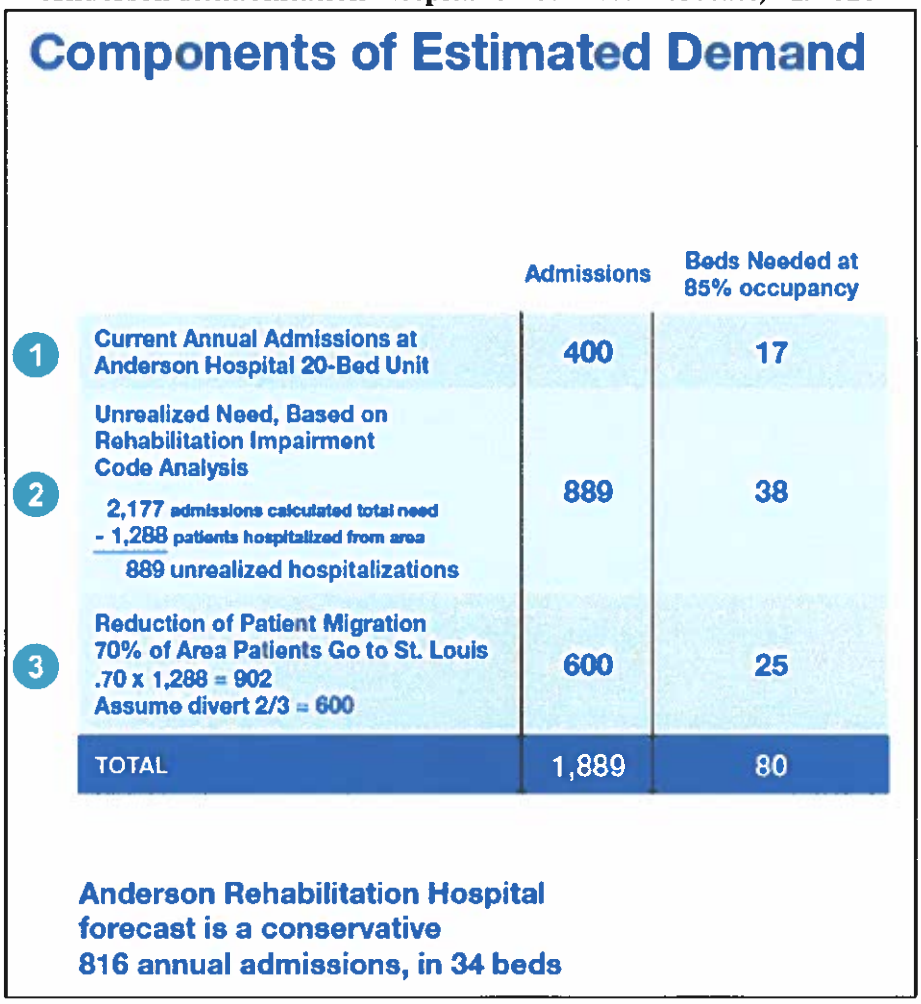
b. Anderson is replacing closed rehabilitation beds in the northern portion of HSA11. Anderson is proposing to serve the patients of the units that Gateway Regional Medical Center in Granite City and St. Clare's Hospital in Alton closed. In its CON application, Anderson stated, "the location of Anderson Rehab Hospital is closer to Granite City and to Alton, and the patients served by the rehab units at those hospitals than is the existing service at HSHS St. Elizabeth (26 miles from Granite City to O'Fallon, and 34 miles from Alton to O'Fallon)." Thus, based on Anderson's own statements, the patients currently utilizing St. Elizabeth's rehab program are not expected to utilize the distant Anderson program. (*See* CON #19-026 p. 80, Attachment 12.)

c. There is minimal overlap in the proposed service areas of the Rehab Institute and Anderson. Anderson's service area includes only Madison County in HSA11 and extends north along I-55 and east along I-70 into contiguous counties outside of HSA11. (*See* CON #19-026 p. 80, Attachment 12 and Figure 3 below.) Thus, Anderson does not address the inpatient rehab needs of more than half (55% or 343,528) of the 600,000+- HSA11 residents. Conversely, as shown in

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

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

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



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

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

Notably:

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

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

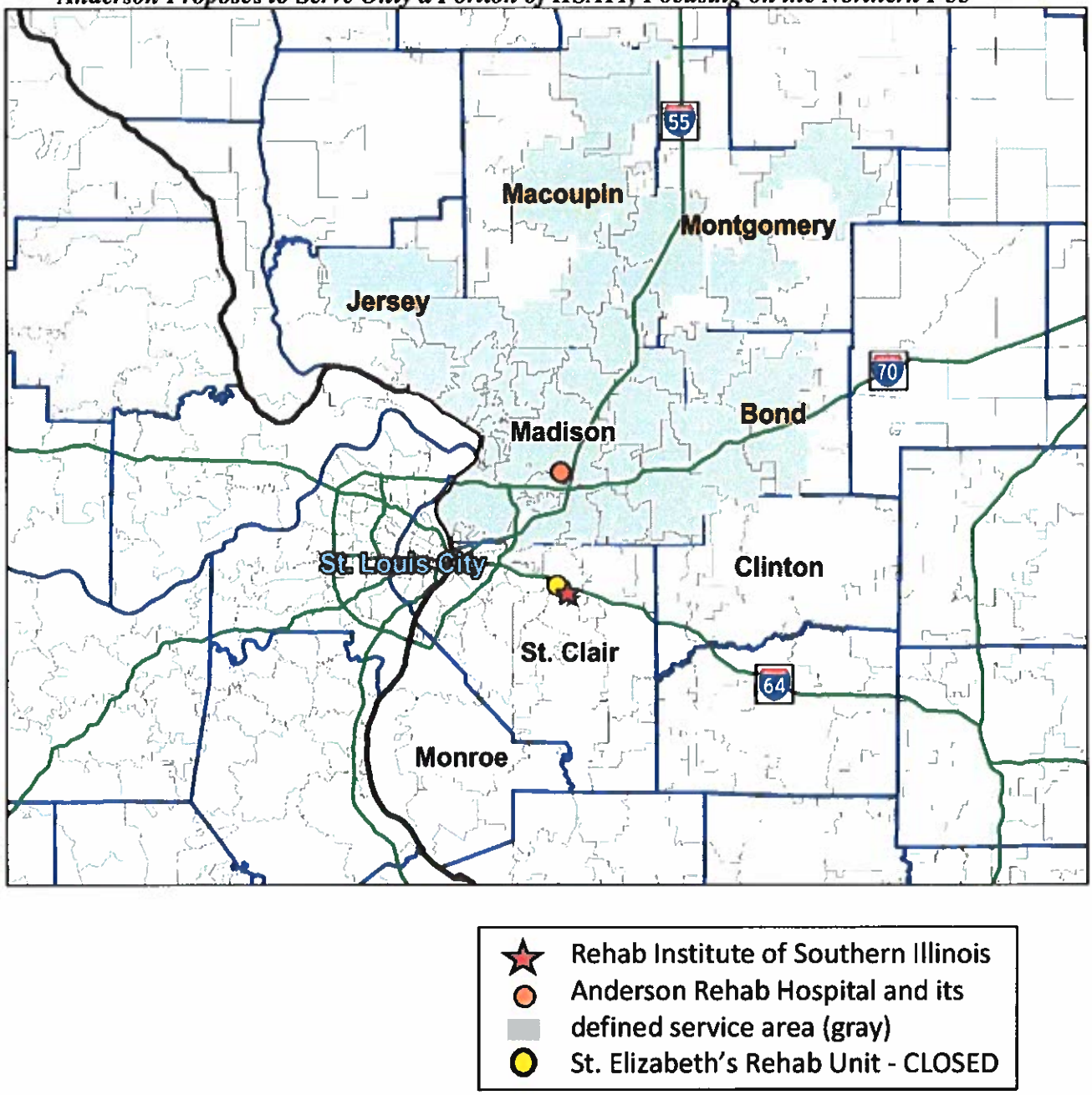
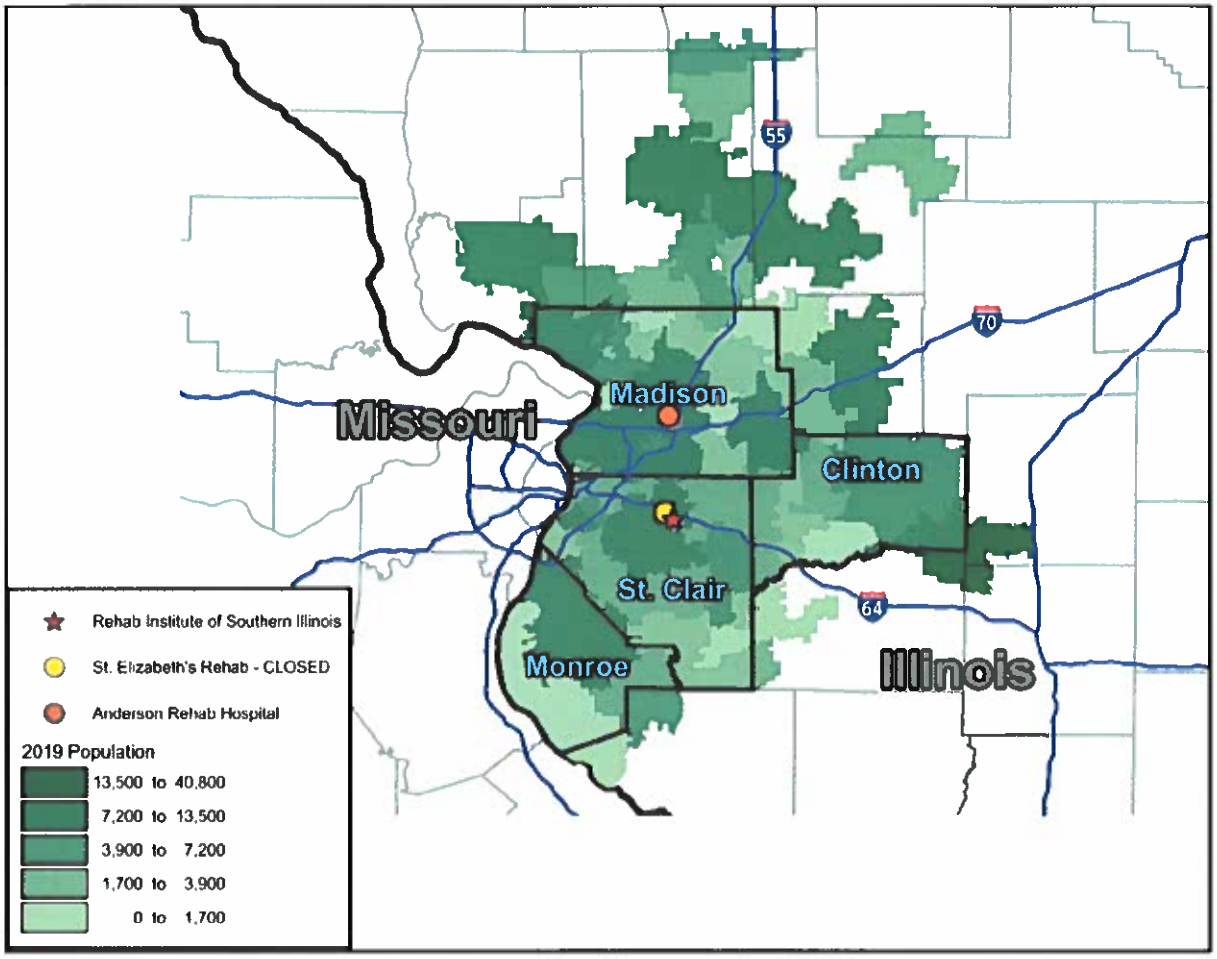


Figure 4
HSA 11 Population Map



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

a. Quantitative Bed Need Projections

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

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

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

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

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

b. Documented Physician Referrals and Community Support

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

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

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

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

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

Dr. James F. Alonso	Neurologist	Barnes-Jewish Hospital
Dr. Jin-Moo Lee	Neurologist	Barnes-Jewish Hospital
Dr. Ketan Patel	Emergency Medical Director Memorial B & E	Team Health
Dr. Kevin Barnett	VP Medical Staff	Memorial East
Dr. Kevin Baumer	Section Head Orthopedics	BJC Medical Group
Dr. Keyrouz	Neurologist	Barnes-Jewish Hospital
Dr. Nicole Werner	Neuropsychologist	Barnes-Jewish Hospital
Dr. Oksana Volshteyn	Physiatrist	Barnes-Jewish Hospital
Dr. Paul Santiago	Neurosurgeon	Barnes-Jewish Hospital
Dr. Randy Freeman	President Medical Staff	Memorial Belleville
Herb Roach	Mayor, O'Fallon	
James A. Vernier	Mayor, Shiloh	
Jay C. Hoffman	State Representative	
Lisa L. Atland, RN, MSN	Memorial Hospital/Director Care Mgmt.	
Mark Kern	St. Clair County	
Ronda Sauget	Leadership Council SW Ill.	
Sidney LeGrand	Chamber of Commerce	O'Fallon-Shiloh
Total Number of Letters		**25**

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

Exhibit C
State of Illinois Use Rate Disparities

Inpatient Rehab Beds per 1,000 Population, 2020 ***Ranked Highest to Lowest Beds per Pop***				
Rank	**HSA**	**2020 Population**	**Inpatient Rehab Beds**	**Beds per 1,000 Residents**
1	6	2,562,700	585	0.228
2	7	3,508,600	432	0.123
3	10	207,100	22	0.106
4	2	672,400	66	0.098
5	4	857,900	80	0.093
6	1	711,700	65	0.091
7	9	1,111,300	96	0.086
8	3	575,500	48	0.083
9	5	613,700	39	0.064
10	11	614,100	34	0.055
11	8	1,692,600	58	0.034
Total		**13,127,600**	**1,525**	**0.116**

Sources: Inventory of Health Care Facilities and Services and Need Determinations, HFSRB 9/1/19 and Addendum to Inventory of Health Care Facilities, HFSRB 10/23/19.

Exhibit D
Clinical Department Allocation

Size of the Project Proposed GSF Compared to State Board Standard						
	Beds/Rooms/	**Proposed GSF**		**State Board Std**		**Met**
Reviewable Service	**Unit**	**Per Bed**	**Total**	**Per Bed**	**Total**	**Standard**
Comprehensive Physical Rehab Beds	40	597.35	23,894	525-660 GSF	26,400	Yes
Pharmacy	1	816	816	N/A	N/A	N/A
PT/OT/ST	N/A	N/A	5,957	N/A	N/A	N/A
Reviewable Space Total			30,667			
Non-Reviewable Space			16,987			
Total Proposed GSF			47,654			

Dobson | DaVanzo

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

Study Highlights

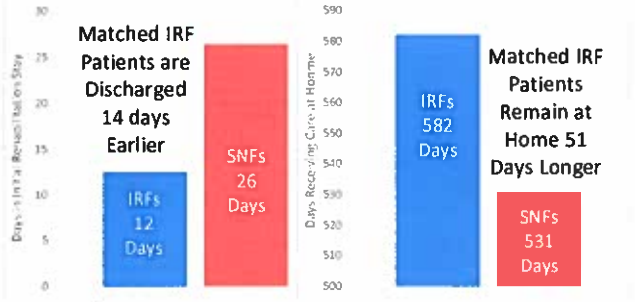
Authors: Joan E. DaVanzo, Ph.D., M.S.W., Al Dobson, Ph.D., Audrey El-Gamil, Justin W. Li, Nikolay Manolov, Ph.D.
Contact: Joan E. DaVanzo, joan.davanzo@dobsondavanzo.com; 703-260-1761

Synopsis of Key Findings

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

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

Matched IRF and SNF Patients: Number of Days during Initial Rehabilitation Stay and Number of Days Treated in the Home*[1]

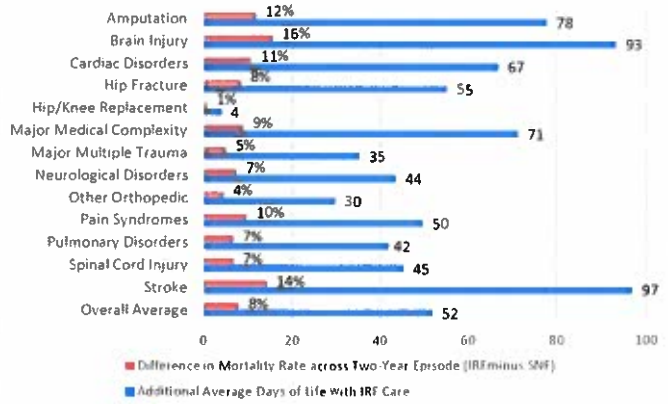


*Days treated in the home represents the average number of days per patient over two-year study period not spent in a hospital, IRF, SNF, or LTCH.

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

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

Matched IRF and SNF Patients: Difference in Mortality Rate[1] across Two-Year Study Period and Resulting Additional Days Alive[3] During Episode*



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

[1] Differences are statistically significant at p<0.0001.
[2] Differences are statistically significant at p<0.0001 with the exception of the number of readmissions per year, which are significant at p<0.01 for five of the 13 conditions.
[3] Differences are statistically significant at p<0.0001 with the exception of major multiple trauma, which is significant at p< 0.01.

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

July 10, 2014

The Issue

To qualify for Medicare payment under the IRF prospective payment system (PPS) at least 60% of an IRF's admissions in a single cost reporting period must be in one or more of 13 CMS specified clinical conditions ("known as the "60% Rule").[1] As a result of this policy, some Medicare beneficiaries with certain conditions previously treated in the IRF are now treated in an alternative setting, such as a SNF. The Medicare Payment Advisory Commission (MedPAC) found, for instance, that the proportion of IRF patients treated for lower joint replacements decreased by 16%, while SNF admissions of this diagnosis increased by the same rate between 2004 and 2011.[2]

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

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

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

About the Study

The ARA Research Institute (an affiliate of the American Medical Rehabilitation Providers Association – AMRPA) commissioned Dobson DaVanzo & Associates, LLC to conduct a retrospective study of IRF patients and clinically similar SNF patients to examine the downstream comparative utilization and effectiveness of post-acute care pathways, as well as total cost of treatment for the five years following implementation of the 60% Rule.

Conclusions in Brief:

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

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

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

Study Limitations

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

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

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

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

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

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

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