ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: The Quad Cities Rehabilitation Institute		
Street Address: Intersection of 52nd Avenue and 7th Street - NW Parcel		
City and Zip Code: Moline, IL 61265		
County: Rock Island	Health Service Area: 10	Health Planning Area:

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

Exact Legal Name:	The Quad Cities Rehabilitation Institute, LLC
Street Address:	9001 Liberty Parkway
City and Zip Code:	Birmingham, AL 35242
Name of Registered Agent:	The Corporation Trust Company
Registered Agent Street Address:	Corporation Trust Center, 1209 Orange Street
Registered Agent City and Zip Code:	Wilmington, DE 19801
Name of Chief Executive Officer:	Douglas E. Coltharp (President, Quad Cities 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 Jr.
Title:	CON Counsel
Company Name:	Benesch Law
Address:	71 South Wacker Drive, Suite 1600, 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):	Katie Pearson
Title:	Chief Strategy Officer
Company Name:	UnityPoint Health – Trinity

Address:	2701 17th Street, Rock Island, IL 61201
Telephone Number:	309.779.3610
E-mail Address:	katie.pearson@unitypoint.org
Fax Number:	309.779.2399
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 Quad Cities Rehabilitation Institute		
Street Address: Intersection of 52nd Avenue and 7th Street - NW Parcel		
City and Zip Code: Moline, IL 61265		
County: Rock Island	Health Service Area: 10	Health Planning Area:

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

Exact Legal Name:	Iowa Health System d/b/a UnityPoint Health
Street Address:	1776 West Lakes Parkway, Suite 400
City and Zip Code:	West Des Moines, IA 50266
Name of Registered Agent:	Elizabeth Kurt
Registered Agent Street Address:	120 NE Glen Oak Avenue, Suite 101
Registered Agent City and Zip Code:	Peoria, IL 61603
Name of Chief Executive Officer:	Kevin Vermeer
CEO Street Address:	1776 West Lakes Parkway, Suite 400
CEO City and Zip Code:	West Des Moines, IA 50266
CEO Telephone Number:	515.241.8215

Type of Ownership of Applicants

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
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Title:	Chief Strategy Officer
Company Name:	UnityPoint Health – Trinity
Address:	2701 17th Street, Rock Island, IL 61201
Telephone Number:	309.779.3610
E-mail Address:	katie.pearson@unitypoint.org
Fax Number:	309.779.2399

Facility/Project Identification

Facility Name: The Quad Cities Rehabilitation Institute		
Street Address: Intersection of 52nd Avenue and 7th Street - NW Parcel		
City and Zip Code: Moline, IL 61265		
County: Rock Island	Health Service Area: 10	Health Planning Area:

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

Exact Legal Name:	Trinity Regional Health System
Street Address:	2710 17th Street
City and Zip Code:	Rock Island, IL 61201
Name of Registered Agent:	Tamara Byram
Registered Agent Street Address:	2701 17th Street
Registered Agent City and Zip Code:	Rock Island, IL 61201
Name of Chief Executive Officer:	Robert J. Erickson
CEO Street Address:	2701 17th Street
CEO City and Zip Code:	Rock Island, IL 61201
CEO Telephone Number:	309.779.2200

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Fax Number:	312.767.9192

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Title:	Chief Strategy Officer
Company Name:	UnityPoint Health – Trinity
Address:	2701 17th Street, Rock Island, IL 61201
Telephone Number:	309.779.3610
E-mail Address:	katie.pearson@unitypoint.org
Fax Number:	309.779.2399

Facility/Project Identification

Facility Name: The Quad Cities Rehabilitation Institute		
Street Address: Intersection of 52nd Avenue and 7th Street - NW Parcel		
City and Zip Code: Moline, IL 61265		
County: Rock Island	Health Service Area: 10	Health Planning Area:

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

Exact Legal Name:	Trinity Medical Center
Street Address:	2710 17th Street
City and Zip Code:	Rock Island, IL 61201
Name of Registered Agent:	Steven J. Gross
Registered Agent Street Address:	2701 17th Street
Registered Agent City and Zip Code:	Rock Island, IL 61201
Name of Chief Executive Officer:	Robert J. Erickson
CEO Street Address:	2701 17th Street
CEO City and Zip Code:	Rock Island, IL 61201
CEO Telephone Number:	309.779.2200

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

Name(s):	Katie Pearson
Title:	Chief Strategy Officer
Company Name:	UnityPoint Health – Trinity
Address:	2701 17th Street, Rock Island, IL 61201
Telephone Number:	309.779.3610
E-mail Address:	katie.pearson@unitypoint.org
Fax Number:	309.779.2399

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City and Zip Code: Moline, IL 61265		
County: Rock Island	Health Service Area: 10	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

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Fax Number:	312.767.9192

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: Trinity Medical Center

Address of Site Owner: 2701 17th Street, Rock Island, IL 61201

Street Address or Legal Description of the Site: ***Intersection of 52nd Avenue and 7th Street - NW Parcel, Moline, IL 61265***

*****Attachment 2 includes the warranty deed for the UnityPoint Health – Trinity Medical Center campus in Moline. The Quad Cities Rehabilitation Institute will be located on the vacant southeast corner of the hospital campus property adjacent to the intersection of 52nd Avenue and 7th Street.***

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 Quad Cities Rehabilitation Institute, LLC

Address: Intersection of 52nd Avenue and 7th Street - NW Parcel, Moline, IL 61265

- ☐ 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 Quad Cities Rehabilitation Institute, LLC ("The Quad Cities Rehab Institute" or "The Rehab Institute"), proposes to establish a new 40-bed freestanding comprehensive physical rehabilitation ("rehab") hospital to be located in Moline, Rock Island County, HSA10. The proposed project addresses the Illinois Health Facilities and Services Review Board ("HFSRB" or "Review Board") identified need and addresses an identified gap in the need for additional beds in the region. 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 Trinity Medical Center and Encompass Health Corporation ("Encompass"). Trinity Medical Center, an affiliate of Iowa Health System dba UnityPoint Health, will have a fifty percent (50%) ownership interest in the Licensee, The Quad Cities Rehabilitation Institute, LLC. Trinity Medical Center is an Illinois nonprofit corporation. Encompass Health also will have a fifty percent (50%) ownership interest in the Licensee, The Quad Cities Rehabilitation Institute, LLC. Encompass is a Delaware corporation.

The proposed project will include all private rooms and will be the only rehab program in the entirety of HSA10. Currently, Trinity Medical Center - Rock Island ("Trinity Rock Island") is the only inpatient rehab provider located in HSA10, with 22 beds in operation. Trinity Rock Island will file a Certificate of Exemption to discontinue offering inpatient rehab services upon the opening of the proposed 40-bed hospital through the permanent discontinuation of its 22 rehab beds.

The Quad Cities Rehab Institute will be located on a 6.77 acre vacant parcel of property on the southeastern corner of Trinity Medical Center - Moline ("Trinity Moline") hospital campus. The parcel is located at the intersection of 52nd Avenue and 7th Street at the northwestern corner of the intersection. The site is easily accessible for all of HSA 10 residents and the greater Quad Cities area because of its close proximity and easy access to Interstates 280, 80, 74, and 88 as well as State Roads 67 and 150.

The total project cost estimate for the new 40-bed freestanding hospital is $33,812,822. The project will be funded by Encompass Health, the co-applicant, with cash and equivalents. The land for the proposed hospital is owned by Trinity Medical Center, the co-applicant.

The Quad Cities Rehabilitation Institute expects to accept its first patient on February 1, 2022 with a project completion date of May 2, 2022.

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	$ 683,420	$ 399,734	$ 1,083,153
Off Site Work			
New Construction Contracts	$ 12,534,419	$ 7,366,541	$ 19,900,960
Modernization Contracts			
Contingencies	$ 1,133,975	$ 628,129	$ 1,762,104
Architectural/Engineering Fees	$ 1,079,431	$ 597,916	$ 1,677,347
Consulting and Other Fees	$ 453,590	$ 251,252	$ 704,842
Movable or Other Equipment (not in construction contracts)	$ 3,280,816	$ 1,817,303	$ 5,098,119
Bond Issuance Expense (project related)			
Net Interest Exp. During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	$ 2,321,533	$ 1,264,764	$ 3,586,297
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$ 21,487,184	$ 12,325,638	**$ 33,812,822**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$ 21,487,184	$ 12,325,638	**$ 33,812,822**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$ 21,487,184	$ 12,325,638	**$ 33,812,822**

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 $ $1,958,117.

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):
May 2, 2022

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 Iowa Health System, Trinity Regional Health System, Trinity Medical Center, and Encompass, as the Quad Cities Rehab Institute 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							
Comprehensive Physical Rehab Beds			24,264 BGSF	24,264 BGSF			
Pharmacy			884 BGSF	884 BGSF			
Therapy – PT/OT/ST			6,306 BGSF	6,306 BGSF			
Total Clinical	$21,487,184		31,454 BGSF	31,454 BGSF			
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical	$12,325,638		16,368 BGSF	16,368 BGSF			
TOTAL	**$33,812,822**		**47,822 BGSF**	**47,822 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 Quad Cities Rehabilitation Institute, 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

Douglas Coltharp
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 12th day of December 2019

Signature of Notary

Seal

MIA K. HAYNES
My Commission Expires
May 9, 2023

SIGNATURE

Patrick Darby
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 12th day of December 2019

Signature of Notary

Seal

MIA K. HAYNES
My Commission Expires
May 9, 2023

*Insert the EXACT legal name of the applicant

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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 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

Douglas Coltharp
PRINTED NAME

Executive Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 12th day of December 2019

Signature of Notary

Seal

SIGNATURE

Patrick Darby
PRINTED NAME

Executive Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 12th day of December 2019

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

MIA K. HAYNES
My Commission Expires
May 9, 2023

MIA K. HAYNES
My Commission Expires
May 9, 2023

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
DISCONTINUATION APPLICATION FOR EXEMPTION- 08/2019 Edition

CERTIFICATION

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This Application is filed on the behalf of Trinity Regional Health System 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

Robert J. Erickson
PRINTED NAME

President/CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10 day of December 2019

Signature of Notary

Seal

PAULA THOMPSON
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 24, 2023

SIGNATURE

Katherine Marchik
PRINTED NAME

Chief Financial Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10 day of December 2019

Signature of Notary

Seal

PAULA THOMPSON
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 24, 2023

*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 Trinity Medical Center 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

Robert J. Erickson
PRINTED NAME

President/CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10 day of December 2019

Signature of Notary

Seal

PAULA THOMPSON
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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 Iowa Health System 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

Kevin E. Vermeer
PRINTED NAME

President/CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of December, 2019

Pamela K. Hoskins
Signature of Notary

Seal

PAMELA K. HOSKINS NOTARIAL SEAL IOWA Commission Number 179554 My Comm. Expires May 24, 2022

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*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 Iowa Health System 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	SIGNATURE
PRINTED NAME	PRINTED NAME: DENNY L DRAKE
PRINTED TITLE	PRINTED TITLE: SVP, CORPORATE INTEGRITY AND GENERAL COUNSEL
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this 9th day of December, 2019
Signature of Notary	Signature of Notary
Seal	Seal: TINA M. PATTEN Commission Number 183262 My Commission Expires 2/14/2020

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION *NOT APPLICABLE*

Trinity Medical Center will be submitting a separate Certificate of Exemption Application for the discontinuation of its existing 22-bed inpatient rehabilitation service. The discontinuation will be contingent upon the approval and subsequent opening of the proposed The Quad Cities Rehabilitation Institute project so as to avoid disruption to patients in need of the service.

This Section is applicable to the discontinuation of a health care facility, relocation of a health care facility, or discontinuation of more than one category of service in a 6-month period. **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

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 the planning area.

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 GROSS SQ FT	STATE STANDARD	DIFFERENCE	MET STANDARD?
Comprehensive Physical Rehab Beds	24,264	26,400 GSF (525-660 per bed)	2,136 GSF	Yes
Pharmacy	884	None	N/A	N/A
PT/OT/ST	6,306	None	N/A	N/A
Non-Reviewable Portions	16,368	None	N/A	N/A
Total BGSF	47,822	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)	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	Rehab Hospital	N/A	9,490 Pt Days 65.0% Occ.	85%	No
YEAR 2	Rehab Hospital	N/A	12,425 Pt Days 85.1% 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		

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(c)(2) - Maldistribution	X	X	
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(c)(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]:**

$33,812,822	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.
$33,812,822	**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:	2016	2017	2018	CON Year 2
Current Ratio	N/A	N/A	N/A	8.9
Net Margin Percentage	N/A	N/A	N/A	10.4%
Percent Debt to Total Capitalization**	N/A	N/A	N/A	N/A
Projected Debt Service Coverage**	N/A	N/A	N/A	N/A
Days Cash on Hand	N/A	N/A	N/A	123.8
Cushion Ratio**	N/A	N/A	N/A	N/A

*The Quad Cities Rehabilitation Institute, 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	$416.15		47,822				$ 19,900,960		
Contingency	$36.85		47,822				$ 1,762,104		
TOTALS	$453.00		47,822				$ 21,663,064		

* 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 Wages	$ 7,721,900
Benefits	2,239,400
Supplies	944,300
Total Operating Costs	$ 10,905,600
Patient Days	12,425
Cost per Day	$ 877.72

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	$1,673,200
Total Capital Costs	$1,673,200
Patient Days	12,425
Cost per Day	$134.67

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 the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE 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 37.

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.

Safety Net Information: *Trinity Medical Center - Rock Island*			
CHARITY CARE			
	2016	**2017**	**2018**
# of Patients			
Inpatients	1,140	1,359	1,385
Outpatients	4,962	6,656	6,988
Total	6,102	8,015	8,373
Cost			
Inpatient	103,000	120,000	123,000
Outpatient	1,034,000	1,221,000	1,283,000
Total	$ 1,137,000	$ 1,341,000	$ 1,406,000
MEDICAID			
# of Patients			
Inpatient	2,215	2,011	1,800
Outpatient	54,432	62,795	67,819
Total	56,647	64,806	69,619
Net Revenue			
Inpatient	13,289,000	14,558,000	13,622,000
Outpatient	18,190,000	20,670,000	22,535,000
Total	$ 31,479,000	$ 35,228,000	$ 36,157,000
Source: IL AHQ Survey Hospital Profiles.			

Safety Net Information: *Trinity Medical Center - Moline*			
CHARITY CARE			
	2016	**2017**	**2018**
# of Patients			
Inpatients	89	96	95
Outpatients	3,183	9,657	3,485
Total	3,272	9,753	3,580
Cost			
Inpatient	97,000	104,000	103,000
Outpatient	788,000	760,000	722,000
Total	$ 885,000	$ 864,000	$ 825,000
MEDICAID			
# of Patients			
Inpatient	566	499	539
Outpatient	23,197	25,908	24,366
Total	23,763	26,407	24,905
Net Revenue			
Inpatient	3,429,000	3,193,000	3,545,000
Outpatient	9,418,000	9,599,000	9,119,000
Total	$ 12,847,000	$ 12,792,000	$ 12,664,000
Source: IL AHQ Survey Hospital Profiles.			

Safety Net Information: *Van Matre Encompass Health Rehabilitation Hospital*			
CHARITY CARE			
	2016	**2017**	**2018**
# of Patients			
Total	0	0	0
Cost			
Total	N/A	N/A	N/A
MEDICAID			
# of Patients			
Inpatient	183	193	181
Outpatient	6	415	313
Total	189	608	494
Net Revenue			
Inpatient	2,526,595	2,357,875	2,818,451
Outpatient	100,547	29,581	33,478
Total	$ 2,627,142	$ 2,387,456	$ 2,851,929
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' UnityPoint Health - Trinity related entities is provided below. Please note that Encompass' Van Matre Rehabilitation Hospital has no reported charity care for the time period shown.

Trinity Medical Center - Rock Island			
CHARITY CARE			
Charity Care Factor	**2016**	**2017**	**2018**
Net Patient Revenue	$ 212,739,000	$ 262,903,000	$ 251,170,000
Amount of Charity Care (Charges)	$ 4,408,000	$ 5,046,000	$ 5,265,000
Cost of Charity Care	$ 1,137,000	$ 1,341,000	$ 1,406,000
Charity Care Cost % of Net Pt Rev	0.5%	0.5%	0.6%
Source: IL AHQ Survey Hospital Profile; Internal Records.			

Trinity Medical Center - Moline			
CHARITY CARE			
Charity Care Factor	**2016**	**2017**	**2018**
Net Patient Revenue	$ 99,538,000	$ 73,505,000	$ 72,788,000
Amount of Charity Care (Charges)	$ 2,551,000	$ 3,011,000	$ 2,862,000
Cost of Charity Care	$ 885,000	$ 864,000	$ 825,000
Charity Care Cost % of Net Pt Rev	0.9%	1.2%	1.1%
Source: IL AHQ Survey Hospital Profile; 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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17	Assurances for Unfinished/Shell Space	N/A
	Service Specific:	
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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
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28	Community-Based Residential Rehabilitation Center	N/A
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30	Clinical Service Areas Other than Categories of Service	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 QUAD CITIES REHABILITATION INSTITUTE, LLC", FILED IN THIS OFFICE ON THE SECOND DAY OF DECEMBER, A.D. 2019, AT 6:39 O`CLOCK P.M.

Jeffrey W. Bullock, Secretary of State

7731281 8100
SR# 20198381625

Authentication: 204122445
Date: 12-03-19

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

State of Delaware
Secretary of State
Division of Corporations
Delivered 06:39 PM 12/02/2019
FILED 06:39 PM 12/02/2019
SR 20198381625 - File Number 7731281

CERTIFICATE OF FORMATION
OF
THE QUAD CITIES REHABILITATION INSTITUTE, LLC

1. The name of the limited liability company is The Quad Cities Rehabilitation Institute, 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 Quad Cities Rehabilitation Institute, LLC this 2nd day of December, 2019.

Robert W. McCallum, III, Authorized Person

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE-Secretary of State

08206031
DECEMBER 04, 2019

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

RE THE QUAD CITIES REHABILITATION INSTITUTE, 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

08206031

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:

This space for use by Secretary of State.

FILED
DEC 04 2019
JESSE WHITE
SECRETARY OF STATE

1. Limited Liability Company name (see Note 1): The Quad Cities Rehabilitation Institute, 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: December 2, 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: 208 South LaSalle Street, Suite 814
(P.O. Box alone or c/o is unacceptable.)
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: N/A

(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:

Patrick Darby, 9001 Liberty Parkway, Birmingham, Al 35242
Douglas E. Coltharp, 9001 Liberty Parkway, Birmingham, Al 35242
Barbara A. Jacobsmeyer, 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 Existance, 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: December 4, 2019
Month, Day, Year

Signature

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

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.

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.

Jeffrey W. Bullock, Secretary of State

2028917 8300

SR# 20194014269

Authentication: 202839409

Date: 05-16-19

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

File Number 6720-693-2

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

IOWA HEALTH SYSTEM, INCORPORATED IN IOWA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 15, 2010, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS 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* 10TH *day of* JUNE *A.D.* 2019 .

Authentication #: 1916103016 verifiable until 06/10/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1
APPLICANT IDENTIFICATION

File Number 4957-982-9

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

TRINITY MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 06, 1969, 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* 10TH *day of* JUNE *A.D.* 2019 .

Jesse White

SECRETARY OF STATE

Authentication #: 1916102846 verifiable until 06/10/2020

Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 1
APPLICANT IDENTIFICATION

File Number 5368-925-6

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

TRINITY REGIONAL HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 21, 1984, 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* 10TH *day of* JUNE *A.D.* 2019 .

Jesse White

SECRETARY OF STATE

Authentication #: 1916102972 verifiable until 06/10/2020

Authenticate at: http://www.cyberdriveillinois.com

ATTACHMENT 1
APPLICANT IDENTIFICATION

Filed and Recorded July 1, 1991 at 10:00 O'Clock A.M. 91-11538 Timothy J. Craig Recorder $15.00

TRUSTEE'S DEED

The Grantor, FIRST NATIONAL BANK OF MOLINE, Moline, Illinois, a national banking association, as Trustee under the provisions of a Deed or Deeds in trust, duly recorded and delivered to it pursuant to a Trust Agreement dated December 29, 19 77, and known as Trust No. 1601, for and in consideration of the sum of Ten Dollars ($10) dollars and other good and valuable consideration in hand paid, grants, bargains, sells and conveys unto UNITED MEDICAL CENTER, an Illinois not-for-profit corporation

whose address is 501 10th Avenue in the City of Moline, State of Illinois, the Grantee, the following described real estate situated in the County of Rock Island, State of Illinois, to-wit:

SEE ATTACHED EXHIBIT A

Exempt under provisions of Paragraph b, Section 4, Real Estate Transfer Tax Act.

June 28, 1991 William R. Ba
Date Buyer, Seller or Representative

Subject to taxes for the years 1990 and thereafter,

together with all the hereditaments and appurtenances thereunto belonging.

This deed is subject to all encumbrances, liens, conditions, and/or restrictions of record, or imposed by law, and is executed by the Bank not personally in its own right, but solely as Trustee as aforesaid, pursuant to the power and authority vested in it as such Trustee.

IN WITNESS WHEREOF, the said Grantor, as Trustee aforesaid, has caused these presents to be signed by its Vice President-Trust Officer, and its corporate seal to be hereto affixed and attested by its Assistant Cashier this 28th day of June, 1991.

FIRST NATIONAL BANK OF MOLINE
as Trustee aforesaid

By _____
Vice President-Trust Officer

ATTEST:

_____
Assistant Cashier

Attachment 2

STATE OF ILLINOIS
COUNTY OF ROCK ISLAND } ss.

I, the undersigned, a Notary Public in and for said County in the State aforesaid, DO HEREBY CERTIFY, that Jack L. Leiby, Vice President-Trust Officer, of First National Bank of Moline, Illinois, and Mark E. Malone, Assistant Cashier of said Bank, who are personally known to me to be the same persons whose names are subscribed to the foregoing Instrument as such Officers appeared before me this day in person and acknowledged that they signed and delivered the said Instrument as their own free and voluntary act, and as the free and voluntary act of said Bank, as Trustee as aforesaid, for the uses and purposes therein set forth, and did affix thereto the corporate seal of said Bank.

GIVEN under my hand and official seal, this 28th day of June, 19 91.

" OFFICIAL SEAL "
BARBARA G. NEWBURG
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 6/3/95

Barbara G. Newburg
Notary Public

THIS INSTRUMENT PREPARED BY:

Pamela M. Anderson
Anderson & Nelson
3725 Blackhawk Road
Rock Island, IL 61204-3487

Trustee's Deed

TO

PROPERTY

MAIL TO
Samuel McHard
1705 2nd Avenue
Rock Island, IL 61201

Attachment 2

TRACT 1: Lot Number Three (3) in Medical Arts Center Second Addition to the City of Moline, Illinois, situated in the County of Rock Island and State of Illinois, excepting therefrom that part deeded to the State of Illinois for highway purposes.

TRACT 2: Lots One (1), Two (2), and Three (3) in Rock Valley Second Addition to the City of Moline, Illinois, situated in the County of Rock Island and State of Illinois; Excepting any interests that the City of Moline may have to the South forty (40) feet of said Lot 2.

TRACT 3: A twelve and five tenths (12.5) foot strip of land lying between Lot 2 in Rock Valley Second Addition to the City of Moline, Illinois and Lot 5 in Rock Valley First Addition to the City of Moline, Illinois, described as follows: Beginning at the southeast corner of Lot 5 in Rock Valley First Addition; thence east a distance of twelve and five tenths (12.5) feet to the southwest corner of Lot 2 of Rock Valley Second Addition to the City of Moline, Illinois; thence North on the west line of said Lot 2 of Rock Valley Second Addition to the northwest corner thereof a distance of one hundred thirty two and eight one-hundredths (132.08) feet; thence northwesterly on the southerly right-of-way line of 52nd Avenue in the City of Moline a distance of fourteen and twelve tenths (14.12) feet to the northeast corner of Lot five (5) of Rock Valley First Addition; thence South on the east line of said Lot 5 of Rock Valley First Addition to the point of beginning, being the southeast corner of said Lot 5; situated in the City of Moline, County of Rock Island, and State of Illinois; Excepting any interests that the City of Moline may have to the said twelve and five tenths (12.5) foot strip of land.

91-11598

RECORDED
ROCK ISLAND COUNTY, ILL.

91 JUL -1 AM 10: 00

RECORD BOOK 1403 PAGE 161

Recorder

15 pp

#19-059

Attachment 2

#19-059

Filed and Recorded July 31, 1991 at 4:07 O'Clock P.M. $15.00

91-12639

Dorothy J. Craig
Recorder

Parcel 391-8

TRUSTEE'S DEED

The Grantor, FIRST NATIONAL BANK OF MOLINE, Moline, Illinois, a national banking association, as Trustee under the provisions of a Deed or Deeds in trust, duly recorded and delivered to it pursuant to a Trust Agreement dated February 5, 1968, and known as Trust No. 206860, for and in consideration of the sum of One and no/100 ($1.00)---------- dollars and other good and valuable consideration in hand paid, grants, bargains, sells and conveys unto UNITED MEDICAL CENTER, an Illinois not for profit corporation,

whose address is 501 - 10th Avenue in the City of Moline, State of Illinois, the Grantee ____, the following described real estate situated in the County of Rock Island, State of Illinois, to-wit:

A tract of land located in the Northeast Quarter (NE 1/4) of Section 18, Township 17 North, Range 1 West of the 4th Principal Meridian of the City of Moline, County of Rock Island, State of Illinois, described as follows:

Commencing at the Southeast Corner of the Northeast Quarter of Section 18, Township 17 North, Range 1 West of the 4th Principal Meridian; thence North along the East Line of said Section, said line having a bearing of N. 0° 00' 30" E., 1730.77 feet; thence S. 75° 07' 21" W., 53.13 feet to the Point of Beginning; thence S. 75° 07' 21" W., 1324.14 feet; thence N. 0° 00' 36" E., 701.31 feet to a point in the South Right-of-Way line of proposed F.A. Route 595; thence Easterly along said line, said line having a bearing of N. 78°53' 16" E., 1212.10 feet; thence S. 47° 04' 41" E., 54.48 feet; thence S. 6° 48' 03" E., 251.52 feet; thence S. 3° 55' 36" E., 300.68 feet; thence S. 0°06' 58" W., 8.62 feet to the Point of Beginning.

Bearings are referenced from the North Line of Rock Valley Second Addition, Lot 3, as bearing N. 75° 07' 21" E.
Distances are given in feet and decimals thereof.

Said tract contains 18.9628 acres, more or less.

together with all the hereditaments and appurtenances thereunto belonging.

This deed is subject to all encumbrances, liens, conditions, and/or restrictions of record, or imposed by law, and is executed by the Bank not personally in its own right, but solely as Trustee as aforesaid, pursuant to the power and authority vested in it as such Trustee.

IN WITNESS WHEREOF, the said Grantor, as Trustee aforesaid, has caused these presents to be signed by its Vice President-Trust Officer, and its corporate seal to be hereto affixed and attested by its Assistant Cashier this 24th day of July, 1991.

FIRST NATIONAL BANK OF MOLINE
as Trustee aforesaid

By _____
Vice President-Trust Officer

ATTEST:

_____
Assistant Cashier

Exempt under provisions of Paragraph 6
7/25 Page 74

Attachment 2

Attachment 2

STATE OF ILLINOIS
COUNTY OF ROCK ISLAND } ss.

I, the undersigned, a Notary Public in and for said County in the State aforesaid, DO HEREBY CERTIFY, that Jack L. Leiby, Vice President-Trust Officer, of First National Bank of Moline, Illinois, and Nikola Batnos, Assistant Cashier of said Bank, who are personally known to me to be the same persons whose names are subscribed to the foregoing Instrument as such Officers appeared before me this day in person and acknowledged that they signed and delivered the said Instrument as their own free and voluntary act, and as the free and voluntary act of said Bank, as Trustee as aforesaid, for the uses and purposes therein set forth, and did affix thereto the corporate seal of said Bank.

GIVEN under my hand and official seal, this 24th day of July, 19 91

Notary Public

- OFFICIAL SEAL -
BARBARA G. NEWBURG
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 6/3/95

91-13633

RECORDED
ROCK ISLAND COUNTY, ILL.
91 JUL 31 PM 4:07
1408 PAGE 23

Trustee's Deed

TO

PROPERTY
Prepared by
L. Schwiebert
501-15th St, Moline, IL.

MAIL TO
Sam McHard
1705-2nd Ave
Rock Island, IL

ALTA Owner's Policy
(4/6/90)

POLICY OF TITLE INSURANCE

Policy No. OP 3024573

ISSUED BY

First American Title Insurance Company

SUBJECT TO THE EXCLUSIONS FROM COVERAGE, THE EXCEPTIONS FROM COVERAGE CONTAINED IN SCHEDULE B AND THE CONDITIONS AND STIPULATIONS, FIRST AMERICAN TITLE INSURANCE COMPANY, a California corporation, herein called the Company, insures, as of Date of Policy shown in Schedule A, against loss or damage, not exceeding the Amount of Insurance stated in Schedule A, sustained or incurred by the insured by reason of:

1. Title to the estate or interest described in Schedule A being vested other than as stated therein;
2. Any defect in or lien or encumbrance on the title;
3. Unmarketability of the title;
4. Lack of a right of access to and from the land.

The Company will also pay the costs, attorneys' fees and expenses incurred in defense of the title, as insured, but only to the extent provided in the Conditions and Stipulations.

First American Title Insurance Company

BY Parker S. Kennedy PRESIDENT

ATTEST William A. Baeyens SECRETARY

COUNTERSIGNED BY

MARTIN TITLE COMPANY

42-204 (1/91)

D-1

Attachment 2

Rider attached to and forming a part of policy or commitment number: 92-TI-3056 OP 3024573

Continuation of SCHEDULE C-I:

PARCEL V:

TRACT I:

Beginning at the Northeast corner of Lot 6, Block 7 in "WEST MOLINE ADDITION" to the City of Moline, Illinois, as recorded in Plat Book 1, Page 5 (sometimes known as "ANDREW'S ADDITION" to the City of Moline, Illinois); Thence South 00 degrees - 09 minutes - 12 seconds East, 664.50 feet along the West right-of-way line of 6th Street to the South right-of-way line of 10th Avenue (vacated); Thence South 90 degrees - 00 minutes - 00 seconds East 3.74 feet; Thence along a 123.85 feet arc with a radius of 345 feet and a chord South 20 degrees - 21 minutes - 23 seconds East, 123.19 feet to a chiseled "X"; Thence South 00 degrees - 40 minutes - 14 seconds East, 142.81 feet; Thence North 90 degrees - 00 minutes - 00 seconds West, 393.20 feet; Thence North 00 degrees - 19 minutes - 20 seconds West, 131.80 feet; Thence North 90 degrees - 00 minutes - 00 seconds West, 200.00 feet; Thence North 00 degrees - 19 minutes - 20 seconds West, 126.50 feet; Thence North 00 degrees - 02 minutes - 29 seconds East, 50.00 feet; Thence North 00 degrees - 10 minutes - 41 seconds West, 138.26 feet; Thence South 88 degrees - 21 minutes - 37 seconds West, 72.78 feet; thence North 13 degrees - 21 minutes - 00 seconds West, 344.64 feet; Thence North 11 degrees - 37 feet 41 seconds West, 315.54 feet; Thence North 82 degrees - 17 minutes - 49 seconds East, 80.10 feet; Thence North 89 degrees - 33 minutes - 10 seconds East, 173.95 feet; Thence South 81 degrees - 53 minutes - 17 seconds East, 142.72 feet; Thence North 89 degrees - 41 minutes - 48 seconds East, 350.90 feet; Thence South 45 degrees - 18 minutes - 12 seconds East, 21.21 feet; Thence South 00 degrees - 09 minutes - 12 seconds East, 145.00 feet to the point of beginning. All situated in the City of Moline, County of Rock Island and State of Illinois.

TRACT II:

A tract of land located in the Southeast Quarter of Section 31, and the Southwest Quarter of Section 32, Township 18 North, Range 1 West of the Fourth Principal Meridian, City of Moline, Rock Island County, State of Illinois, described as follows: Commencing at the Southeast corner of Section 31; Thence North 00 degrees - 08 minutes - 59 seconds West along the East line of the Southeast Quarter of said Section 31, a distance of 455.09 feet to a point on the North line of 11th Avenue and the point of beginning of the following described parcel:

SEE NEXT PAGE FOR CONTINUATION OF SCHEDULE C-I.

Rider attached to and forming a part of policy or commitment number: 92-TI-3056 OP 3024573

Continuation of SCHEDULE C-I.:

Thence North 90 degrees - 00 minutes - 00 seconds west along the North line of 11th Avenue a distance of 33.00 feet to a point on the West line of 7th Street; said point also being on the East line of outlot 2 of G. A. STEPHEN'S 1ST ADDITION; Thence North 41 degrees - 20 minutes - 51 seconds West along the East line of 6th Street Place, a distance of 70.05 feet; Thence North 52 degrees - 12 minutes - 49 seconds West along the East line of 6th Street Place, a distance of 109.69 feet to a point on the South line of a vacated alley, said point being 132 feet West of the West line of 7th Street vacated; Thence North 00 degrees - 00 minutes - 00 seconds East, a distance 16.00 feet to the North line of said vacated alley, said point being 132 feet West of the West line of 7th Street vacated; Thence South 90 degrees - 00 minutes - 00 seconds West along the North line of said vacated alley extended, a distance of 14.00 feet; Thence North 24 degrees - 39 minutes - 01 seconds West, along the East line of 6th Street Place, a distance of 134.89 feet to the South line of 10th Avenue vacated, said point being 202 feet West of the West line of said 7th Street vacated; Thence North 00 degrees - 00 minutes - 00 seconds West, a distance of 50 feet to the North line of 10th Avenue vacated, said point being 202 feet West of the West line of said 7th Street vacated; Thence South 90 degrees - 00 minutes - 00 seconds West along the North line of 10th Avenue extended, a distance of 21.00 feet to the East line of 6th Street; Thence North 00 degrees - 08 minutes - 28 seconds West along the East line of 6th Street, a distance of 414.73 feet; Thence North 90 degrees - 00 minutes - 00 seconds East, a distance of 10.00 feet; Thence North 00 degrees - 08 minutes - 28 seconds West along the East line of said 6th Street, a distance of 200.00 feet to the South line of a vacated alley; Thence North 00 degrees - 08 minutes - 28 seconds West along the East line of said 6th Street a distance of 143.57 feet to the South line of 5th Avenue; Thence South 60 degrees - 34 minutes - 05 seconds East along the South line of 5th Avenue, a distance of 280.94 feet to the West line of Section 32; Thence continuing South 60 degrees - 34 minutes - 05 seconds East, a distance of 90.99 feet to the North edge of a concrete and stone retaining wall; Thence North 89 degrees - 42 minutes - 20 seconds East along the South line of 5th Avenue to a point 2 feet North of the Northeast corner of Lot 4, Block 13, of PITTS, GILBERT & PITTS 2ND ADDITION to the City of Moline; Thence South 00 degrees - 38 minutes - 34 seconds East along the East line of Lot 4, a distance of 172.00 feet to the South line of a public alley; Thence North 89 degrees - 14 minutes - 48 seconds East along the South line of said public alley, a distance of 185.79 feet to the West line of 8th Street; Thence South 00 degrees - 40 minutes - 50 seconds East along the West line of 8th Street, a

SEE NEXT PAGE FOR CONTINUATION OF SCHEDULE C-I.

Rider attached to and forming a part of policy or commitment number: 92-TI-3056 OP 3024573

Continuation of SCHEDULE C-I :

distance of 234.57 feet to the point of intersection with the FLACK & BEAN INDIAN BOUNDARY LINE; Thence South 23 degrees - 18 minutes - 50 seconds West along the West line of said 8th Street, a distance of 376.93 feet; said point being 135.00 feet North of and perpendicular to the North line of 11th Avenue; Thence South 90 degrees - 00 minutes - 00 seconds West along a line 135 feet North of and parallel with the said North line of 11th Avenue, a distance of 364.09 feet to the West line of the Southwest Quarter of Section 32; Thence South 00 degrees - 09 minutes - 00 seconds East along the West line of the Southwest Quarter of said Section 32, a distance of 135.00 feet to the point of beginning. All situated in the City of Moline, County of Rock Island and State of Illinois.

SEE NEXT PAGE FOR CONTINUATION OF SCHEDULE C-I.

44-051

Rider attached to and forming a part of policy or commitment number: 92-TI-3056 OP 3024573

Continuation of SCHEDULE C-I:

PARCEL VI:

TRACT I:

Lot Number Three (3) in MEDICAL ARTS CENTER SECOND ADDITION to the City of Moline, Illinois, situated in the County of Rock Island and State of Illinois, excepting therefrom that part deeded to the State of Illinois for highway purposes.

TRACT II:

Lots One (1), Two (2) and Three (3) in ROCK VALLEY SECOND ADDITION to the City of Moline, Illinois, situated in the County of Rock Island and State of Illinois.

TRACT III:

A Twelve and Five Tenths (12.5) Foot strip of land lying between Lot 2 in ROCK VALLEY SECOND ADDITION to the City of Moline, Illinois and Lot 5 in ROCK VALLEY FIRST ADDITION to the City of Moline, Illinois, described as follows: Beginning at the Southeast corner of Lot 5 in ROCK VALLEY FIRST ADDITION; Thence East a distance of Twelve and Five Tenths (12.5) feet to the Southwest corner of Lot 2 of ROCK VALLEY SECOND ADDITION to the City of Moline, Illinois; Thence North on the West line of said Lot 2 of ROCK VALLEY SECOND ADDITION to the Northwest corner thereof a distance of One Hundred Thirty-Two and Eight One-Hundredths (132.08) feet; Thence Northwesterly on the Southerly right-of-way line of 52nd Avenue in the City of Moline as distance of Fourteen and Twelve Tenths (14.12) feet to the Northeast corner of Lot Five (5) of ROCK VALLEY FIRST ADDITION; Thence South on the East line of said Lot 5 of ROCK VALLEY FIRST ADDITION to the point of beginning, being the Southeast corner of said Lot 5; situated in the City of Moline, County of Rock Island and State of Illinois.

SEE NEXT PAGE FOR CONTINUATION OF SCHEDULE C-I.

44-051

Attachment 2

FY MEDACHE
JRNEY. FRANK EDWARDS

Commitment No. [illegible]

COMMITMENT FOR TITLE INSURANCE

ISSUED BY

First American Title Insurance Company

AGREEMENT TO ISSUE POLICY

We agree to issue a policy to you according to the terms of this Commitment. When we show the policy amount and your name as the proposed insured in Schedule A, this Commitment becomes effective as of the Commitment Date shown in Schedule A.

If the Requirements shown in this Commitment have not been met within six months after the Commitment Date, our obligation under this Commitment will end. Also, our obligation under this Commitment will end when the Policy is issued and then our obligation to you will be under the Policy.

Our obligation under this Commitment is limited by the following:

The Provisions in Schedule A.

The Requirements in Schedule B-1.

The Exceptions in Schedule B-2.

The Conditions on the other side of this page 1.

This Commitment is not valid without SCHEDULE A and Sections 1 and 2 of SCHEDULE B.

FIRST AMERICAN TITLE INSURANCE COMPANY has caused this Commitment to be signed and sealed by its authorized officers and the Commitment will become valid when countersigned by an authorized signatory as of Effective Date shown in Schedule A.

First American Title Insurance Company

BY Parker S. Kennedy PRESIDENT

ATTEST William C. Gaeyle SECRETARY

COUNTERSIGNED BY _____

MARTIN TITLE COMPANY

1. Commitment Date: December 1, 1992 at 8:00 o'clock a.m.

2. Policy (or policies) to be issued:

(a) ALTA Owner's Policy — Policy Amount $ 5,000,000.00
Proposed Insured:
TRINITY MEDICAL CENTER

(b) ALTA Loan Policy — Policy Amount $
Proposed Insured:

(c) — Policy Amount $
Proposed Insured:

3. Fee simple interest in the land described in this Commitment is owned, at the Commitment Date, by

TRINITY MEDICAL CENTER, an Illinois not-for-profit corporation, as to Schedule "C-I;"

UNITED MEDICAL CENTER, an Illinois not-for-profit corporation, as to Schedule "C-II."

A leasehold interest in the land described in this Commitment is held, at the Commitment Date, by TRINITY MEDICAL CENTER as to Lease Tracts A and B, Schedule "C-III."

4. The land referred to in this Commitment is described in Schedule "C-I," in Schedule "C-II" and in Schedule "C-III."

C-5 C-6

attached to and forming a part of policy or commitment number: 92-TI-3056

Continuation of SCHEDULE C-II:

Thence North 90 degrees - 00 minutes - 00 seconds west along the North line of 11th Avenue a distance of 33.00 feet to a point on the West line of 7th Street; said point also being on the East line of outlot 2 of G. A. STEPHEN'S 1ST ADDITION; Thence North 41 degrees - 20 minutes - 51 seconds West along the East line of 6th Street Place, a distance of 70.05 feet; Thence North 52 degrees - 12 minutes - 49 seconds West along the East line of 6th Street Place, a distance of 109.69 feet to a point on the South line of a vacated alley, said point being 132 feet West of the West line of 7th Street vacated; Thence North 00 degrees - 00 minutes - 00 seconds East, a distance 16.00 feet to the North line of said vacated alley, said point being 132 feet West of the West line of 7th Street vacated; Thence South 90 degrees - 00 minutes - 00 seconds West along the North line of said vacated alley extended, a distance of 14.00 feet; Thence North 24 degrees - 39 minutes - 01 seconds West, along the East line of 6th Street Place, a distance of 134.89 feet to the South line of 10th Avenue vacated, said point being 202 feet West of the West line of said 7th Street vacated; Thence North 00 degrees - 00 minutes - 00 seconds West, a distance of 50 feet to the North line of 10th Avenue vacated, said point being 202 feet West of the West line of said 7th Street vacated; Thence South 90 degrees - 00 minutes - 00 seconds West along the North line of 10th Avenue extended, a distance of 21.00 feet to the East line of 6th Street; Thence North 00 degrees - 08 minutes - 28 seconds West along the East line of 6th Street, a distance of 414.73 feet; Thence North 90 degrees - 00 minutes - 00 seconds East, a distance of 10.00 feet; Thence North 00 degrees - 08 minutes - 28 seconds West along the East line of said 6th Street, a distance of 200.00 feet to the South line of a vacated alley; Thence North 00 degrees - 08 minutes - 28 seconds West along the East line of said 6th Street a distance of 143.57 feet to the South line of 5th Avenue; Thence South 60 degrees - 34 minutes - 05 seconds East along the South line of 5th Avenue, a distance of 280.94 feet to the West line of Section 32; Thence continuing South 60 degrees - 34 minutes - 05 seconds East, a distance of 90.99 feet to the North edge of a concrete and stone retaining wall; Thence North 89 degrees - 42 minutes - 20 seconds East along the South line of 5th Avenue to a point 2 feet North of the Northeast corner of Lot 4, Block 13, of PITTS, GILBERT & PITTS 2ND ADDITION to the City of Moline; Thence South 00 degrees - 38 minutes - 34 seconds East along the East line of Lot 4, a distance of 172.00 feet to the South line of a public alley; Thence North 89 degrees - 14 minutes - 48 seconds East along the South line of said public alley, a distance of 185.79 feet to the West line of 8th Street; Thence South 00 degrees - 40 minutes - 50 seconds East along the West line of 8th Street, a

Attachment 2

ttached to and forming a part of policy or commitment number: 92-TI-3056

nuation of **SCHEDULE** C-II :

distance of 234.57 feet to the point of intersection with the FLACK & BEAN INDIAN BOUNDARY LINE; Thence South 23 degrees - 18 minutes - 50 seconds West along the West line of said 8th Street, a distance of 376.93 feet; said point being 135.00 feet North of and perpendicular to the North line of 11th Avenue; Thence South 90 degrees - 00 minutes - 00 seconds West along a line 135 feet North of and parallel with the said North line of 11th Avenue, a distance of 364.09 feet to the West line of the Southwest Quarter of Section 32; Thence South 00 degrees - 09 minutes - 00 seconds East along the West line of the Southwest Quarter of said Section 32, a distance of 135.00 feet to the point of beginning. All situated in the City of Moline, County of Rock Island and State of Illinois.

attached to and forming a part of policy or commitment number: 92-TI-3056

tinuation of **SCHEDULE** C-II :

PARCEL II:

TRACT I:

Lot Number Three (3) in MEDICAL ARTS CENTER SECOND ADDITION to the City of Moline, Illinois, situated in the County of Rock Island and State of Illinois, excepting therefrom that part deeded to the State of Illinois for highway purposes.

TRACT II:

Lots One (1), Two (2) and Three (3) in ROCK VALLEY SECOND ADDITION to the City of Moline, Illinois, situated in the County of Rock Island and State of Illinois.

TRACT III:

A Twelve and Five Tenths (12.5) Foot strip of land lying between Lot 2 in ROCK VALLEY SECOND ADDITION to the City of Moline, Illinois and Lot 5 in ROCK VALLEY FIRST ADDITION to the City of Moline, Illinois, described as follows: Beginning at the Southeast corner of Lot 5 in ROCK VALLEY FIRST ADDITION; Thence East a distance of Twelve and Five Tenths (12.5) feet to the Southwest corner of Lot 2 of ROCK VALLEY SECOND ADDITION to the City of Moline, Illinois; Thence North on the West line of said Lot 2 of ROCK VALLEY SECOND ADDITION to the Northwest corner thereof a distance of One Hundred Thirty-Two and Eight One-Hundredths (132.08) feet; Thence Northwesterly on the Southerly right-of-way line of 52nd Avenue in the City of Moline as distance of Fourteen and Twelve Tenths (14.12) feet to the Northeast corner of Lot Five (5) of ROCK VALLEY FIRST ADDITION; Thence South on the East line of said Lot 5 of ROCK VALLEY FIRST ADDITION to the point of beginning, being the Southeast corner of said Lot 5; situated in the City of Moline, County of Rock Island and State of Illinois.

Attachment 2

attached to and forming a part of policy or commitment number: 92-TI-3056

nuation of **SCHEDULE** C-II :

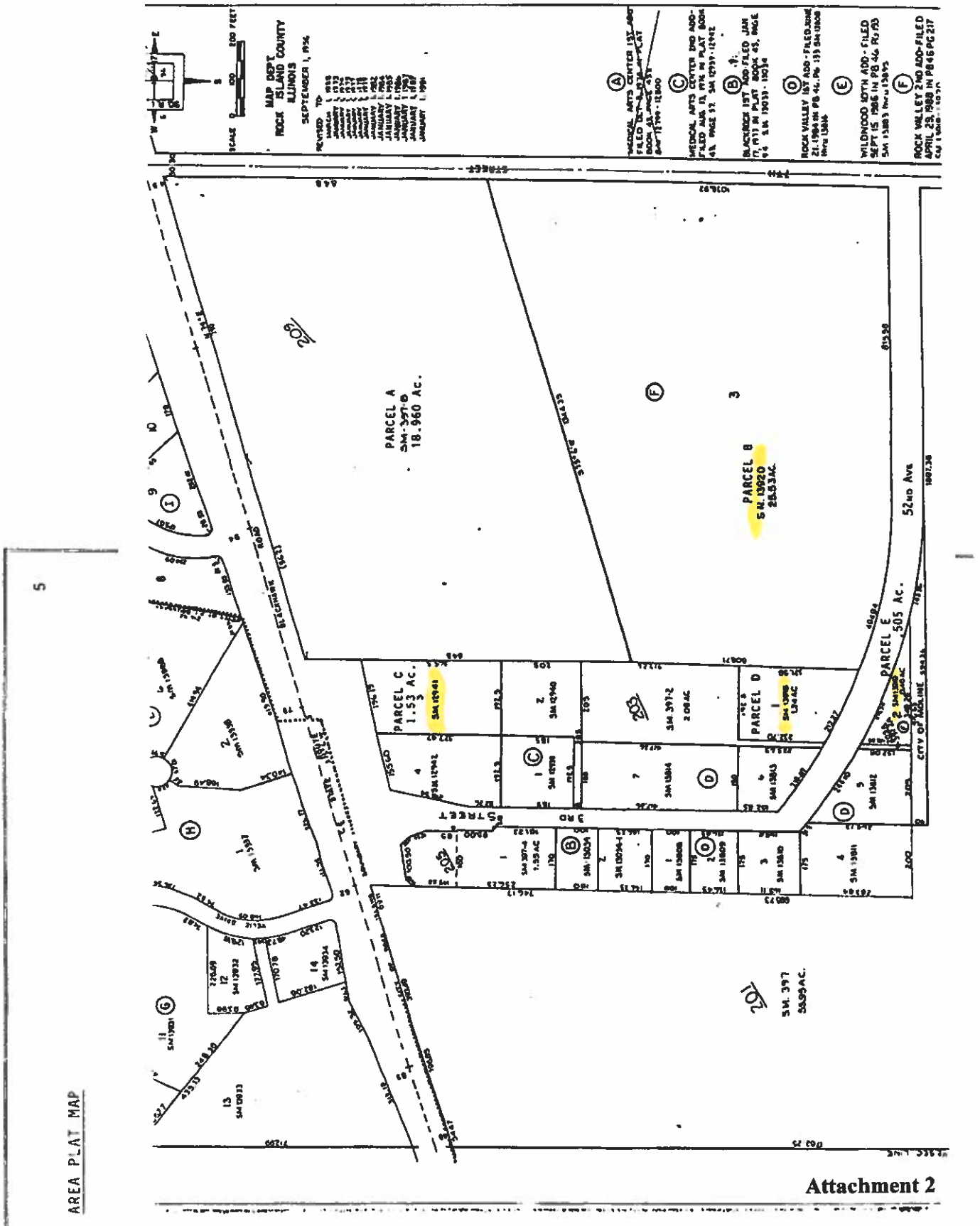
PARCEL III:

A tract of land located in the Northeast Quarter (NE 1/4) of Section 18, Township 17 North, Range 1 West of the 4th Principal Meridian of the City of Moline, County of Rock Island, State of Illinois, described as follows:

Commencing at the Southeast Corner of the Northeast Quarter of Section 18, Township 17 North, Range 1 West of the 4th Principal Meridian; thence North along the East Line of said Section, said line having a bearing of N. 0 degrees 00' 00" E., 1730.77 feet; thence S. 75 degrees 07' 21" W., 53.13 feet to the Point of Beginning; thence S. 75 degrees 07' 21" W. 1324.14 feet; thence N. 0 degrees 00' 36" E., 701.31 feet to a point in the South Right-of-Way line of proposed F.A. Route 595; thence Easterly along said line, said line having a bearing of N. 78 degrees 53' 16" E., 1212.10 feet; thence S. 47 degrees 04' 41" E., 54.48 feet; thence S. 6 degrees 48' 03" E., 251.32 feet; thence S. 3 degrees 55' 36" E., 300.68 feet; thence S. 0 degrees 06' 58" W., 8.62 feet to the Point of Beginning.

Bearings are referenced from the North Line of Rock Valley Second Addition, Lot 3, as Bearing N. 75 degrees 07' 21" E. Distances are given in feet and decimals thereof. Said tract contains 18.9628 acres, more or less.

Attachment 2


AREA PLAT MAP
MAP DEPT.
ROCK ISLAND COUNTY
ILLINOIS
SEPTEMBER 1, 1994
PARCEL A
SM-397-6
18.960 Ac.
PARCEL B
SM.13920
28.53AC.
PARCEL C
1.53 Ac.
PARCEL D
PARCEL E
.505 Ac.
52nd Ave
3 RD STREET
SM. 397
55.95AC.
Attachment 2

DISCUSSION OF THE FIVE PARCELS

The following is a brief discussion of each of the five parcels that are under appraisement.

397-8

PARCEL A: This tract contains approximately 18.960 acres. Based on information taken from the Beling Report, this tract contains 2.8 acres of Wetlands and .3 Acre of Farmed Wetland. There is public electrical service, natural gas, city water and city sewer are available to the site. This is tract is generally level and slopes to the south.

13920

PARCEL B: This tract contains approximately 25.53 acres. Based on information taken from the Beling Report, this tract contains 2.9 acres of Wetlands and 5.5 acres of Farmed Wetlands. A portion of this tract is in the flood plain. Also mentioned in the Beling report is the existence of an abandoned septic tank and two 55 gallon drums on this site. The assumption if made that there is no toxic material in these containers. There is public electrical service, natural gas, city water and city sewer are available to the site. The tract is generally level and slopes to the south.

12941

PARCEL C: This tract contains 1.53 acres. This is a land locked tract since the north part of the tract was taken by the Department of Transportation for right of way purposes. There is complete access control along the north line of the lot. Access to the parcel would be be in cooperation with lots to the west, east and south. This tract is generally level and slopes to the south. There is public electrical service, natural gas, city water and city sewer available to the tract.

13918

PARCEL D: The tract contains 1.24 acres. There is public electrical service, natural gas, city water and city sewer are available to the site. This tract is level and slopes to the south. Access to this tract is direct from 52nd Ave.

13919

PARCEL E: This tract contains approximately .505 acre. There is public electrical service, natural gas, city water and sewer are available to the site. This tract is level and is slightly below the grade of 52nd Ave. Access to the tract is direct from 52nd Ave.

IDENTIFICATION OF THE PROPERTY

Property Type:
Vacant land

Property Location:
Site of Trinity Medical Center Moline (500 John Deere Road) & Site 1, Moline, Illinois

Site of Trinity Medical Center Moline

Site 1

Persons with 5% or Greater Interest in the Licensee
The Quad Cities Rehabilitation Institute, LLC

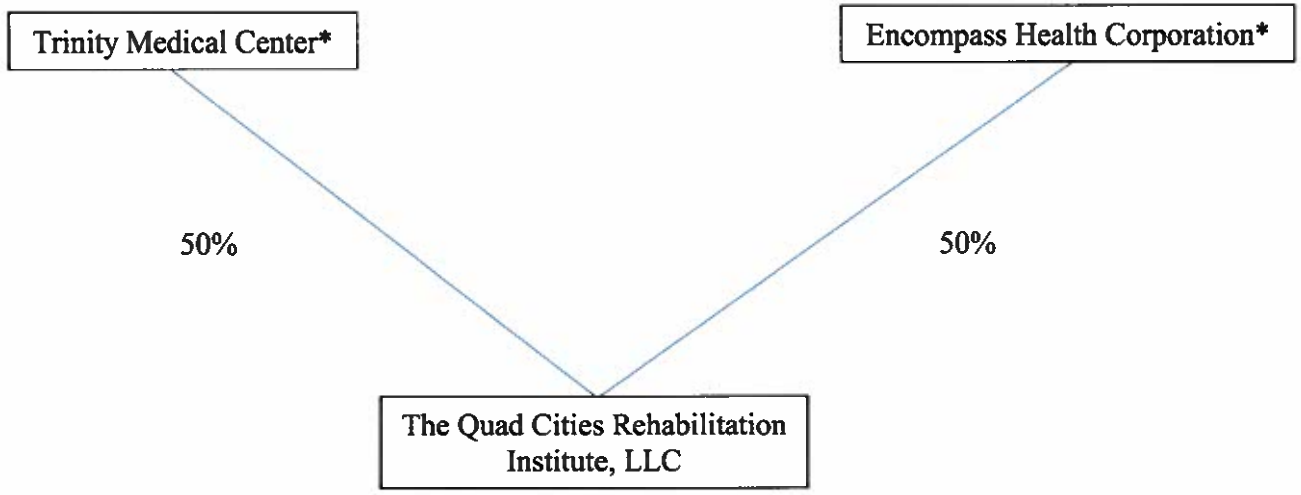
The Quad Cities Rehabilitation Institute, LLC will be a joint venture between Trinity Medical Center and Encompass Health Corporation. The corporate entity is a Delaware corporation.

The Quad Cities Rehabilitation Institute, the Licensee, will be a 50-50 joint venture between Trinity Medical Center, an affiliate of Iowa Health System dba UnityPoint Health, and Encompass Health Corporation ("Encompass"). Trinity Medical Center is an Illinois nonprofit corporation. Encompass is a Delaware corporation.

Trinity Regional Health System has been identified as a Co-Applicant for the proposed project.

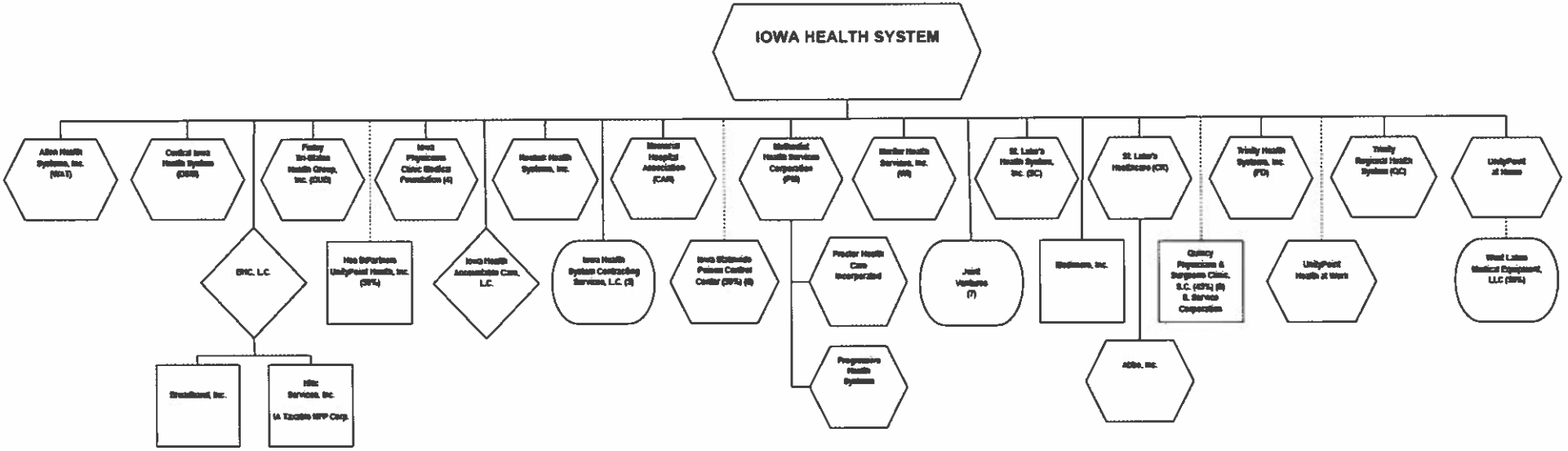
Trinity Medical Center owns the land on which The Quad Cities Rehab Institute will be constructed. The land will be transferred to the joint venture, Quad Cities Rehabilitation Institute, LLC. The deed to the property owned by Trinity Medical Center is provided in Attachment 2.

Organizational Relationships to Licensee
The Quad Cities Rehabilitation Institute, LLC



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

#19-059



KEY

Exempt Organization

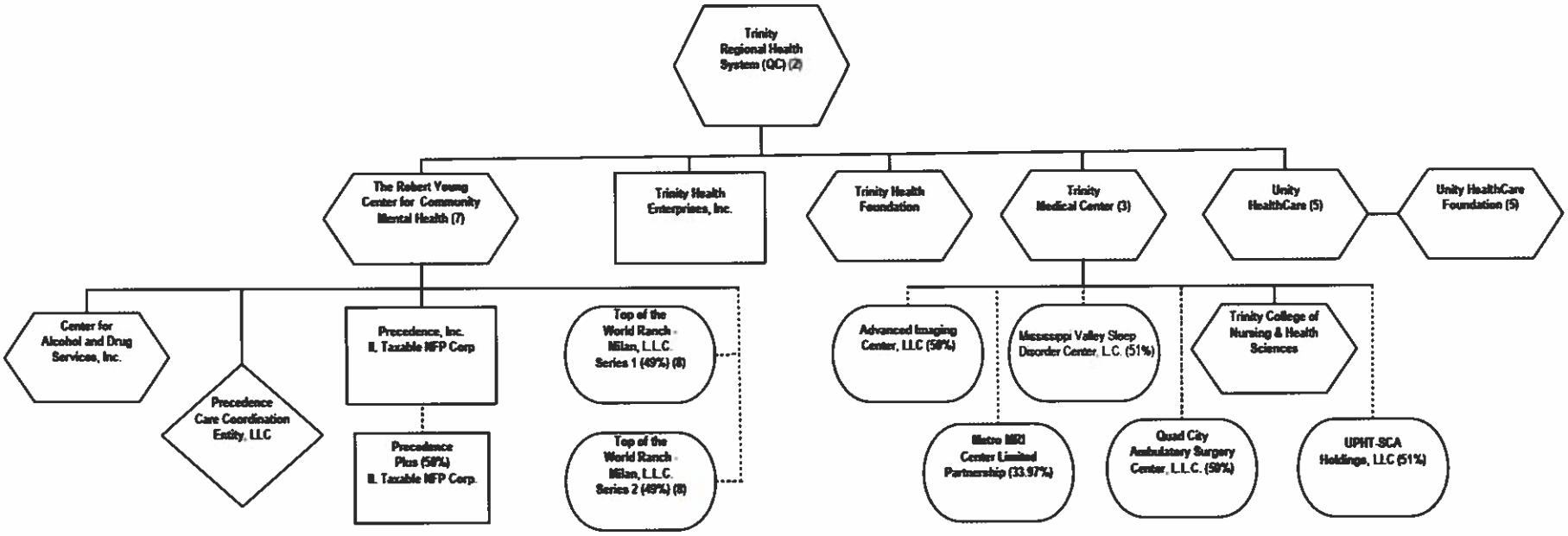
Corporation

Partnership/LLC

1 Member LLC

Attachment 4
Page 2

#19-059



KEY: Exempt Organization | Corporation | Partnership/LLC | 1-Member LLC

Attachment 4
Page 3

#19-059

Lawrence Whatley
Encompass Health
9001 Liberty Parkway
Birmingham, AL 35242

RE: Trinity Moline/Encompass Health Site Review- Floodplain
IMEG#: 18003587.01

Dear Lawrence:

We have prepared a preliminary site layout, attached, for a future medical facility in Moline, IL, at the intersection of 7th Street and 52nd Avenue.

The undeveloped area on the existing site falls within portions of Zone X, Zone A, and Zone AE, see attached Firmette. The proposed building location is within Zone X, so no further action will need to be taken. The parking lot and entrance drive will be within Zone A, Special Flood Hazard Zone with no listed BFE.

The project will be designed to comply with the Flood Plain Rule under Executive Order #2006-5.

Sincerely,

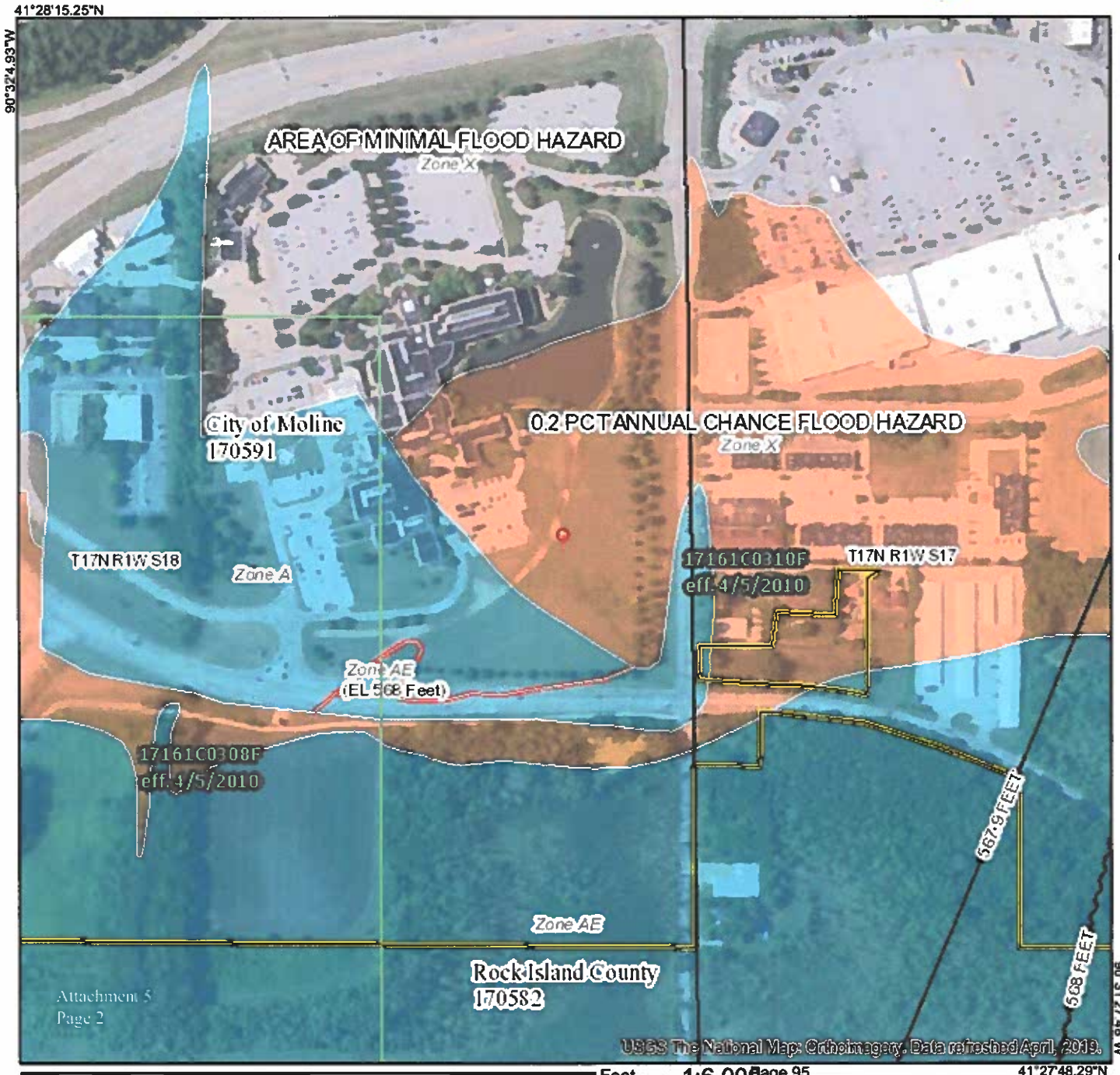
Kristin Crawford, PE
IMEG Corp.

Attachment 5
Page 1

623 26th Avenue, Rock Island, IL 61201
›309.788.0673 ›Fax: 309.786.5967 ›imegcorp.com

National Flood Hazard Layer FIRMette

FEMA



Attachment 5
Page 2

Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS
- Without Base Flood Elevation (BFE) Zone A, V, A99
- With BFE or Depth Zone AE, AO, AH, VE, AR
- Regulatory Floodway

OTHER AREAS OF FLOOD HAZARD
- 0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X
- Future Conditions 1% Annual Chance Flood Hazard Zone X
- Area with Reduced Flood Risk due to Levee. See Notes. Zone X
- Area with Flood Risk due to Levee Zone D

OTHER AREAS
- NO SCREEN Area of Minimal Flood Hazard Zone X
- Effective LOMRs
- Area of Undetermined Flood Hazard Zone D

GENERAL STRUCTURES
- Channel, Culvert, or Storm Sewer
- Levee, Dike, or Floodwall

OTHER FEATURES
- 20.2 / 17.5 Cross Sections with 1% Annual Chance / Water Surface Elevation
- Coastal Transect
- Base Flood Elevation Line (BFE)
- Limit of Study
- Jurisdiction Boundary
- Coastal Transect Baseline
- Profile Baseline
- Hydrographic Feature

MAP PANELS
- Digital Data Available
- No Digital Data Available
- Unmapped

N

The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 8/6/2019 at 12:09:31 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.

#19-059

December 13, 2019

Ms. Rachel Leibowitz
STATE HISTORIC PRESERVATION OFFICE
Illinois Department of Natural Resources
Attn: Review & Compliance
1 Old State Capitol Plaza
Springfield, Illinois 62701

RE: Historic Preservation
Proposed Encompass Health/Unity Point Project
N.W. Corner of 7th Street & 52nd Avenue
Moline, Rock Island County, Illinois
IMEG Project No. 18003587.01

Dear Ms. Leibowitz:

This correspondence is intended to inform your agency of the proposed project that includes the construction of a rehabilitation/physical therapy facility located in the northeast Quarter of Section 18, Township 17N, and Range 1 West. Specifically, the site is located at the northwest corner of the intersection at 7th Street and 52nd Avenue in Moline, Rock Island County Illinois. With this submittal, we are requesting determination as to whether the project has satisfied all applicable requirements of Illinois law with respect to Historic Preservation. We have attached a USGS Quadrangle Map showing the location of the proposed construction site along with a Google image of the project area disturbance. In addition, attached is a proposed Site Plan drawing.

The client will be applying for the NPDES storm water permit through the IL EPA's Storm Water Permit Section for this project. Our client will be utilizing private capital funding for the project. No State or Federal funding assistance is being sought after for this project.

The project includes excavation/mass grading, utility installation, paving, and finish grading for the construction of one approximate 47, 866 sq/ft commercial building with associated parking lot. The construction shall also include construction of a storm water detention basin. The proposed building is intended to be utilized for hospital patients as a recovery and physical therapy facility following medical procedures. This building will be part of the overall Unity Point Hospital campus located to the north/northwest. Soils within the construction disturbance area is mapped as mainly Moline silty clay soil series (see attached NRCS Soil Survey). The current conditions at the approximate 6.5-acre site disturbance area is characterized by mainly manicured grass along with consisting of a drainage swale along the western boundary. The adjoining area is mainly developed and includes a hospital campus to

the north/northwest, commercial use to the east (beyond 7th Street), and a wetland area to the south (beyond 52nd Avenue).

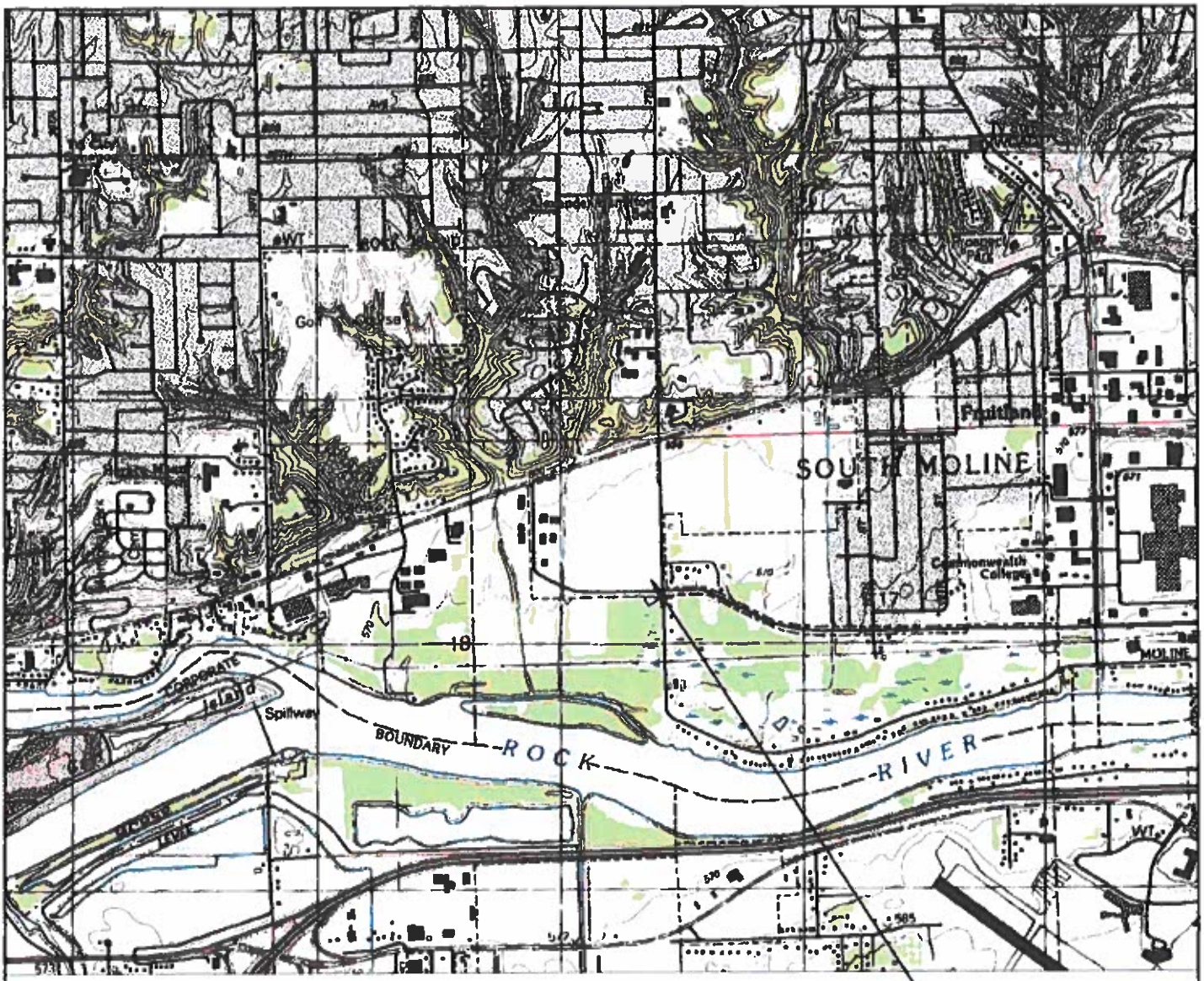
It is noted that no structures will be disturbed during construction activities. We look forward to your timely response as construction work on the site is proposed to begin as soon as all approvals have been received. If you have any questions regarding this correspondence or the proposed project, please do not hesitate to contact our office.

Sincerely,

IMEG Corp.

Mike Harnung
Civil Designer II

G:\2018\18003587.01\Design\Civil\IHPA Submittal\IHPA Letter.docx



SCALE 1:24 000

1 .5 0 KILOMETERS 1 2

1000 0 METERS 1000 2000

1 .5 0 1

MILES

1000 0 1000 2000 3000 4000 5000 6000 7000 8000 9000 10,000

FEET

CONTOUR INTERVAL 10 FEET
NATIONAL GEODETIC VERTICAL DATUM OF 1929

Milan, Ill. -- Iowa
41090-D5-TF-024

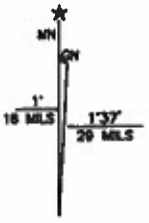
1992

DMA 2866 I N.E.-SERIES V863

IL DESIGN FIRM NO. 184-000843

QUADRANGLE LOCATION

Attachment 6
Page 3

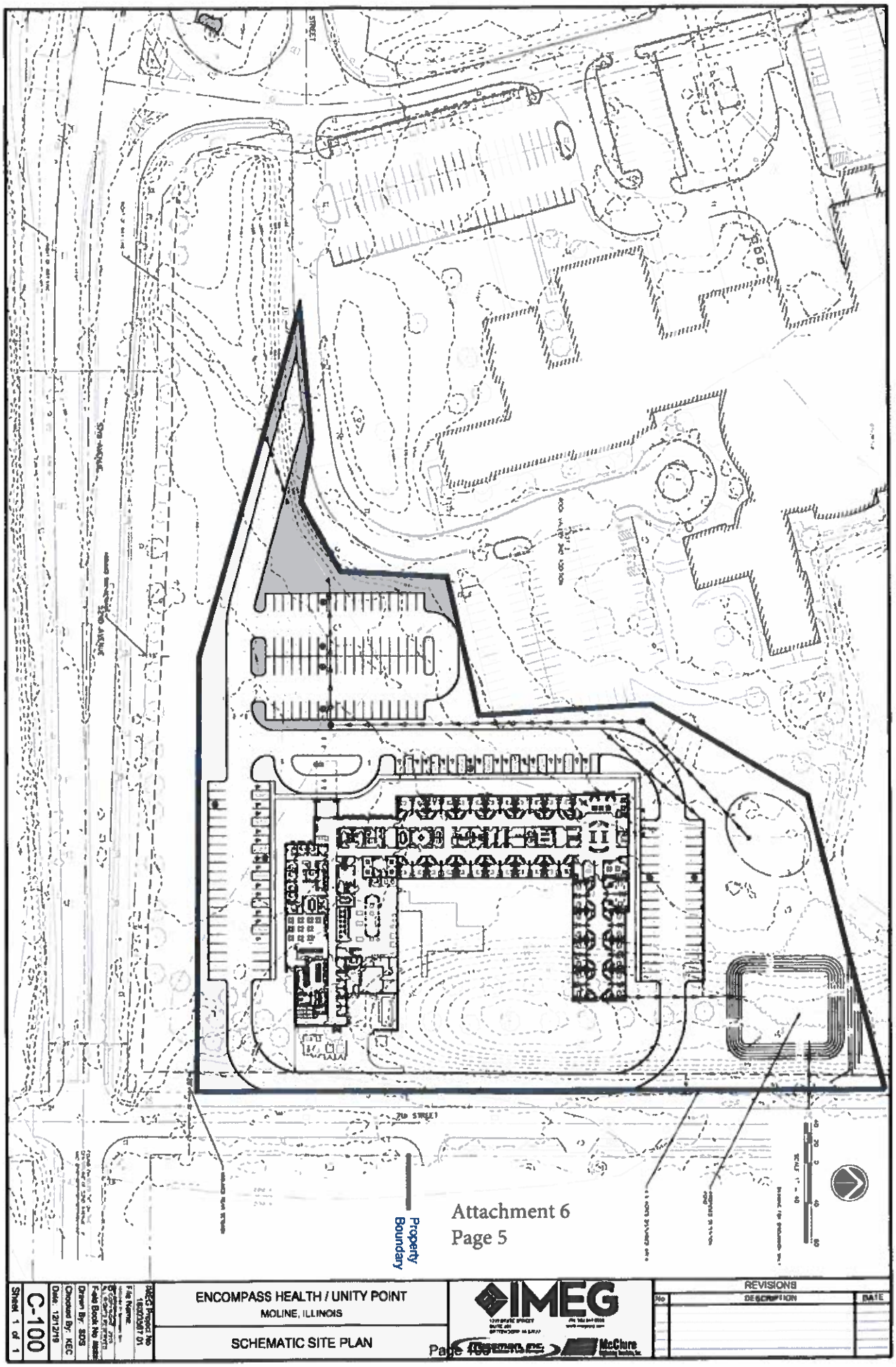


UTM GRID AND 1992 MAGNETIC NORTH DECLINATION AT CENTER OF SHEET

Sheet 1 of 1	FIGURE 1	Date: 12/2019	Checked By: N/A	Drawn By: MWH	Field Book No N/A	File Name:	IMEG Project No. 18003587.01.00	ENCOMPASS HEALTH / UNITY POINT N.W. OF 7TH ST. & 52ND AVE., MOLINE, ILLINOIS SITE LOCATION MAP	IMEG

REVISIONS		
No.	DESCRIPTION	DATE

SITE AREA
42nd Ave
43rd Ave
52nd Ave
7th St
600 ft
N
Google Earth



Attachment 6
Page 5

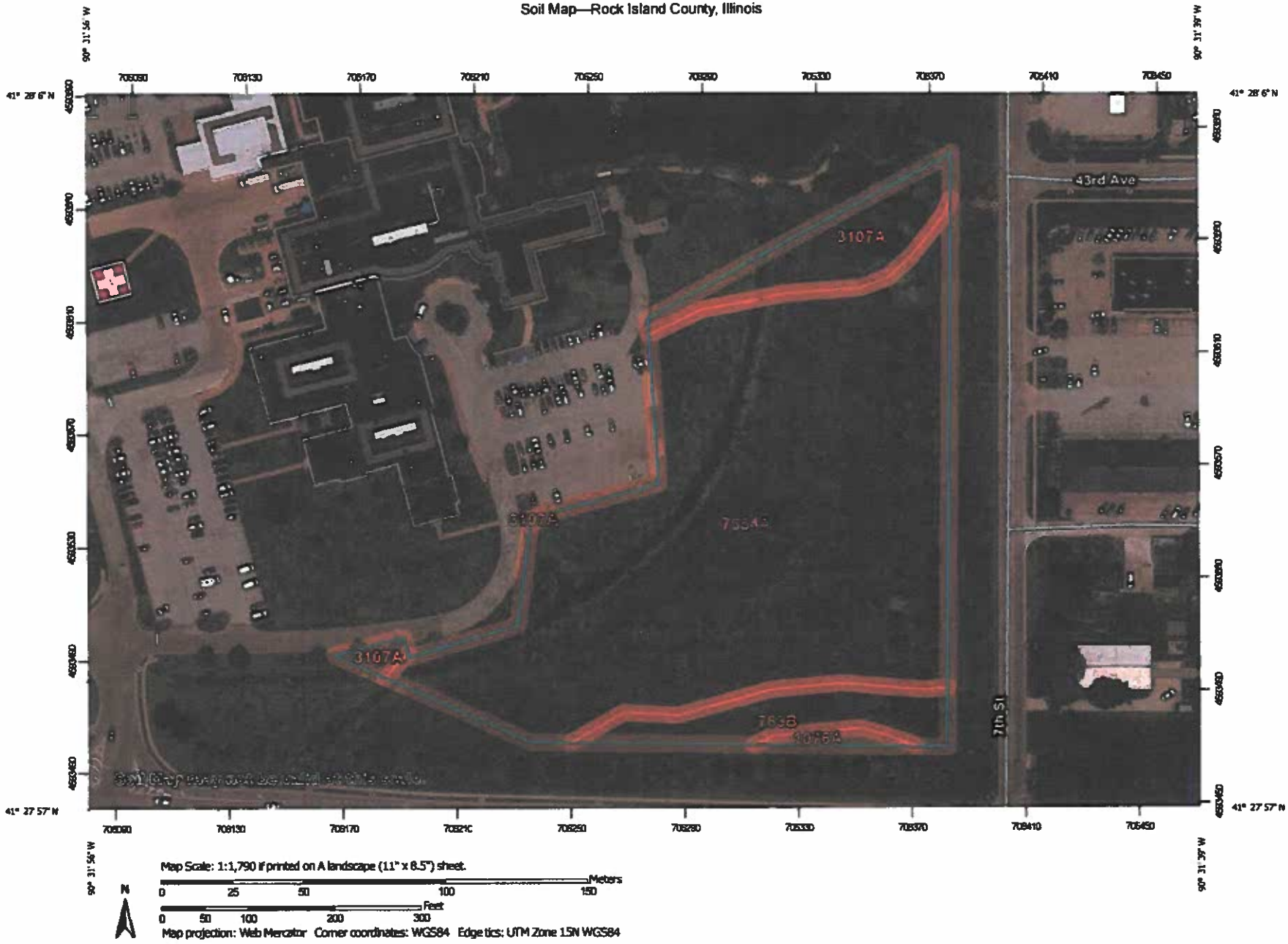
ENCOMPASS HEALTH / UNITY POINT
MOLINE, ILLINOIS

SCHEMATIC SITE PLAN

C-100

IMEG

REVISIONS


90° 31' 56" W
90° 31' 39" W
41° 28' 6" N
41° 27' 57" N
708090
708130
708170
708210
708250
708290
708330
708370
708410
708450
4930950
4930990
4931030
4931070
4931110
4931150
4931190
4931230
43rd Ave
7th St
3107A
3107A
3107A
7534A
763B
1076A
Map Scale: 1:1,790 if printed on A landscape (11" x 8.5") sheet.
Meters
0
25
50
100
150
N
Feet
0
50
100
200
300
Map projection: Web Mercator Corner coordinates: WGS84 Edge tics: UTM Zone 15N WGS84

MAP LEGEND

Area of Interest (AOI)
- Area of Interest (AOI)

Soils
- Soil Map Unit Polygons
- Soil Map Unit Lines
- Soil Map Unit Points

Special Point Features
- Blowout
- Borrow Pit
- Clay Spot
- Closed Depression
- Gravel Pit
- Gravelly Spot
- Landfill
- Lava Flow
- Marsh or swamp
- Mine or Quarry
- Miscellaneous Water
- Perennial Water
- Rock Outcrop
- Saline Spot
- Sandy Spot
- Severely Eroded Spot
- Sinkhole
- Slide or Slip
- Sodic Spot
- Spoil Area
- Stony Spot
- Very Stony Spot
- Wet Spot
- Other
- Special Line Features

Water Features
- Streams and Canals

Transportation
- Rails
- Interstate Highways
- US Routes
- Major Roads
- Local Roads

Background
- Aerial Photography

MAP INFORMATION

The soil surveys that comprise your AOI were mapped at 1:12,000.

Warning: Soil Map may not be valid at this scale.

Enlargement of maps beyond the scale of mapping can cause misunderstanding of the detail of mapping and accuracy of soil line placement. The maps do not show the small areas of contrasting soils that could have been shown at a more detailed scale.

Please rely on the bar scale on each map sheet for map measurements.

Source of Map: Natural Resources Conservation Service
Web Soil Survey URL:
Coordinate System: Web Mercator (EPSG:3857)

Maps from the Web Soil Survey are based on the Web Mercator projection, which preserves direction and shape but distorts distance and area. A projection that preserves area, such as the Albers equal-area conic projection, should be used if more accurate calculations of distance or area are required.

This product is generated from the USDA-NRCS certified data as of the version date(s) listed below.

Soil Survey Area: Rock Island County, Illinois
Survey Area Data: Version 15, Sep 16, 2019

Soil map units are labeled (as space allows) for map scales 1:50,000 or larger.

Date(s) aerial images were photographed: Jun 3, 2014—Jul 9, 2014

The orthophoto or other base map on which the soil lines were compiled and digitized probably differs from the background imagery displayed on these maps. As a result, some minor shifting of map unit boundaries may be evident.

#19-059

Map Unit Legend

Map Unit Symbol	Map Unit Name	Acres in AOI	Percent of AOI
763B	Joslin silt loam, 2 to 5 percent slopes	0.5	7.8%
1076A	Otter silt loam, undrained, 0 to 2 percent slopes, frequently flooded	0.1	0.9%
3107A	Sawmill silty clay loam, 0 to 2 percent slopes, frequently flooded	0.5	9.1%
7654A	Moline silty clay, 0 to 2 percent slopes, rarely flooded	4.9	82.1%
Totals for Area of Interest		**6.0**	**100.0%**

Project and Sources of Funds Itemization
The Quad Cities Rehabilitation Institute, LLC

Summary of Project and Related Cost Data Assumptions

Project Costs and Sources of Funds			
Component	**Clinical**	**Non-Clinical**	**Total**
Site Preparation	$ 683,420	$ 399,734	$ 1,083,153
New Construction Contracts	$ 12,534,419	$ 7,366,541	$ 19,900,960
Contingencies	$ 1,133,975	$ 628,129	$ 1,762,104
Architectural/Engineering Fees	$ 1,079,431	$ 597,916	$ 1,677,347
Consulting and Other Fees	$ 453,590	$ 251,252	$ 704,842
Movable/Other Equipment (not in contracts)	$ 3,280,816	$ 1,817,303	$ 5,098,119
Other Costs To Be Capitalized	$ 2,321,533	$ 1,264,764	$ 3,586,297
Total Project Cost	**$ 21,487,184**	**$ 12,325,638**	**$ 33,812,822**

Site Preparation
Project site preparation costs are based upon the proposed site location in Moline, IL and Encompass Health and UnityPoint experience. Clinical site preparation costs are estimated to be $683,420 approximating 5.0% of projected clinical construction and contingency costs.

New Construction
The proposed project is a new, freestanding 40-bed comprehensive physical rehabilitation hospital located in Moline, Rock Island County, IL. The new construction will be a single-story 47,822 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. Construction costs are estimated based on national architectural/construction standards adjusted for Rock Island County building code compliance and Encompass Health and UnityPoint experience. Clinical construction costs are projected to be $12,534,419, or $398.50 per clinical square foot.

Project and Sources of Funds Itemization
The Quad Cities Rehabilitation Institute, LLC

Contingencies
Project contingencies costs are an allowance for unforeseeable events related to construction. Clinical construction costs contingencies are estimated to be $1,133,975, or 9.1% of projected clinical new construction costs.

Architectural/Engineering fees
Clinical project cost architectural/engineering fees are projected to be $1,079,431, or 7.9% of clinical new construction and contingencies costs. These costs are consistent with Encompass Health and UnityPoint experience.

Consulting and Other fees
Project consulting and other fees are primarily comprised of permits and state/local fees.

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 UnityPoint experience.

Other Costs that are to be Capitalized
Project other costs to be capitalized are estimated based on Encompass Health and Unity Point experience and primarily consist of pre-operating costs.

Cost Space Requirements
The Quad Cities Rehabilitation Institute, 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.**

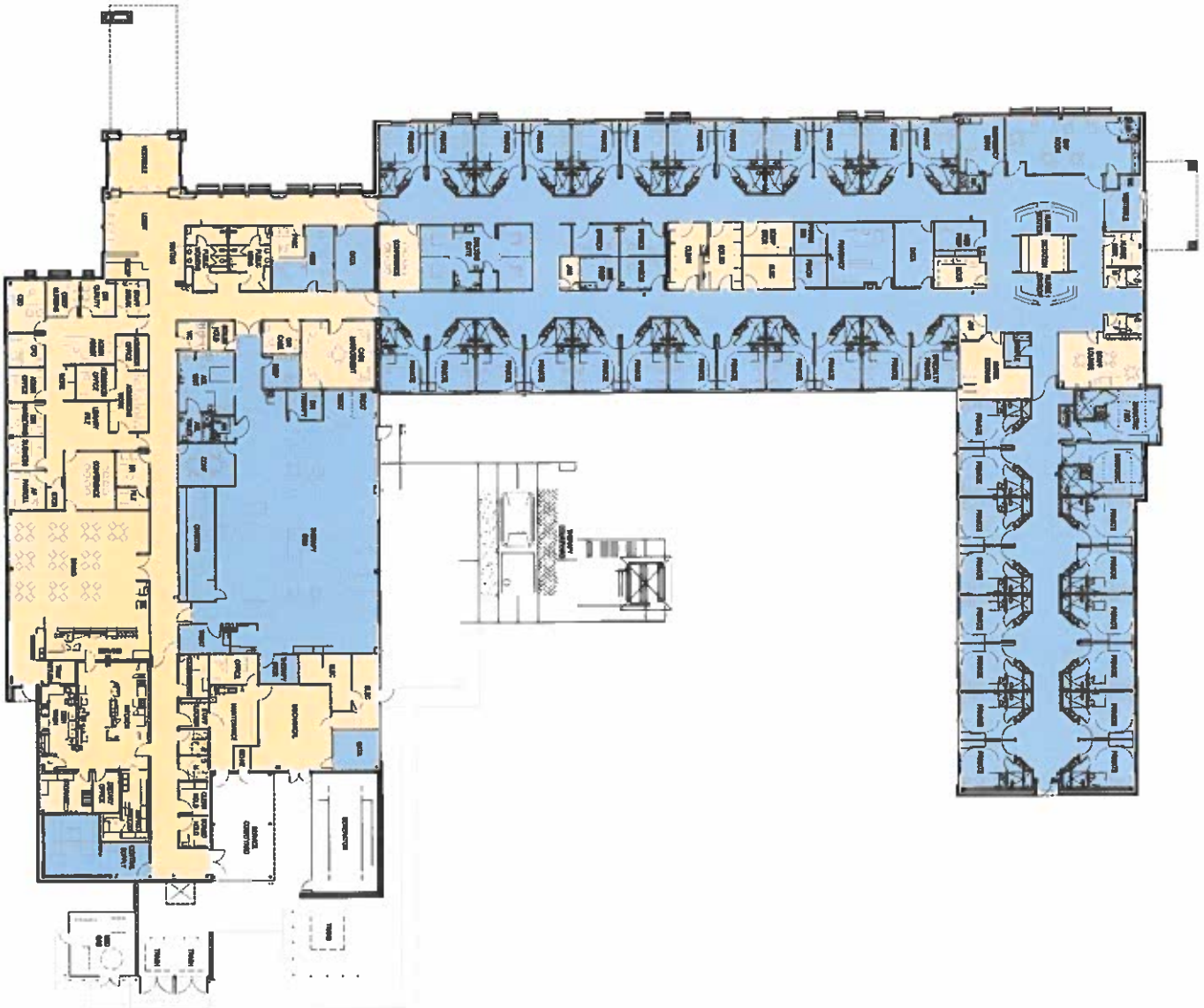
		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	$21,487,184		31,454 BGSF	31,454 BGSF			
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical	$12,325,638		16,368 BGSF	16,368 BGSF			
TOTAL	**$33,812,822**		**47,822 BGSF**	**47,822 BGSF**			

Attachment 9
Page 1

SCHEMATIC SITE PLAN
ENCOMPASS HEALTH / UNITY POINT
MOLINE, ILLINOIS
IMEG
REVISIONS
NO.
DESCRIPTION
DATE
IMEG Project No:
160035871.01
File Name:
Field Book No: ####
Drawn By: SDS
Checked By: KEC
Date: 12/12/19
C-100
Sheet 1 of 1
SCALE: 1" = 40'
7th STREET
32ND AVENUE
STREET

FLOOR PLAN

40 BED - 47,000 SF



NON-CLINICAL SPACES

CLINICAL SPACES

A1	FLOOR PLAN	NO.	REVISION	BY	DATE

FLOOR PLAN

MOLINE, ILLINOIS

40 BED REHABILITATION HOSPITAL

Encompass Health

#19-059

Background of the Applicant
The Quad Cities Rehabilitation Institute, 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 Quad Cities Rehabilitation Institute, LLC ("Quad Cities Rehab Institute")

1. The proposed project will be a 50/50 joint venture between Trinity Medical Center and Encompass Health Corporation ("Encompass"). Trinity Medical Center, an affiliate of Iowa Health System dba UnityPoint Health, will have a fifty percent (50%) ownership interest in the Licensee, The Quad Cities Rehabilitation Institute, LLC. Trinity Medical Center is an Illinois nonprofit corporation. Encompass Health also will have a fifty percent (50%) ownership interest in the Licensee, The Quad Cities Rehabilitation Institute, LLC. Encompass is a Delaware corporation.

2. Quad Cities Rehab Institute 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 the Quad Cities Rehab Institute at Attachment 11.

UnityPoint Health- Trinity Medical Center

1. Iowa Health System d/b/a UnityPoint Health is the sole corporate member of Trinity Regional Health System, the sole corporate member of Trinity Medical Center. Trinity Medical Center is also a member of Quad City Ambulatory Surgery Center, LLC, which is an Illinois health facility. Trinity Medical Center operates three hospitals, two of which are located in Illinois: Trinity Rock Island and Trinity Moline. Trinity Bettendorf is located in Bettendorf, Iowa. Trinity Regional Health System also operates Trinity Muscatine, located in Muscatine, Iowa.

The following is a listing of all health care facilities owned or operated by the applicants with applicable license numbers and accreditation information. Copies of these licenses and Joint Commission/AAAHC letters are attached.

As documented, UnityPoint Health – Trinity Medical Center's hospitals are accredited. Trinity Rock Island and Trinity Moline are represented by one Medicare provider number and, therefore, jointly accredited as Trinity Medical Center – Rock Island.

Trinity Medical Center operates the following licensed health care facilities in Illinois:

- UnityPoint Health – Trinity Rock Island, IDPH License #0003244.
- UnityPoint Health – Trinity Moline, IDPH License #0005140.
- Quad City Ambulatory Surgery Center, LLC, AAAHC ID# 12794.

Note: UnityPoint Health, the parent organization of Trinity Medical Center, operates three other hospitals in Illinois: UnityPoint Health – Methodist Hospital ("UPH Methodist") and UnityPoint Health – Proctor Hospital ("UPH Proctor"), both in Peoria and UnityPoint Health – Pekin Hospital in

Background of the Applicant
The Quad Cities Rehabilitation Institute, LLC

Pekin ("UPH Pekin"). UPH Methodist, UPH Proctor and UPH Pekin are not hospital members of Trinity Medical Center or Trinity Regional Health System.

2. There have been no adverse action taken against any facility owned or operated by Trinity Medical Center 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 Trinity Medical Center 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.

Encompass Health (f/k/a HealthSouth Rehabilitation Corporation) is a national leader in inpatient rehabilitation services with 133 inpatient rehab hospitals in 33 states and Puerto Rico, representing over 20% of the licensed acute rehabilitation beds nationally. Currently, one hundred and eighteen (118) 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 proposed hospital brings to the local market the strength of two parent organizations so that HSA10 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 Quad Cities 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.

Walter C. Smith
Director, State Regulatory
Affairs - Legal Services
9001 Liberty Parkway
Birmingham, AL 35242
205.970.7926
walter.smith@encompasshealth.com

Encompass Health

December 12, 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 Corporation, 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 has an ownership interest in Van Matre Encompass Health Rehabilitation Hospital located in Rockford, Illinois, 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

#19-059

Walter C. Smith
Director, State Regulatory
Affairs - Legal Services
9001 Liberty Parkway
Birmingham, AL 35242
205.970.7926
walter.smith@encompasshealth.com

Encompass Health

December 12, 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 Quad Cities Rehabilitation Institute, 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 Quad Cities Rehabilitation Institute, LLC, is a joint venture arrangement and has no other direct ownership interest in a health care facility 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

UnityPoint Health

DENNY DRAKE
SENIOR VP, CORPORATE INTEGRITY
AND GENERAL COUNSEL

WRITER'S DIRECT PHONE: 515-241-4655
DIGITAL PAGER: 515-242-2227
E-MAIL: DENNY.DRAKE@UNITYPOINT.ORG

LAW DEPARTMENT

1776 WEST LAKES PARKWAY, SUITE 400
WEST DES MOINES, IA 50266-8239
515-241-4650
FAX 515-241-4656
unitypoint.org

December 9, 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 Iowa Health System, d/b/a UnityPoint Health, I, Denny Drake, Senior Vice President, Corporate Integrity and General Counsel, 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, UnityPoint Health has an ownership interest in the following health care facilities:

- UnityPoint Health – Trinity Rock Island
- UnityPoint Health – Trinity Moline
- Quad City Ambulatory Surgery Center, LLC

None of the above facilities have had an 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,

Denny Drake

Denny Drake

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.

HF 118215

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.

Ngozi O. Ezike, M.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
6/30/2020		0003244

General Hospital

Effective: 07/01/2019

Trinity Medical Center (West)
dba Trinity Rock Island
2701 17th Street

Rock Island, IL 61201

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← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 6/30/2020

Lic Number 0003244

Date Printed 5/13/2019

Trinity Medical Center (West)
dba Trinity Rock Island
2701 17th Street
Rock Island, IL 61201

FEE RECEIPT NO.

Attachment 11

Illinois Department of PUBLIC HEALTH

HF 119040

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.

Ngozi O. Ezike, M.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
11/28/2020		0005140

General Hospital

Effective: 11/29/2019

Trinity Medical Center - 7th St Campus
dba Trinity Moline
500 John Deere Rd, 7th St Campus

Moline, IL 61265

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-493-001 10M 9/18

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 11/28/2020

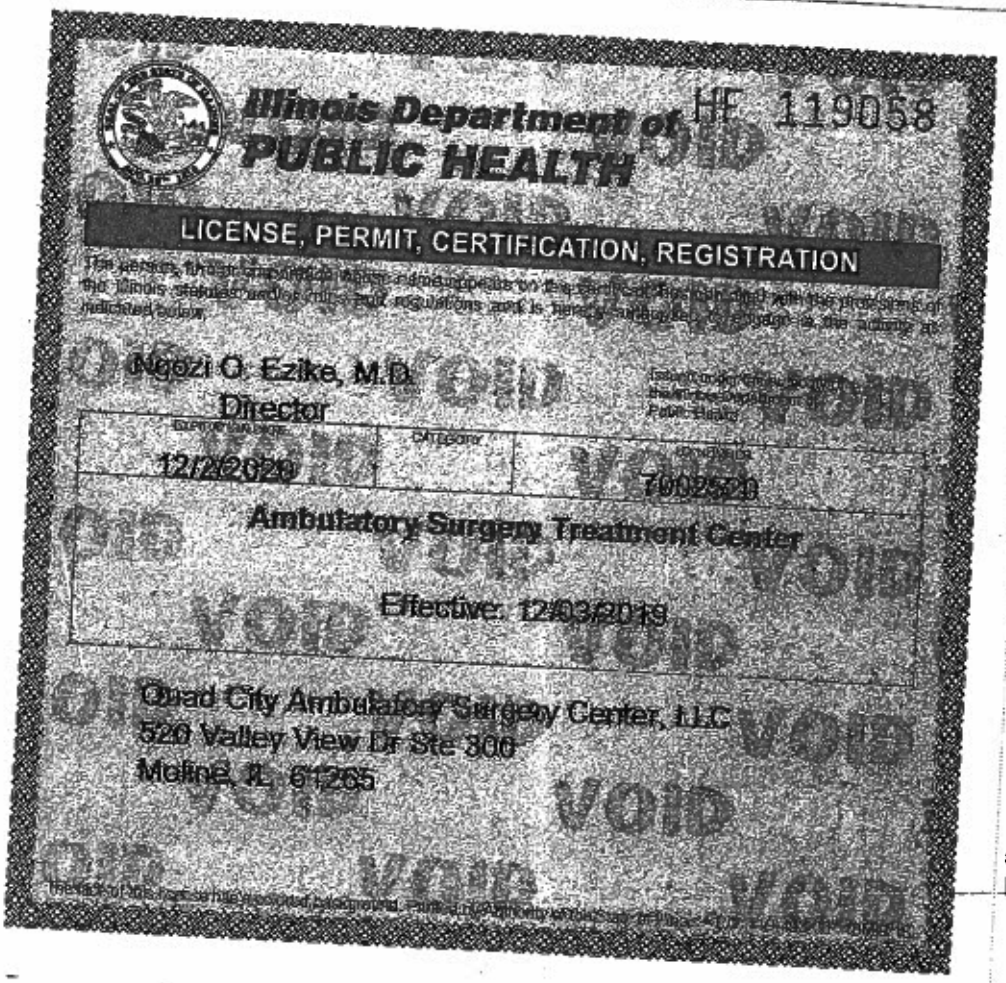
Lic Number 0005140

Date Printed 10/15/2019

Trinity Medical Center - 7th St Campus
dba Trinity Moline
500 John Deere Rd, 7th St Campus
Moline, IL 61265

FEE RECEIPT NO.

Attachment 11



Illinois Department of PUBLIC HEALTH

HF 119058

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

Ngozi O. Ezike, M.D.
Director

Expiration Date	Category	Number
12/2/2020		7002520

Ambulatory Surgery Treatment Center

Effective: 12/03/2019

Quad City Ambulatory Surgery Center, LLC
520 Valley View Dr Ste 300
Moline, IL 61265

VOID

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/2/2020

Lic Number 7002520

Date Printed 10/17/2019

Quad City Ambulatory Surgery Center,

520 Valley View Dr Ste 300
Moline, IL 61265-6152

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 Pelletier

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

Trinity Medical Center

Rock Island, 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

May 12, 2018

Accreditation is customarily valid for up to 36 months.

Craig A. Jones, FACHE
Chair, Board of Commissioners

ID #7421
Print/Reprint Date: 08/14/2018

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

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

grants this

CERTIFICATE OF ACCREDITATION

to

QUAD CITY AMBULATORY SURGERY CENTER, LLC
DBA QCASC

520 VALLEY VIEW DR, SUITE 300
MOLINE, IL 61265

In recognition of its commitment to high quality of care and substantial compliance with the Accreditation Association for Ambulatory Health Care standards for ambulatory health care organizations.

12794
Organization Identification Number

AUGUST 23, 2021
The Award of Accreditation expires on the above date

ARNALDO VALEDON, MD
Chair of the Board

NOEL ADACHI, MBA
President & CEO

5250 OLD ORCHARD ROAD, SUITE 200 • SKOKIE, IL 60077
PHONE: 847/853.6060 • E-MAIL: INFO@AAAHC.ORG • WEB SITE: WWW.AAAHC.ORG

Attachment 11

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

Executive Summary

UnityPoint Health offers comprehensive medical services in the Quad Cities area through its subsidiaries, Trinity Regional Health System and Trinity Medical Center. Trinity Regional Health System ("Trinity Regional" or "Trinity") includes four hospitals located in and serving the greater Quad Cities area, two of which are located in and primarily serve Illinois HSA10 residents:

- Trinity Rock Island and,
- Trinity Moline.

The other two UnityPoint Health Trinity Regional hospitals are in Iowa counties contiguous to HSA10: Scott and Muscatine, where Trinity Bettendorf and Trinity Muscatine are respectively located. (As noted previously, Trinity Rock Island, Moline and Bettendorf are operated by Trinity Medical Center.)

The residents of HSA10 (Rock Island, Henry, and Mercer counties) are reliant on Trinity Regional hospitals for inpatient services, evidenced by the fact that more than half (53.6%) of all HSA10 general acute care inpatients are discharged from a Trinity Regional hospital. Because of Trinity Regional's campus locations in HSA10 and the two bordering Iowa counties, residents in contiguous Scott and Muscatine counties (Iowa) also depend on Trinity Regional for their inpatient health care needs. In fact, two out of every ten Trinity Regional inpatients (approximately 20%) reside in bordering Scott and Muscatine counties in Iowa. Thus, Trinity Regional serves as the leading provider for HSA10 residents (this project's defined service area) and cares for a significant patient population in-migrating to its hospitals from outside HSA10, including the bordering Iowa counties.

As a local community-based organization, Trinity Regional and its physicians recognize that there are patients discharged from its HSA10 general acute care hospitals in need of inpatient rehab services that are not receiving that care. Instead, patients are discharged to a less intensive setting such as a skilled nursing facility ("SNF") or home with home health care services rather than the more appropriate inpatient rehab setting; or, are foregoing needed rehab care altogether. This gap in care between what's needed and what has been historically received results in less than optimal care for the many HSA10 residents and residents from the greater Quad Cities area that rely on Trinity Regional, and therefore Trinity Medical Center, for health care services.

Trinity Medical Center also recognizes that there are non-Trinity HSA10 patients in need of inpatient rehab care. Because the proposed freestanding rehab hospital will serve patients from all health systems, the Quad Cities Rehab Institute will provide HSA10 residents locally available and accessible intensive rehab services close to home. Particularly for HSA10 residents discharged from distant hospitals, *e.g.,* University of Iowa Hospitals & Clinics and OSF Saint Francis Medical Center, the proposed HSA10 rehab hospital will enable HSA10 residents to return to their home medical community for post-acute inpatient rehab care rather than remain away from home for an even longer time. The ability to receive needed services close to home ensures access to both community providers as well as the support network of family and friends.

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

As the Health Facilities and Services Review Board is aware, it is important for patients and families to have accessible and available health care services, such as the proposed inpatient rehab services, close to home. The ability of the patient's family to actively participate in the patient's care plan and provide support to the patient enhances quality of care for patients and prepares the patient for the ultimate goal of returning to the community. For elderly family members particularly, the ability to participate in the care without having to travel significant distances on a daily basis means more participation and involvement in the patient's care.

To be clear, the proposed project is needed to serve two categories of patients in need of intensive inpatient rehab services:

- **HSA10 residents in need of inpatient rehab care regardless of the general acute care hospital from which the patient is discharged,** recognizing that the majority of HSA10 patients currently rely on Trinity hospitals for their health care needs; and,

- **Trinity's existing in-migration patient population from outside HSA10,** including patients from contiguous Iowa counties, who currently rely on Trinity hospitals for their health care needs.

Trinity Rock Island is the sole inpatient rehab provider in HSA10, with 22 rehab beds. However, due to facility constraints (such as the lack of private rooms and overall age and limitations of a hospital unit originally designed to care for general medical/surgical patients), Rock Island operates significantly fewer inpatient rehab beds than for which it is licensed, which negatively impacts HSA10 residents' accessibility to needed inpatient rehab services. For that reason, Trinity Medical Center proposes to partner with a recognized national leader in inpatient rehab services, Encompass Health, to develop a freestanding 40-bed inpatient rehab hospital in HSA10.

The combination of complementary skills and expertise of a local, community-based health system and a national leader in inpatient rehab care will ensure that HSA10 residents have available and accessible rehab beds when needed. As detailed later in this application, Encompass will bring its proven programs and services to the local market, including an open medical staff and community education and training, to ensure patients and their families in need of intensive inpatient rehab services are able to receive that care close to home.

The proposed Quad Cities Rehab Institute will be located on the campus of Trinity Moline, easily accessible to all residents in HSA10 as well as to UnityPoint's existing patient population that resides in surrounding areas, including the contiguous Iowa counties. The total project cost to develop the new rehab hospital is $33,812,822. The first patient is expected to be treated on February 1, 2022 with a project completion date estimated as May 2, 2022.

Trinity Rock Island will discontinue its 22-bed inpatient rehab program upon the opening of the proposed new 40-bed facility on the Moline campus. A separate Certificate of Exemption ("COE") for discontinuation of Rock Island's inpatient rehab program will be submitted to the HFSRB at a later date. The detailed response follows.

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

For ease of review, the response is organized as follows:

A. The Quad Cities Rehab Institute will improve the health care of HSA10 residents.

1. HSA10 and Quad Cities residents depend on Trinity Regional for general acute care services.
   a) The planning area to be served is the 3-county HSA10.
   b) Trinity Regional is the inpatient market share leader for HSA10 residents.
   c) Trinity Regional hospitals care for residents of bordering Iowa counties.

2. The proposed project will address a gap in care for HSA10 residents.
   a) Historical utilization demonstrates the gap in care.
   b) Nursing home services are not an appropriate substitute for inpatient rehab care.

3. There is a quantified need for more than 40 inpatient rehab beds in HSA10.

4. There are no existing alternatives to the proposed Quad Cities Rehab Institute.
   a) Trinity Medical Center's existing in-hospital rehab unit is not an optimal alternative.
   b) Applicants' existing inpatient rehab programs are too distant.
   c) Iowa-based inpatient rehab programs are not viable alternatives.

5. Trinity Medical Center's partnership with Encompass is the optimal solution to meet residents' needs.
   a) Benefits of a local community-based hospital partnering with a national expert.
   b) Encompass' quality outcomes are the result of proven programs, services, and facility design.

6. Trinity Medical Center will discontinue offering inpatient rehab services on its Rock Island campus.

B. The project will address the lack of available and accessible HSA10 inpatient rehab beds.

C. *Sources used in the analyses.*

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

A. The Quad Cities Rehab Institute will improve the health care of HSA10 residents.

1. **HSA10 & Quad Cities residents depend on Trinity Medical Center for general acute care services.**

a) The planning area to be served is the 3-county HSA10.

The proposed project will be located in and primarily serve residents of HSA10: Rock Island, Henry, and Mercer counties. HSA10's relatively large and growing population ages 65 and over ("65+" or "elderly") is an important consideration in the need for inpatient rehab services because the elderly population is the primary user of inpatient rehab services. Nationally and in Illinois, more than 60% of rehab inpatients are Medicare patients.

Specifically, Medicare Fee-for-Service ("FFS") beneficiaries comprise approximately 58% of the nation's total inpatient rehab facility ("IRF") discharges.[1] Illinois' percentage of IRF discharges is similar, with approximately 57% of IRF discharges comprised of Medicare FFS beneficiaries in CY18.[2] When Illinois' eight percent (8%) Medicare Managed Care patients are added to the FFS beneficiaries in inpatient rehab facilities, the total Medicare population in Illinois inpatient rehab facilities rises to 65%.

Thus, the fact that nearly one-fourth (23.1%) of HSA10 population in 2024 is projected to be ages 65 and over is an important consideration in the evaluation of community need for the proposed project. Moreover, as shown, the projected percentage of HSA10 residents ages 65 and over (23.1%) is higher than the statewide percentage of elderly population (18.1%) projected for 2024.

Table 1
HSA10 Population Ages 65 and Over

	Total Population		Pop Ages 65 and Over			65+ Pop as a % of Total Pop	
County	2019	2024	2019	2024	% Change	2019	2024
Rock Island	143,429	141,659	28,993	32,301	11.4%	20.2%	22.8%
Henry	48,434	47,445	10,109	11,146	10.3%	20.9%	23.5%
Mercer	15,946	15,701	3,614	3,924	8.6%	22.7%	25.0%
HSA10 Total	**207,809**	**204,805**	**42,716**	**47,371**	**10.9%**	**20.6%**	**23.1%**
State of IL	13,099,008	13,236,667	2,074,046	2,397,905	15.6%	15.8%	18.1%

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.

The following table further highlights the importance of HSA10's large and increasing elderly population. As shown, the service area population ages 65+ is projected to increase 21% between

[1] Source: Report to the Congress: Medicare Payment Policy, Medicare Payment Advisory Commission (MedPAC), March 2019.
[2] Source: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database.

2019 and 2024 while the number of CON-authorized beds remains flat. The result is a declining number of rehab beds per 1,000 population ages 65+ for HSA10 residents. Notably, the declining beds per population illustrates the need for accessible and available beds even before the reality of the use of fewer beds (due to facility constraints) is considered.

Table 2
HSA10 Comprehensive Physical Rehab Beds per Person are Declining Despite an Increasing Senior Population

Indicator	2015	2019	2024	% Change, 2015 - 2024
Total Licensed HSA10 Rehab Beds	22	22	22	N/A
Service Area (HSA10) Population Ages 65+	**39,135**	**42,716**	**47,370**	**21.0%**
Pop Ages 65+ as % of Total	18.6%	20.6%	23.2%	N/A
Rehab Beds/1,000 Population Ages 65+	**0.562**	**0.515**	**0.464**	**-17.4%**

Source: Illinois Department of Public Health Certificate of Need Population Projections, 2014 Edition.

b) HSA10 residents rely on Trinity for health care services.

HSA10 residents rely on Trinity Medical Center for their general acute care inpatient needs. As shown below, Trinity Medical Center is the market leader in HSA10, serving more than half (53.6%) of HSA10 residents in need of general acute care services in CY18.

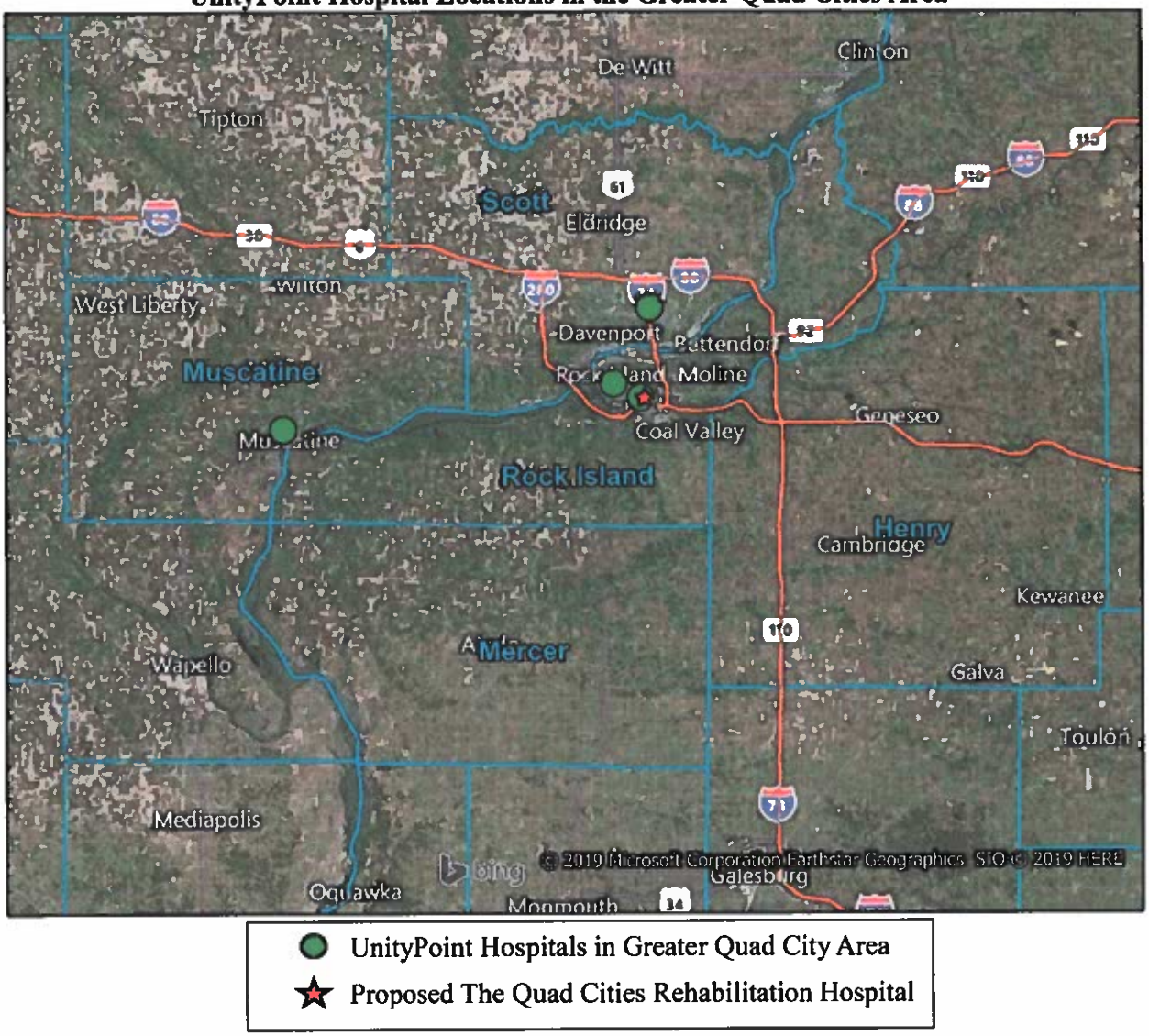
Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

Table 3 ***HSA10 Residents Rely on UnityPoint for Inpatient Care*** **HSA10 Residents' Inpatient Discharges, CY18**			
UnityPoint Health - Trinity Rock Island	9,938	43.1%	43.1%
Genesis Medical Center - Silvis	3,168	13.7%	56.8%
OSF Saint Francis Medical Center	1,745	7.6%	64.4%
University of Iowa Hospital & Clinic	1,503	6.5%	70.9%
UnityPoint Health - Trinity Moline	1,329	5.8%	76.7%
Genesis Medical Center	1,317	5.7%	82.4%
Trinity at Terrace Park (UnityPoint Health - Trinity Bettendorf)	1,092	4.7%	87.1%
Hammond - Henry Hospital	707	3.1%	**90.2%**
OSF Saint Luke Medical Center	449	1.9%	92.1%
OSF St Mary Medical Center	376	1.6%	93.7%
UnityPoint Health - Methodist - Peoria	177	0.8%	94.5%
Galesburg Cottage Hospital	168	0.7%	95.2%
All Other Hospitals	1,099	4.8%	100.0%
Total	**23,068**	**100.0%**	--
UnityPoint Trinity HSA10 Hospitals	**12,359**	**53.6%**	--
Source: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database. Note: all inpatients, excluding newborns.			

The reliance of HSA10 residents on Trinity hospitals for their healthcare service is of course due to many factors, including for example quality of care, relationship with physicians, and array of services offered. The location of UnityPoint Trinity hospitals is also an important consideration in terms of Trinity's accessibility and availability to its community members. The following map shows Trinity's hospital campus locations in the greater Quad Cities area, including their Iowa locations.

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

Figure 1
UnityPoint Hospital Locations in the Greater Quad Cities Area



Also, of note on the map is the location of the proposed The Quad Cities Rehabilitation Institute, which will be on the Trinity Moline hospital campus. As shown, the proposed rehab hospital is centrally located near the population centers of the service area and in close proximity to major interstates and roadways, ensuring that residents can easily access the facility.

In total, the Trinity Regional Quad Cities hospitals have 555 licensed inpatient beds and a comprehensive array of healthcare services. Thus, it is no surprise that HSA10 residents rely on UnityPoint Trinity for their inpatient healthcare needs.

- **Trinity Rock Island**: A 298-bed, Level II Trauma Center with advanced cardiovascular and neurosurgical services. The hospital includes 7 shared inpatient/outpatient surgical suites,

intensive care units, cardiac catheterization and rehabilitation services, as well as 54-licensed acute mental illness beds. The inpatient rehab unit is located on the 5th floor of the Rock Island hospital.

- **Trinity Moline**: A 38-bed hospital in Illinois. The campus includes Trinity Cancer Center, Trinity BirthPlace, 9 shared inpatient/outpatient surgical suites and a full-service emergency department. The proposed The Quad Cities Rehabilitation Institute will be located on this campus.
- **Trinity Bettendorf**: A 139-bed hospital in neighboring Scott County, Iowa with 5 shared inpatient/outpatient surgical suites, an intensive care unit, a BirthPlace, a full-service emergency department, cardiac catheterization services and wound care and pain management services.
- **Trinity Muscatine**: The 80-bed hospital in neighboring Muscatine County, Iowa offers a full-service emergency department, surgical suites, an intensive care unit, a BirthPlace and a spectrum of imaging services.

With Trinity Medical Center operating 3 of the 4 Trinity Regional Health System hospitals, Trinity Medical Center accounts for the majority of the acute care services within Trinity Regional Health System. Trinity Medical Center's licensed bed inventory accounts for over 85% of the total licensed bed capacity of Trinity Regional Health System.

Just as HSA10 residents rely on Trinity for their health care needs, Trinity is dependent on HSA10 residents as well. As shown on the following page, HSA10 residents comprise approximately two-thirds (65.2%) of Trinity's general acute care discharges of patients who would likely benefit from intensive inpatient rehab care, *i.e.*, "rehab-appropriate" patients with select diagnosis. Thus, Trinity's current *in-migration of rehab-appropriate patients to its facilities from outside HSA10 is approximately 35%.*

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

Table 4 HSA10 Residents Comprise the Majority of Rehab-Appropriate Trinity Inpatients, CY18		
County	**Discharges**	**% of Total**
Rock Island	2,845	53.4%
Henry	389	7.3%
Mercer	245	4.6%
Subtotal HSA10	***3,479***	***65.2%***
Scott County, IA	810	15.2%
Muscatine County, IA	332	6.2%
All Other counties	711	13.3%
Subtotal Non-HSA10	***1,853***	***34.8%***
Total	**5,332**	**100.0%**
Source: UnityPoint Trinity internal data. Note: Rehab-appropriate discharges exclude obstetrical, neonatal, psychiatric, substance abuse, and skilled nursing patients.		

Similar to total inpatients, approximately two-thirds (67.6%) of Trinity Rock Island's rehab inpatients are HSA10 residents, with the remaining approximate one-third (32.4%) in-migrating to Trinity Rock Island from outside HSA10. Of the approximate one-third rehab inpatients in-migrating to Rock Island, 17.5% are from the contiguous Scott and Muscatine counties in Iowa.

Table 5 HSA10 Residents Comprise the Majority of Trinity Rock Island Rehab Inpatients, CY18		
County	**Discharges**	**% of Total**
Rock Island	86	58.1%
Henry	9	6.1%
Mercer	5	3.4%
Subtotal HSA10	***100***	***67.6%***
Scott County, IA	23	15.5%
Muscatine County, IA	3	2.0%
All Other counties	22	14.9%
Subtotal Non-HSA10	***48***	***32.4%***
Total	**148**	**100.0%**
Source: UnityPoint Trinity internal data.		

The patient origin for Trinity's inpatient rehabilitation services outside of HSA10 is addressed and supported in the Illinois Health Care Facilities Plan (Section 1100.510, Introduction, Formula

Components, Planning Area Development Policies, and Distance Determinations) which notes that planning area boundaries can be influenced by factors including *affiliations between health care facilities and other health care entities that affect patterns of service.*

c) UnityPoint Trinity hospitals care for residents of bordering Iowa counties.

The previous map and tables document that residents beyond HSA10, including residents in contiguous Scott and Muscatine counties in Iowa where Trinity hospitals are located, rely on Trinity for inpatient services. Though these patients are outside the planning area, they are patients of Trinity hospitals, thus are expected to utilize and benefit from the proposed The Quad Cities Rehabilitation Institute.

The relative population of the five-county area (HSA10 plus Scott and Muscatine counties in Iowa) and the significant increase in that area's 65+ population further support the projected demand for inpatient rehab services detailed later in this application.

As shown below, the population ages 65 and over is growing significantly faster than the total population, with an expected growth of nearly 13% between 2019 and 2024 compared to the total population's growth rate of less than one percent (0.7%).

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

Table 6
HSA10 and UnityPoint Hospital Iowa Home Counties
Population Ages 65 and Over as Percentage of Total Population, 2019 – 2024

	Total Population		Pop Ages 65 and Over		Ages 65+ as % of Total Population	
County	**2019**	**2024**	**2019**	**2024**	**2019**	**2024**
Rock Island, IL	143,920	142,438	27,952	30,674	19.4%	21.5%
Henry, IL	49,079	48,600	10,025	11,062	20.4%	22.8%
Mercer, IL	15,482	15,174	3,495	3,797	22.6%	25.0%
Scott, IA	173,532	178,252	28,275	33,059	16.3%	18.5%
Muscatine, IA	42,869	43,319	7,312	8,303	17.1%	19.2%
TOTAL	**424,882**	**427,783**	**77,059**	**86,895**	**18.1%**	**20.3%**
% Increase	***0.7%***		***12.8%***		*N/A*	

Source: Environics Analytics (EA). Source: ©Claritas, LLC 2019.

2. **<u>The proposed project will address a gap in care for HSA10 residents</u>.**

a) Historical utilization demonstrates the gap in care.

The abysmally low utilization rates of inpatient rehab services for HSA10 residents reflect the current barriers to inpatient rehab care facing residents in the three-county planning area. As shown on the following page, HSA10 residents are utilizing all post-acute care ("PAC") services at significantly lower rates than Illinois and the nation. The low PAC utilization is particularly profound for patients in need of intensive inpatient rehab care.

For example, Rock Island County's Medicare residents' rate of inpatient rehab discharge is only 45.5% of the statewide rehab discharge rate (5 discharges for Rock Island County residents divided by 11 discharges statewide). Henry County has an even lower inpatient rehab discharge rate, while Mercer County has too few Medicare residents discharged from an inpatient rehab facility to even quantify. (*See* the following table and graph.)

The significant disparity between HSA10 counties inpatient rehab discharge rates and the state as a whole (as well as the nation) demonstrates a gap in care for HSA10 patients in need of intensive inpatient rehab care.

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Table 7
Significant Disparity Exists Between HSA10 Counties' Post-Acute Care Utilization
Acute Care and Post-Acute Care Utilization, Medicare Beneficiaries (All Ages), 2017

Health Care Utilization (Discharges/Visits per 1,000 persons)	US Average	Illinois Average	HSA10 Counties		
			Rock Island	Henry	Mercer
General Acute Care	273	299	276	230	229
Post-Acute Care Services					
Home Health (episodes)	175	186	135	116	116
Inpatient Rehab Facilities ("IRF")	11	11	5	3	*
Skilled Nursing	67	82	64	56	54
Ratio: SNF to IRF	**6.1**	**7.5**	**12.8**	**18.7**	**N/A**

Source: Centers for Medicare & Medicaid Services (CMS), Geographic Variation Public Use File, data represents Medicare FFS Enrollees and is for select post-acute care services.
*Note: represents suppressed value by CMS when total users are less than 11.

With such a low utilization of PAC services, particularly inpatient rehab, the question then becomes, "Do HSA10 residents have reasonable access to general acute care services"? In other words, is the significant disparity between HSA10 residents' PAC services unique only to PAC or do HSA10 residents not have adequate access to general acute care services as well. The accessibility to general acute care hospitals is relevant for two reasons:

i. A comparison of accessibility to general acute care services provides a benchmark against which to compare the PAC utilization, including inpatient rehab.

ii. The vast majority (approximately 90%) of rehab patients are admitted to an inpatient rehab facility upon discharge from a general acute care hospital. (The remainder of patients are admitted from SNFs or home.)

As shown on the following page, HSA10 residents appear to have no problem getting in the 'front door' of a general acute care hospital, *i.e.*, HSA10 residents' discharge rates from general acute care hospitals are highest as a percentage of the statewide rate compared to all discharge rates measured. However, when patients in need of inpatient rehab care are discharged 'out the back door', it is clear they do not have available and accessible beds. Thus, a significant gap in care exists for HSA10 residents in need of inpatient rehab services.

Notably, this quantitative assessment supports the identification of the gap in care that Trinity and its physicians have noted, and which are referenced in physicians' letters of support.

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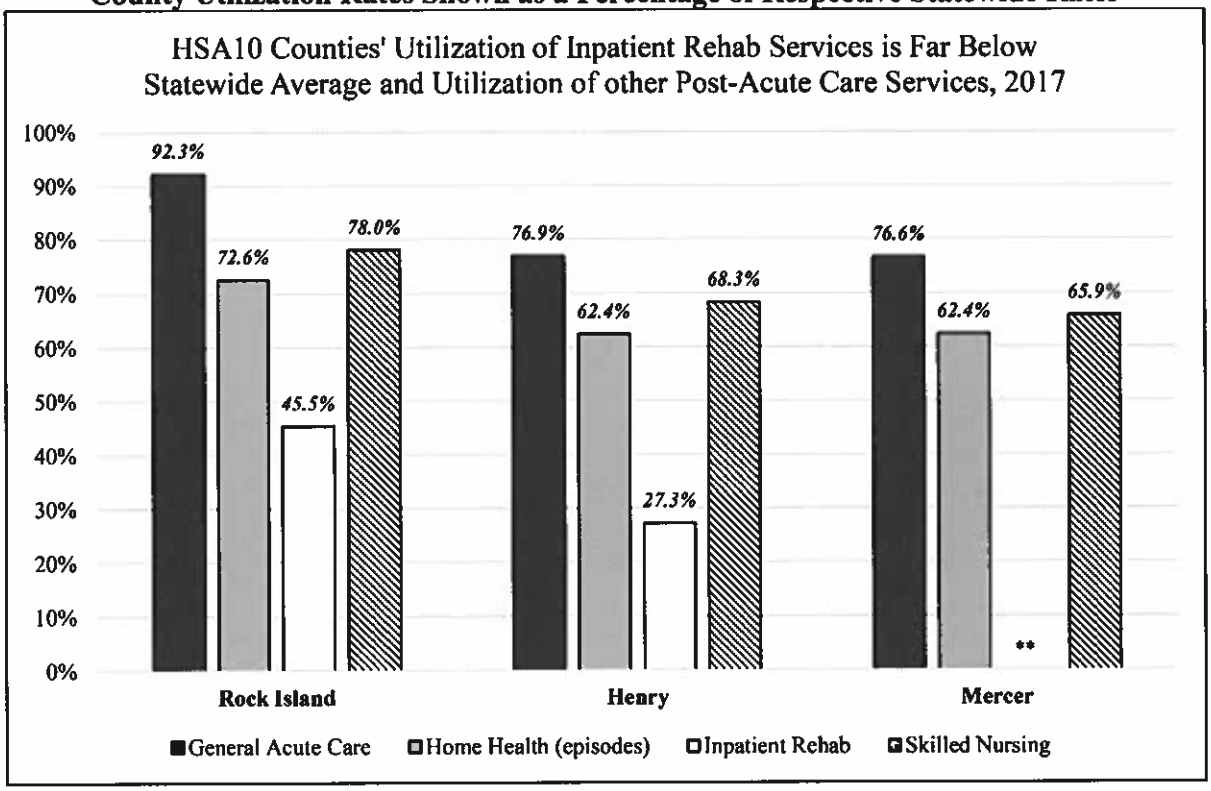
Figure 2
County Utilization Rates Shown as a Percentage of Respective Statewide Rates



Source: CMS Geographic Variation Public Use File. Data represents Medicare Fee for Service Enrollees.
**Note: Data suppressed because fewer than 11 Mercer County Medicare residents were discharged from an inpatient rehab facility in 2017.

The current low utilization of inpatient rehab beds is the basis for the HFSRB projected bed need for HSA10, which is a total of 11 beds. The HFSRB methodology projects future need based solely on historical utilization of inpatient rehab beds in the state. Thus, the HFSRB bed need methodology understates actual demand for the service because there is no way for HFSRB to identify the 'gap in care' that exists in each planning region. Rather, HFSRB relies on providers, with knowledge of the individual market dynamics, to determine if there is a gap in care, and if so, to quantify that gap in care.

The following HFSRB inpatient bed need projection is based on 2017 data. Notably, as shown above, HSA10 residents faced a significant gap in inpatient rehab care in 2017.

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Figure 3
HFSRB Inpatient Rehab Bed Need Projections

STATE SUMMARY
REVISED BED NEED DETERMINATIONS
10/23/2019

REHABILITATION BEDS

REHAB SERVICE AREA	APPROVED EXISTING BEDS	CALCULATED BED NEED	ADDITIONAL BEDS NEEDED	EXCESS REHAB BEDS
HSA 1	65	64	0	1
HSA 2	66	44	0	22
HSA 3	48	34	0	14
HSA 4	80	49	0	31
HSA 5	39	34	0	5
HSA 6	585	406	0	179
HSA 7	432	345	0	87
HSA 8	58	98	40	0
HSA 9	96	109	13	0
HSA 10	22	11	0	11
HSA 11	34	35	1	0
ILLINOIS TOTAL	**1,525**	**1,229**	**54**	**350**

Source: HFSRB, Department of Public Health.

It is important to note that the documented gap in care is not a new problem facing HSA10 residents. Unfortunately, the gap in care is a long-term problem that is worsening for HSA10 residents.

As shown on the following page, the gap in care for inpatient rehab services that exists for HSA10 residents when compared to the state as a whole or the target national benchmark (13 discharges per 1,000 Medicare residents) is increasing due to the planning area's increasing population ages 65 and over.

Notably, while the Illinois average discharge rate from an inpatient rehabilitation facility has remained fairly constant since 2007, HSA10 residents' inpatient rehab discharges rates have markedly declined, and those rates were already far below the statewide rate before declining significantly over the past few years.

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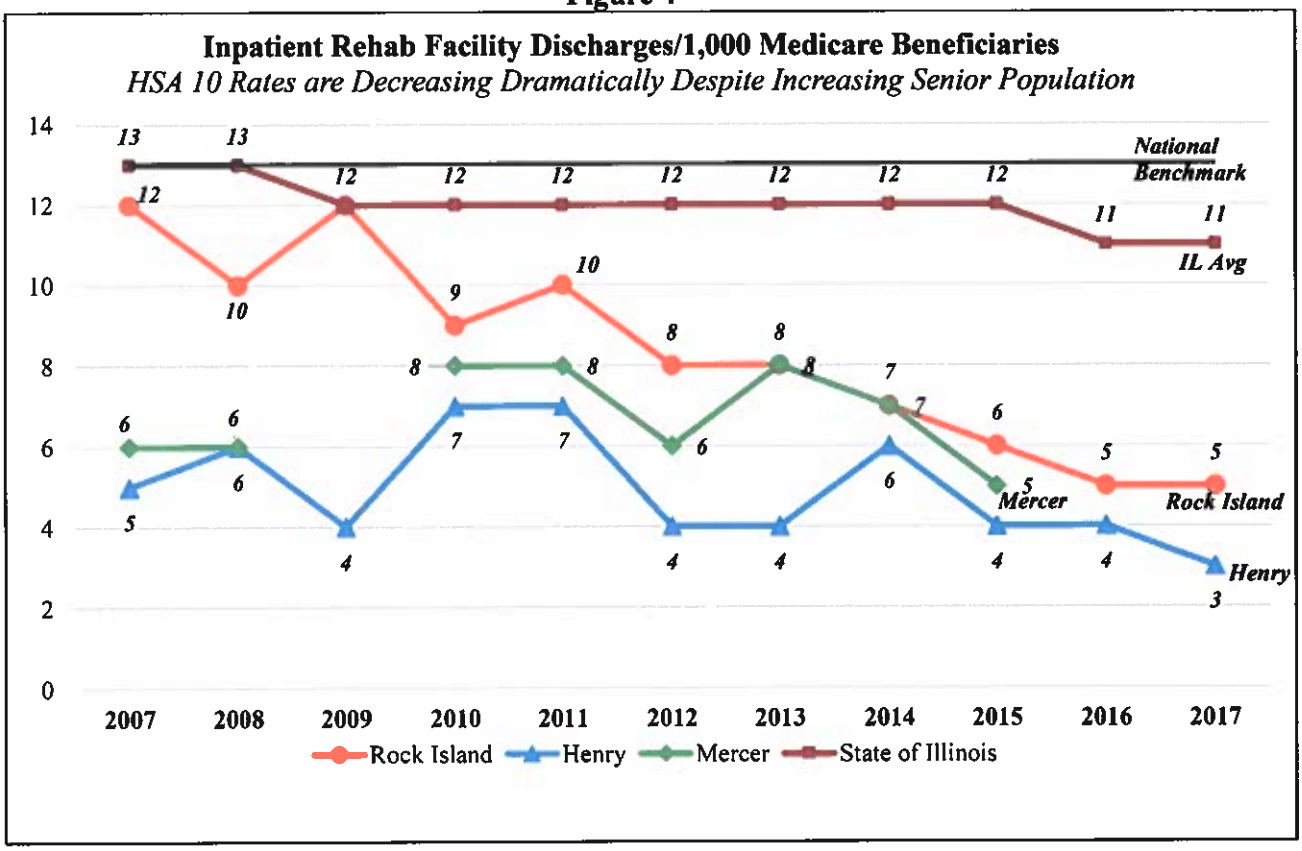
Figure 4



Source: CMS Geographic Variation Public Use File. Data represents Medicare Fee for Service Enrollees.
Notes: National benchmark is based on 75th percentile rate (13 discharges per 1,000).
Mercer County data suppressed when <11 Medicare residents were discharged from an inpatient rehab facility.

b) Nursing home services are not an appropriate substitute for inpatient rehab care.

As shown in Figure 2 above, all post-acute care services' discharge rates are generally lower than expected, with *inpatient rehab services significantly below* what is expected and needed for HSA10 residents. The low utilization of all PAC services, particularly inpatient rehab, means that patients who are in need of intensive inpatient rehab care are receiving less intensive rehab care or foregoing that care altogether. The lack of available and accessible inpatient rehab beds close to home means HSA10 residents are oftentimes choosing less intensive (and therefore less optimal) services such as SNF in lieu of inpatient rehab when intensive inpatient rehab care is needed.

Regardless of the reasons HSA10 patients are currently receiving less intensive rehab services in a nursing home rather than in an inpatient rehab facility when needed, those patients will likely have less access to the previous suboptimal nursing home rehab option in the future because of recent (October 1, 2019) reimbursement changes. The result: the current gap in care is expected to increase.

Details follow.

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SNF is not an appropriate substitute for IRF services.
The physician letters of support repeatedly reference the need for HSA10 residents to have available and accessible intensive inpatient rehabilitation services 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 letter from Dr. Olutade, the Medical Director for UnityPoint Health – Trinity's Hospitalist Group*, 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 5
Inpatient Rehabilitation is More Intensive, More Comprehensive, and has Better Outcomes than Skilled Nursing
(Comparison of IRFs to SNFs)

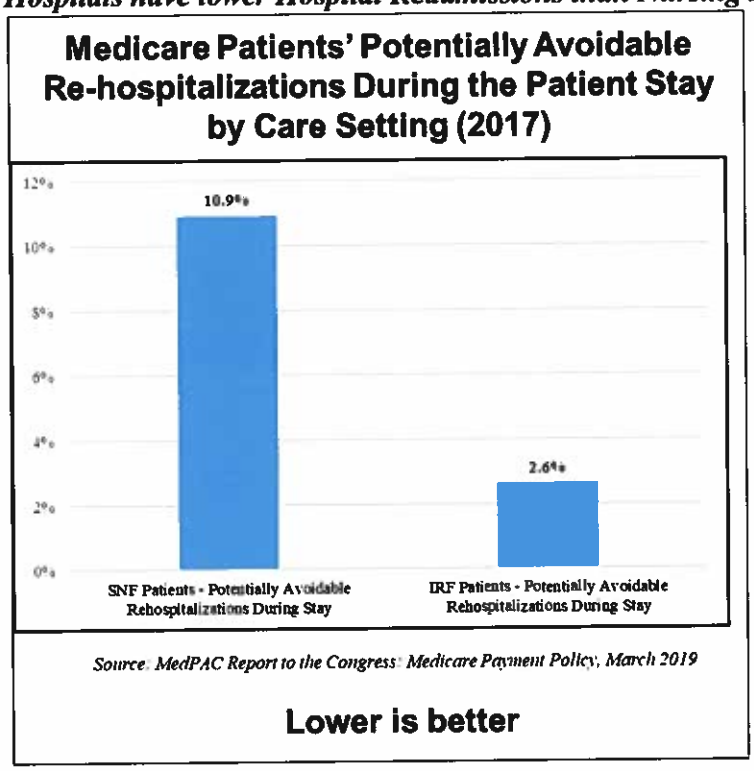
Required by Medicare	Inpatient Rehabilitation Facilities	Skilled Nursing Facilities
Close Medical Supervision by a Physician with Specialized Training	✓	✗
24-Hour Rehabilitation Nursing	✓	✗
Medical Care and Therapy Provided by Physician-Led Multidisciplinary Medical Team Including Specialty-Trained Registered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

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

For comparison purposes, Encompass' discharge rate back to the community is 79.9%.

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

Figure 6
Rehab Hospitals have lower Hospital Readmissions than Nursing Homes



The differences between the comprehensive IRF 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 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."[3] (*See* Exhibit A at the end of Attachment 12 for an illustrative exhibit regarding the study and a two-page summary of the findings.)

Despite the differences between therapy services provided in an inpatient rehab program and a nursing home, many HSA10 residents have historically chosen to receive care in the less intensive, suboptimal nursing home setting for a variety of reasons, including primarily the lack of available and accessible

[3] Source: Joan E. DaVanzo, Ph.D., M.S.W., Al Dobson, Ph.D., Audrey El-Gamil, Justin W. Li, and Nikolay Manolov, Ph.D.; *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities and After Discharge;* 2014.

inpatient rehab beds in HSA10 as well as a general lack of understanding and education regarding the benefits of intensive inpatient rehab services.

While SNFs most definitely have an important role as a post-acute care provider, the inappropriate substitution of SNF rehab services for comprehensive inpatient rehab care when inpatient rehab care is needed is not one of them. Numerous physician letters of support address the use of suboptimal post-acute care because HSA10 residents lack sufficient inpatient rehab beds close to their homes.

A patient example may be illustrative. 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".[4]

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 physician letters provide valuable insight.

For example, the following excerpts from the letter of support from the Medical Director of UnityPoint Health – Trinity's Hospitalist Group clearly demonstrate both need and support for the proposed project.

Currently we have limited comprehensive inpatient rehab capabilities for our patients, even within Trinity Rock Island 's own inpatient hospital-based unit. The existing unit at Rock Island is outdated. with the majority of the patient beds in semi-private rooms where space is limited. Additionally, the therapy gym is small and the unit's overall footprint does not easily allow for expansion of the gym or the addition of new and advanced equipment and technology. Because of these facility limitations and the need for private rooms for optimal patient care and recovery, Rock Island's inpatient rehab program has had declining admissions despite the unmet need for inpatient rehab care for residents of the Quad-Cities communities....

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[4] 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.

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This gap in care adversely impacts the patient 's outcome and ability to fully recover. Examples of the adverse impact on patients in need of intensive inpatient rehab but who do not receive that level of care is a much slower recovery; the inability to return to the highest level of cognitive and physical functioning; increased risk of complications including infections and falls; and higher rates of readmission back to the acute care hospital, to name just a few....

I'm proud of UnityPoint Health - Trinity for partnering with Encompass Health to ensure that a new, state-of-the-art freestanding hospital will be built in our local community to care for local residents.

Toyosi T. Olutae, MD
Medical Director, Hospitalist Group
UnityPoint Health -Trinity

The benefits of the intensive rehabilitative care provided in a comprehensive inpatient rehabilitation program are also clearly identified in the letter of support from the Chief Medical Officer of UnityPoint Health-Trinity.

All of our physician and advanced clinicians endorse and promote evidence-based clinical practices for all of their patients. For example, it is widely recognized that the best opportunity to achieve optimal physical and cognitive function and recovery for stroke patients is the provision of advanced, comprehensive inpatient rehabilitation. The interdisciplinary team approach in a comprehensive inpatient rehab hospital surpasses all other post-acute delivery models for optimal outcomes for patients suffering from traumatic brain injuries, neurological conditions, spinal cord injuries, amputations, hip fractures and so many other conditions.

While the existing inpatient rehabilitation program at UnityPoint Health-Trinity Rock Island hospital provides excellent care, the unit is small, outdated, and in dire need of space for the advanced equipment technologies and private rooms for all patients needing inpatient rehabilitation.

Deepak Ahuja, MD
Chief Medical Officer
UnityPoint Health-Trinity
Regional Vice President
UnityPoint Clinic – Quad Cities/Muscatine

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 been utilizing SNF in lieu of IRF when inpatient rehab was the most appropriate level of care, as indicated in the many physicians' letters of support. Recent reimbursement changes by the Centers for Medicare and

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Medicaid ("CMS" or Medicare) are expected to drastically reduce the amount of therapy provided in nursing homes.

Effective October 1, 2019, CMS implemented a new payment system for SNFs that 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.[5]

The Patient Driven Payment Model ("PDPM") reduces the Resource-Utilization Group ("RUG") framework which primarily based pay on the volume of therapy services, so that the more therapy provided to a patient, the higher the Medicare reimbursement. As noted by CMS, "the former reimbursement model encouraged potentially unnecessary therapy services".[6] The PDPM is a budget-neutral change that is expected to significantly impact SNFs that provided high levels of therapy. Simply put: the proposed PDPM is a total shift of the entire SNF reimbursement scheme. SNFs were previously reimbursed based on fee-for-service with Medicare to capture as much therapy as possible, meaning the more therapy provided, the higher the reimbursement. The current system changes that.

As a result, some 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 skilled nursing chains 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.[7]

In fact, thousands of physical, occupational, and speech therapists were laid off nationally only days after the PDPM reimbursement scheme took effect.[8] 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 nearly 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.[9]

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[5] Source: *Nursing homes brace for new Medicare payment system,* Modern Healthcare; Maria Castellucci, May 25, 2019.
[6] Source: *New nursing home payment model kicks in next month*, Modern Healthcare; Alex Kacik, September 14, 2019.
[7] Source: *Therapists look to CMS for aide as SNFs restructure*, Modern Healthcare; Alex Kacik, October 4, 2019.
[8] Source: *Therapists decry layoffs amid SNF reimbursement overhaul*, Modern Healthcare; Alex Kacik, October 2, 2019.
[9] Source: *Therapy strategies begin to shift post-PDPM as Genesis lays off 5% of rehab staff*; Skilled Nursing News; Alex Spanko, October 2, 2019.

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The impact of the recently-implemented Medicare payment system is an expected significant reduction in the amount of therapy services (particularly one-on-one sessions) nursing homes will provide to their residents in the future. Thus, HSA10 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 less options for even that care because of the reimbursement changes.

The result will be increased inpatient rehab bed need as patients who historically utilized nursing home care in lieu of intensive inpatient rehab services will have limited options to do so in the future.

3. **There is a quantified need for more than 40 inpatient rehab beds in HSA10.**

The following analysis attempts to quantify the number of HSA10 patients who should have received Rehab services but were unable to receive that optimal level of care, regardless of the reason.

First, the number of relevant or rehab-appropriate discharges for HSA10 residents was determined. For the most recent 12-month period (CY18), HSA10 residents had a total 7,294 rehab-appropriate discharges from any hospital, regardless of hospital location (*i.e.*, includes Iowa hospitals and those outside of HSA10 in Illinois). It is important to note that the estimated rehab-appropriate discharges are conservative because they are based on CY18 data without any projected increase in rehab-appropriate discharges due to the aging of the population.

Next, the expected discharge rate to inpatient rehab is applied to the HSA10 CY18 rehab-appropriate discharges to determine the HSA10 patients who needed, and thus would benefit from, inpatient rehab services. This 8% target rate is based on Encompass' experience in the Central US market, which is a reasonable basis to project patients in need of inpatient rehab services.

Because UnityPoint Trinity cares for a significant number of patients outside HSA10, including residents from Scott and Muscatine counties in Iowa where they have hospitals, an in-migration factor of 35% was used to determine total patients in need of rehab services. This in-migration factor is consistent with Trinity's CY18 rehab-appropriate in-migration percentage. (*See* Table 4 above.)

As shown in the following table, there is a projected net need for **a total of 41 inpatient rehab beds** to be located in and serve the residents in HSA10. Calculations follow.

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Table 8 Projected Rehab Bed Need Based on HSA10 Discharges from All Hospitals & Actual In-Migration to HSA10, CY18	
Calculations	**Current Need**
HSA10 Residents' Rehab-Appropriate Discharges	7,294
Multiplied by Expected (or Target) Discharge Rate to Inpatient Rehab	8.0%
Equals Estimated HSA10 Residents Discharged from Acute Care in Need of Rehab Bed	584
Plus In-migration Factor (based on % of UnityPoint Patients Requiring a Rehab Bed)	35.0%
Equals Total Projected Rehab Discharges from Greater Quad Cities Area	898
Multiplied by CY18 Illinois Statewide Rehab Average Length of Stay	14.2
Equals Projected Rehab Patient Days in Need of Rehab Bed	12,748
Divided by Calendar Days	365
Equals Inpatient Rehab Bed Need @ 100% Occupancy	35
Divided by Target Occupancy Factor	85%
***Equals* Bed Need @ 85% Target Occupancy**	**41**
Sources: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database; and Encompass Health.	

Clearly, the proposed project is needed to meet the inpatient rehab needs of HSA10 residents and the greater Quad Cities' residents who depend on UnityPoint Trinity for their healthcare needs. As discussed above, the analysis is based on the following assumptions:

- Rehab-appropriate discharges exclude obstetrical, neonatal, psychiatric, and substance abuse patients.
- The 8% target rehab discharge rate for HSA10 patients is based on Encompass' experience in the U.S. Central Region, a multistate area including Illinois and five other states.
- The majority of discharges (approximately 65%) driving the need for the new facility are from the HSA10 service area, with an additional approximate 35% expected to be for residents in-migrating to the proposed inpatient rehabilitation hospital for care.
- The bed need is based on current discharges, thus conservatively excludes expected growth in rehab-appropriate discharges due to the aging of patient population.

The forecasted utilization of the new 40-bed hospital further supports the need for the project, as demonstrated on the following page.

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Table 9 The Quad Cities Rehab Institute Projected Utilization		
Indicator	**Year 1**	**Year 2**
Discharges	775	1,014
Days	9,490	12,425
Average Daily Census	26.0	34.0
Occupancy	65.0%	85.1%

The inmigration of Trinity's existing acute care patients outside of HSA10 for care at the proposed The Quad Cities Rehabilitation Institute is supported by Trinity's current approach to concentrating specialized services at one hospital campus in order to serve all of its patients across the entire Trinity Medical Center network. Examples of this are displayed in Trinity's focus of advanced behavioral health services at the Robert Young Center in Moline, the concentration of advanced cardiac services at Trinity Heart Center in Rock Island and the centralization of oncology services at Trinity Cancer Center in Moline. As stated in the Illinois Health Care Facilities Plan, *'The State Board encourages the development of interrelationships between and among health care providers when such relationships increase efficiency, effectiveness, and quality of care.'* (Section 1100.350 Multi-Institutional Systems).

4. **There are no existing alternatives to the proposed The Quad Cities Rehabilitation Institute.**

    a) Trinity's existing in-hospital rehab unit is not an optimal alternative.

As mentioned previously, Trinity Rock Island hospital is the sole inpatient rehab provider in HSA10, with 22 rehab beds. However, due to facility constraints (such as the lack of private rooms and overall age and limitations of a hospital unit originally designed to care for general medical/surgical patients), Trinity Rock Island operates significantly fewer inpatient rehab beds than for which it is licensed, which negatively impacts HSA10 residents' accessibility to needed inpatient rehab services. In fact, as shown below, the limitations of the current facility have resulted in declining utilization for the past few years which is in part reflected in HSA10 residents low and declining inpatient rehab discharge rates. (*See* Figure 4 above.)

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Table 10
Trinity Rock Island's Inpatient Rehabilitation Unit Continues to Experience Declining Utilization Driven at Least in Part by Facility Limitations

Indicator	2014	2015	2016	2017	2018
Licensed Inpatient Rehab Beds	22	22	22	22	22
Admissions	279	240	211	209	145
Patient Days	4,105	3,378	3,270	3,028	2,123
Average Length of Stay - Days	14.7	14.1	15.5	14.5	14.6
Unit Occupancy Rate	51.1%	42.1%	40.7%	37.7%	26.4%

Source: Illinois Health Facilities and Services Review Board, AHQ Data Files.

A number of facility limitations have led to the measurable drop in patient admissions. For example, the unit is located on the 5th Floor of the main hospital tower in space originally designed and constructed for general medical/surgical patients. Moreover, the hospital itself was designed and constructed in the 1970's so is nearly 50 years old. The use of renovated, outdated space to house specialty inpatient rehab services contrasts significantly with the proposed construction of a new state-of-the-art freestanding rehab hospital designed and built solely to care for patients in need of inpatient rehab services.

Current Limitations with Trinity Rock Island's in-hospital rehab unit ("IRU") include the following. These design and space limitations are also noted in the physician letters of support.

- **Bed Complement Consists of Semi-Private Rooms**: The IRU consists of 8 private rooms and 7 semi-private rooms which creates placement issues related to patient gender as well as patient preference for private rooms. This layout has led to the 8 private rooms designated as the core bed capacity on the unit.

- **Overall Space Limitations**: The therapy gym, patient dining area, and support space are located in former patient rooms and staff offices that have been redesigned to meet the unit's needs, limiting the amount of space available for any of these important components. Lack of available space also limits the variety of patient therapy equipment that can be utilized on the unit as well as the development of a full Activities of Daily Living ("ADL") suite.

- **Lack of Sufficiently-Sized and Designed Amenities**: As noted above, the main hospital tower in which the IRU is located was originally built in the 1970s, therefore lacks many of the infrastructure upgrades found in newer facilities such as expanded electrical and technology networking capacity to meet the demands of patients and visitors. Also, community space, and family conference space, and waiting areas for family members are all limited within the confines of the former medical/surgical acute care floor.

The challenges associated with Trinity Rock Island's existing in-hospital unit design, aging infrastructure, and location within the main hospital have led Trinity's IRU to offer care to a patient

population with a limited set of clinical conditions as well, as indicated by the distribution of Medicare patients. (*See* Table 11 below.) For example, nearly half (48.8%) of Trinity's rehab discharges are for stroke. While inpatient rehab care is documented to provide significant benefit to stroke patients compared to other post-acute care alternatives, inpatient rehab care is also beneficial for patients with a number of other clinical conditions that currently are not being referred to inpatient rehab services comparable to national levels.

The proposed project will remedy the facility limitations: Encompass' proven facility design and programs and services will resolve each of these issues. Moreover, Encompass will bring to the local community its proven community education and training programs which includes peer-to-peer education for physicians, case managers, and nurses to ensure that healthcare professionals can appropriate identify patients in need of inpatient rehab care.

Trinity's request to modernize and expand its inpatient rehab service through construction of a new facility mirrors its recent Heart Center and Emergency Department modernization and expansion project. In April 2015, UnityPoint opened a 90,000 square-foot, three-story expansion of its Heart Center and Emergency Department (Project # 12-101) on its Trinity Rock Island campus at a cost of $61.3 million; the largest expansion project in the hospital's history.

There, as is the case here, Trinity's project was designed to improve patient safety and privacy, better coordinate care, reduce operational costs, and accommodate demand. In sum, the Heart Center project included additional capacity and a needed redesign of key community services in order to best meet the growing needs of the residents of the Quad Cities area. The proposed rehab hospital has similar goals. Additionally, the expanded cardiac and emergency services at Trinity Rock Island will continue to increase the number of patients with rehab-appropriate conditions that are treated within the Trinity system.

b) Applicants' existing inpatient rehab programs are too distant.

Two of the three closest Illinois inpatient rehab facilities to HSA10 residents are entities affiliated with the Applicants: UnityPoint's Methodist – Proctor Hospital in Peoria and Encompass' Van Matre Rehab Hospital in Rockford. (Peoria has two inpatient rehab facilities; the other is OSF Saint Francis Medical Center.) However, as shown on the following map, those facilities are too distant from HSA10 residents to be considered viable alternatives.

Proximity to inpatient rehab services for HSA10 residents is critically important given the need for patients to have access to both community providers (*e.g.*, their primary care physician, cardiologist, et al) as well as the support network of family and friends.

At Encompass, the patient's family and caregiver's involvement is a critical component of the patient's recovery. To that end, the family and caregivers are involved throughout the patient's stay, including for example:

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- Participation in developing the patient's care plan and goals for discharge, which leads to greater involvement encouraging and supporting the patient's recovery goals upon discharge.

- Frequent visitation with the patient during his/her inpatient stay, facilitated by sufficiently-sized:
  - Private inpatient rooms that allow for caregivers and family members to interact with the patient comfortably; and,
  - A therapy gym that affords caregivers and family members the opportunity to attend the patient's daily rehabilitation.

- Working with the case manager prior to the patient's discharge to receive training to help care for the patient after discharge.

- Interacting with the case manager when s/he visits the patient's home prior to discharge to identify and then address any special needs (such as equipment) the patient will have upon returning home.

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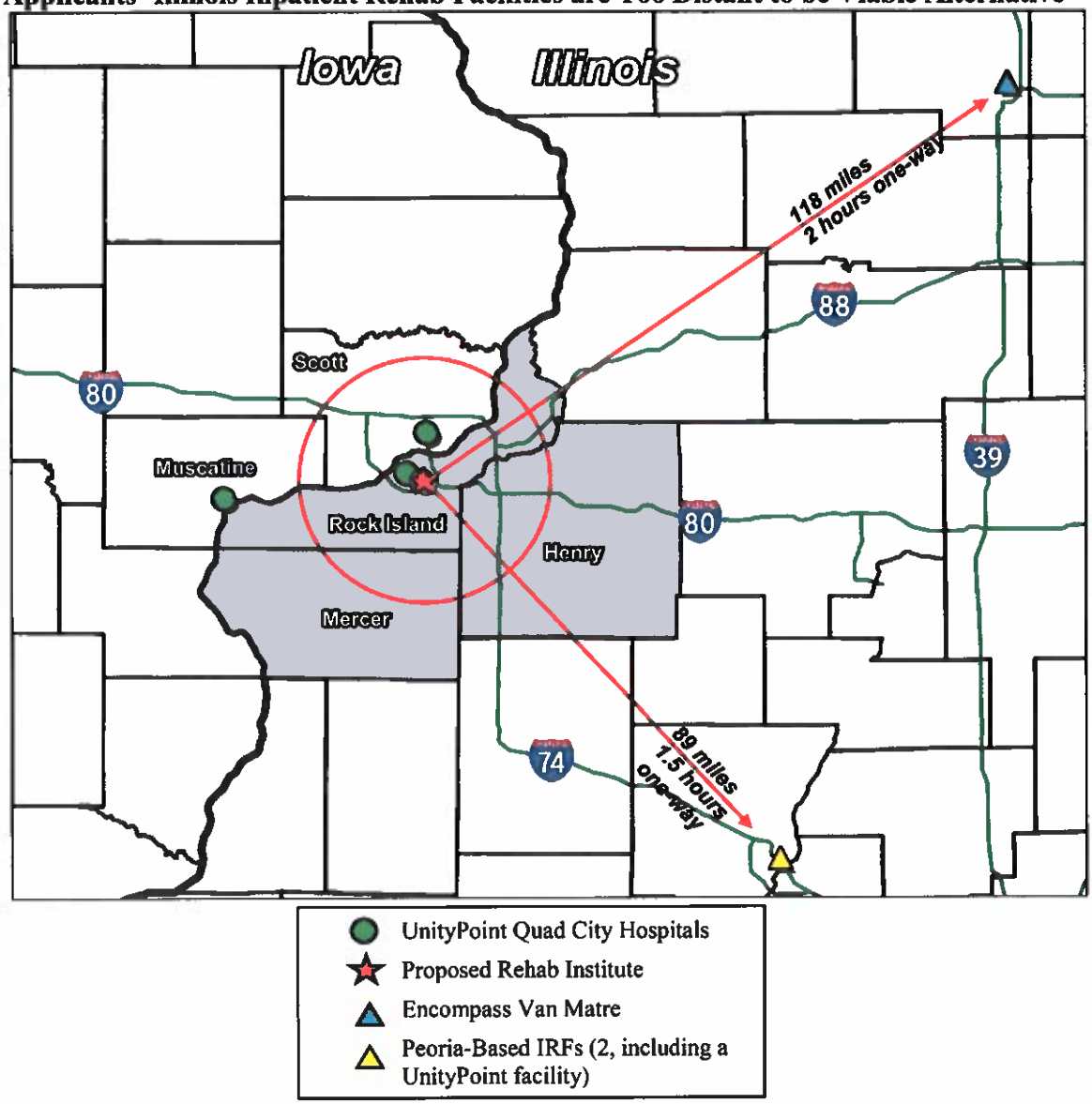
Figure 7
Applicants' Illinois Inpatient Rehab Facilities are Too Distant to be Viable Alternative



c) Iowa-based inpatient rehab programs are not viable alternatives.

Absent the proposed project, HSA10 residents will either continue to forego needed inpatient rehab services; travel out-of-area to distant Illinois facilities; or, travel out-of-state to Iowa inpatient rehab facilities. None of those options are viable.

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For patients who must travel to Iowa for inpatient rehab care, the closest program is the in-hospital patient unit at Genesis Medical Center ("Genesis") in Davenport, Iowa. As shown on the following table, Genesis appears to focus on a limited number of diagnoses, with over 50% of their patient population having a clinical condition of stroke, brain disease or nervous system disorder. Patients with hip, knee, femur or other bone or joint conditions are less likely to receive inpatient rehabilitation care at Genesis Medical Center when comparing their patient population to national patient distributions by clinical conditions at inpatient rehabilitation facilities. Additionally, Genesis has experienced a lower discharge rate to the community for its inpatient rehabilitation patients in recent years compared to the national average, as reported on the Medicare.gov Inpatient Rehabilitation Facility (IRF) Compare site.

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Table 11
Comparison to National Averages for Medical Conditions
Treated at UnityPoint Health and Encompass Health
Medicare Patients Only (April 2017 - March 2018)

Conditions	National Percentage of Cases	*UnityPoint Health - Trinity Rock Island*		*Encompass Van Matre Rehab Hosp.*		*Genesis Medical Center*	
		Discharges	% of Total	Discharges	% of Total	Discharges	% of Total
Stroke	22.6%	78	48.8%	306	26.8%	113	31.1%
Nervous System Disorder (Excluding Stroke)	13.9%	10	6.3%	216	18.9%	38	10.5%
Brain Disease or Condition (Non-Traumatic)	7.4%	10	6.3%	92	8.0%	44	12.1%
Brain Injury (Traumatic)	4.6%	10	6.3%	64	5.6%	10	2.8%
Spinal Cord Disease or Condition (Non-Traumatic)	4.7%	10	6.3%	48	4.2%	30	8.3%
Spinal Cord Injury (Traumatic)	1.9%	0	0.0%	10	0.9%	10	2.8%
Hip or Femur Fracture	9.6%	10	6.3%	78	6.8%	10	2.8%
Hip or Knee Replacement, Amputation or Other Bone or Joint Condition	16.4%	12	7.5%	159	13.9%	28	7.7%
All Other Conditions	19.0%	20	12.5%	170	14.9%	80	22.0%
Estimated Total	**100.0%**	**160**	**100.0%**	**1,143**	**100.0%**	**363**	**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 with between 1 to 10 patients.
Source: Data.Medicare.gov, Inpatient Rehabilitation Facility (IRF) Compare datasets, IRF-Conditions dataset, updated March 6, 2019.

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5. Trinity's partnership with Encompass is the optimal solution to meet residents' needs.

a) Benefits of a local community-based hospital partnering with a national expert.

The proposed project will be owned and operated as a 50/50 joint venture project. Consistent with the HFSRB rules regarding joint ventures, the combination of complementary skills and expertise of Trinity Medical Center, a local community-based health system, and Encompass, a national leader in inpatient rehab care, will ensure that HSA10 residents have available and accessible rehab beds when needed.

Trinity Medical Center is an affiliate of Iowa Health System, dba UnityPoint Health. UnityPoint Health is a nonprofit health care organization with 22 hospitals and over 300 clinics serving residents of Illinois, Iowa and Wisconsin. UnityPoint Health is the nation's 13th largest nonprofit health system and the 4th largest nondenominational health system in the United States. UnityPoint's hospitals range in size from 49-bed hospitals such as UnityPoint Health - Marshalltown, a community hospital in Iowa, to the 370-bed Iowa Methodist Medical Center, a Level I Trauma Center located in Des Moines. All of UnityPoint's hospitals are accredited.

As documented previously, HSA10 residents rely on UnityPoint Trinity hospitals for their health care needs, with the majority of HSA10 residents discharged from Trinity hospitals. (*See* Table 3 above.) Trinity hospitals also serve residents of the greater Quad Cities area who reside outside, but in close proximity to, HSA10. Thus, UnityPoint Trinity is an important health care provider currently located in and serving residents of HSA10.

Encompass Health is the nation's leading owner and operator of inpatient rehab hospitals, representing over 20% of the licensed acute rehabilitation beds nationally. HSA10 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. Encompass will bring its proven programs and services to the local market, including an open medical staff and community education and training, to ensure patients and their families in need of intensive inpatient rehab services are able to receive that care close to home.

A listing of select Encompass programs and services that will benefit the patients and families of the proposed new hospital follows.

- **TeamWorks** is a company-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.

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- **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 118 of Encompass Health's inpatient rehab hospitals currently 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 its 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, UnityPoint 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.

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b) Encompass' quality outcomes are the result of proven programs, services, and facility design.

Quality Outcomes for a Wide Array of Patient Diagnoses Served
The Quad Cities Rehabilitation Institute 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 ensure 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 proposed HSA10 rehab hospital expects to serve a similarly wide array of patient types, thus expanding the services locally available to HSA10 patients and their families.

Figure 8

IRF patient mix

Admission sources:

Acute care hospitals - 90%
Physician offices / community - 8%
Skilled nursing facilities - 2%

Rehabilitation impairment category		YTD-19	2018
RIC 01	Stroke	18.5%	18.0%
RIC 02/03	Brain dysfunction	10.0%	10.3%
RIC 04/05	Spinal cord dysfunction	3.9%	3.8%
RIC 06	Neurological conditions	21.5%	21.0%
RIC 07	Fracture of lower extremity	7.4%	7.7%
RIC 08	Replacement of lower extremity joint	3.4%	3.9%
RIC 09	Other orthopedic	8.5%	9.0%
RIC 10/11	Amputation	2.7%	2.6%
RIC 14	Cardiac	4.5%	4.5%
RIC 17/18	Major multiple trauma	5.2%	5.3%
RIC 20	Other disabling impairments	11.3%	11.1%
–	All other RICs	3.1%	2.8%

Average age of the Company's IRF patients:
all patients = 71 Medicare FFS = 76

Source: Investor Reference Book, Post Q2 2019 Earnings Release Updated August 20, 2019, Encompass Health.

Notably, an integral component in the provision of services to a wide array of patient diagnoses (or Rehabilitation Impairment Categories) is Trinity's and Encompass' **open medical staff model** which ensures that community-based physicians are available to care for patients' medical needs alongside the Physiatrists or Physical Medicine and Rehabilitation ("PMR") physicians caring for their physical rehabilitative needs. Nationally, Encompass 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. The open medical staff model and direct communication between Encompass and community-based physicians also means that patients return to their primary and specialty care physicians upon discharge from Encompass with no interruption or gap in care.

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 significant distances or into another state daily basis means more participation and involvement in the patient's care.

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. The high-quality care at the proposed The Quad Cities Rehabilitation Institute will reflect the proven programs and services of Encompass, regardless of how quality is defined.

Currently, a total of 118 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' Van Matre Rehabilitation Hospital in Rockford, Illinois, for example has earned Disease-Specific Care Certifications for its stroke, spinal cord and brain injury rehabilitation programs.

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 on the following page, Encompass Health's FIM® Gain exceeded the UDSMR® expected FIM® Gain for each year from 2009 through 2017, the most recent available year of comparative data. [10] UDSMR® (Uniform Data Set for Medical Rehabilitation) maintains the largest independent benchmarking database for inpatient rehabilitation, representing over 80% of all inpatient rehabilitation facilities.

[10] Figure 9 displays the most recent data available for FIM scores as CMS recently replaced the FIM functional assessment instrument with the new Section GG measurement tool effective October 1, 2019.

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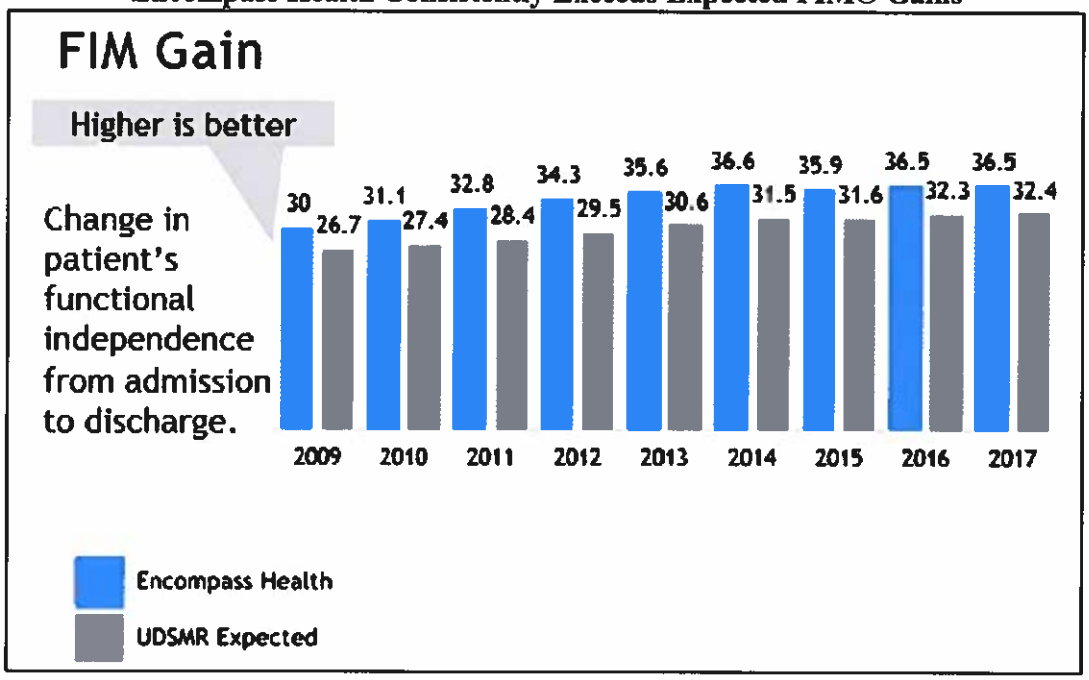
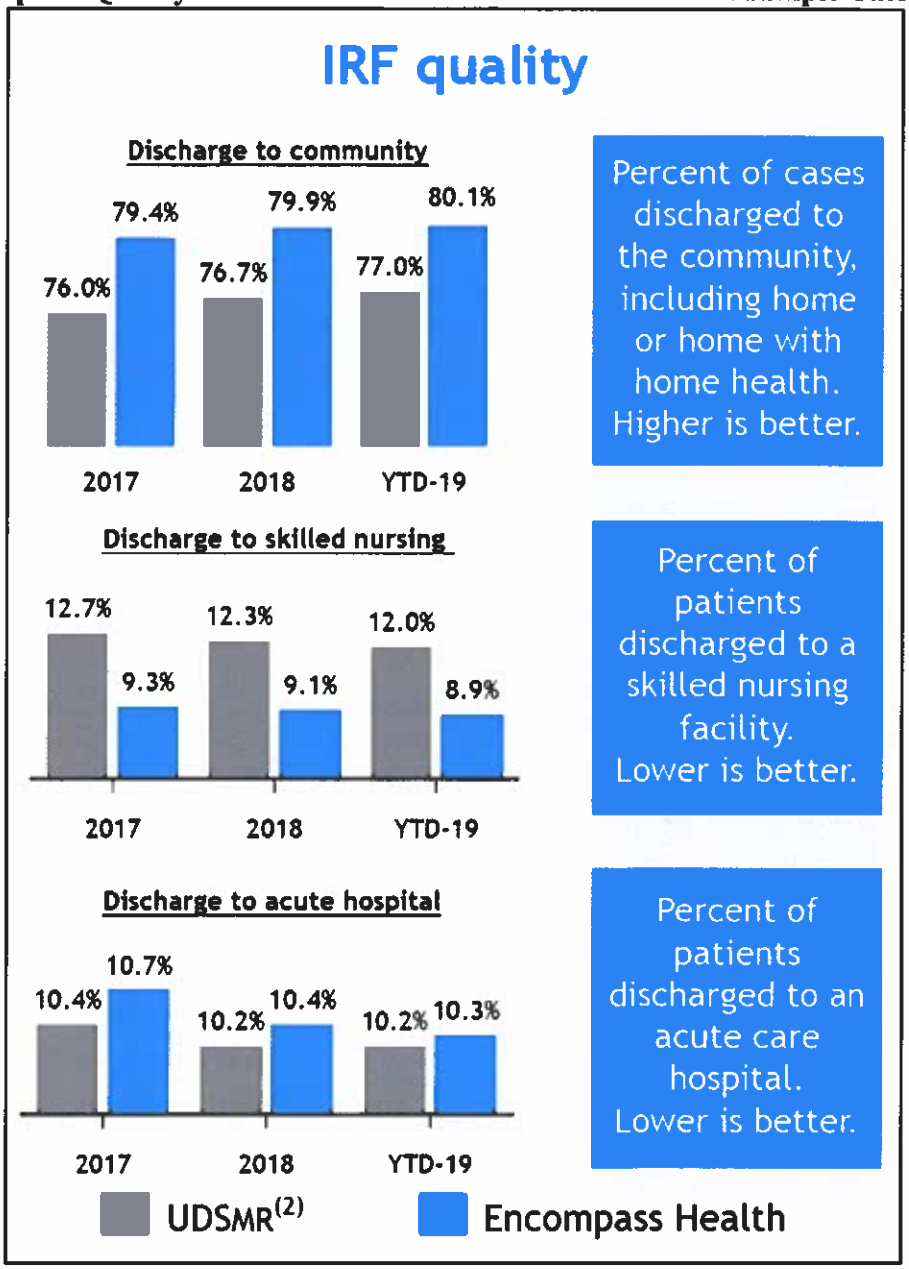
Figure 9
Encompass Health Consistently Exceeds Expected FIM® Gains



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 below, Encompass has a proven track record of returning approximately 80% of its patients back to the community, outperforming other providers nationally. The proposed new rehab hospital will utilize Encompass Health's proven programs to ensure high quality care is provided to its patients.

Figure 10
Encompass' Quality Measures Exceed National Standards in Multiple Categories



Source: Investor Reference Book, Post Q2 2019 Earnings Release Updated August 20, 2019, Encompass Health.

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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

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Proven Programs, Services, and Staffing to Ensure High Quality Outcomes
The proposed project will implement the following programs, services, and facility amenities specific to Encompass Health hospitals throughout the nation, and in place at Encompass' Van Matre Rehabilitation Hospital in Rockford, Illinois.

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. (*See* Exhibit B for rehab-specific technology that will be used to care for patients in the rehab hospital.)

Specific ***programs and services*** to be offered at The Quad Cities Rehabilitation 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.

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- **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 Quad Cities 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.)

Encompass' Proven Facility Design Benefits Patients and their Families

The ***facility design*** 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 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) of the patient rooms are designed as 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. One of the bariatric rooms has been designed as an isolation room 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.

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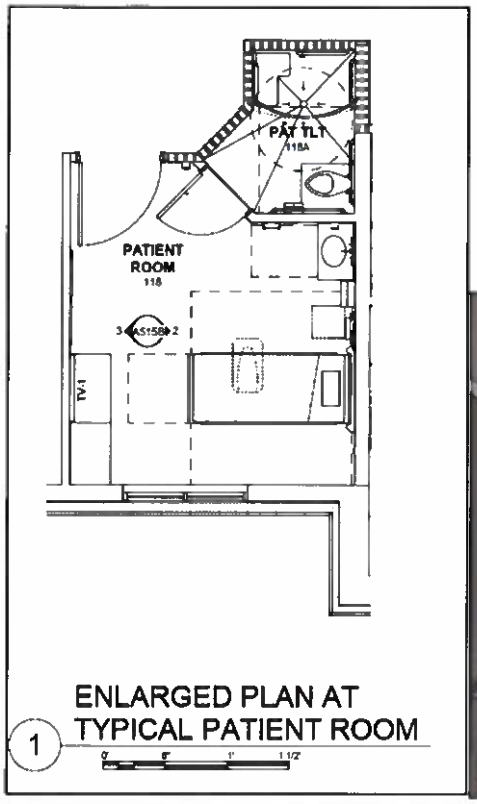
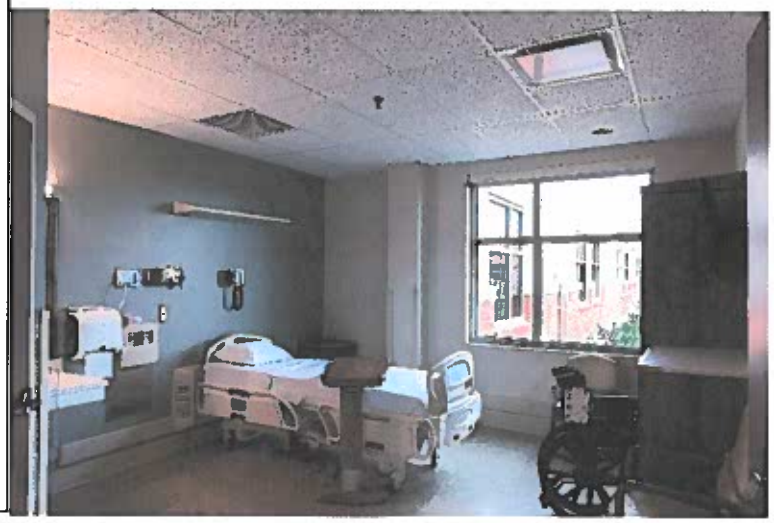


Architectural Figure A



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.

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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.)

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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.)

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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)

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Patients will also benefit from ***patient-centric facility design features*** that are in place at all Encompass facilities and will be included in The Quad Cities Rehabilitation Institute.

- **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.

See Attachment 9 for a floor plan of the proposed facility and Attachment 14 for the department-specific programmatic plan.

6. UnityPoint will discontinue offering inpatient rehab services on its Rock Island campus.

Trinity Rock Island will delicense its 22-bed inpatient rehab program upon the opening of the proposed new 40-bed facility on the Moline campus. A separate Certificate of Exemption ("COE") for discontinuation of Trinity Rock Island's inpatient rehab program will be submitted to the HFSRB at a later date.

Notably, the proposed new inpatient rehab hospital will not only provide needed services to HSA10 patients, but the closing of the Trinity Rock Island inpatient rehab unit will free up much-needed space for the hospital to use as it modernizes and renovates its existing patient units, enabling the hospital to create private rooms within the patient tower as the existing patient tower rooms are mainly semi-private.

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B. The project will address the lack of available and accessible HSA10 inpatient rehab beds.

As documented previously, there are three primary existing problems facing HSA10 residents that will be addressed by the proposed project:

(1) Lack of a sufficient number of available and accessible inpatient rehab beds in HSA10 to meet the needs of patients with clinical conditions appropriate for intensive inpatient rehab services.

(2) Inability of Trinity Medical Center's current facility to meet the needs of referring physicians and patients in need of post-acute rehab care.

(3) A patient population cared for by Trinity hospitals in the greater Quad Cities area beyond HSA10 who do not have a geographically accessible inpatient rehab center that is willing and able to admit patients with a wide array of diagnoses.

The proposed bed addition will address the current gap in utilization, offering local and accessible intensive inpatient rehab services to the HSA10 patients in need.

C. 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, 10/23/2019.
- Illinois HFSRB Inventory of Health Care Facilities and Services and Need Determinations, 9/01/2019.
- 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.
- 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.
- Internal records from UnityPoint Health hospital operations – inpatient discharge data.

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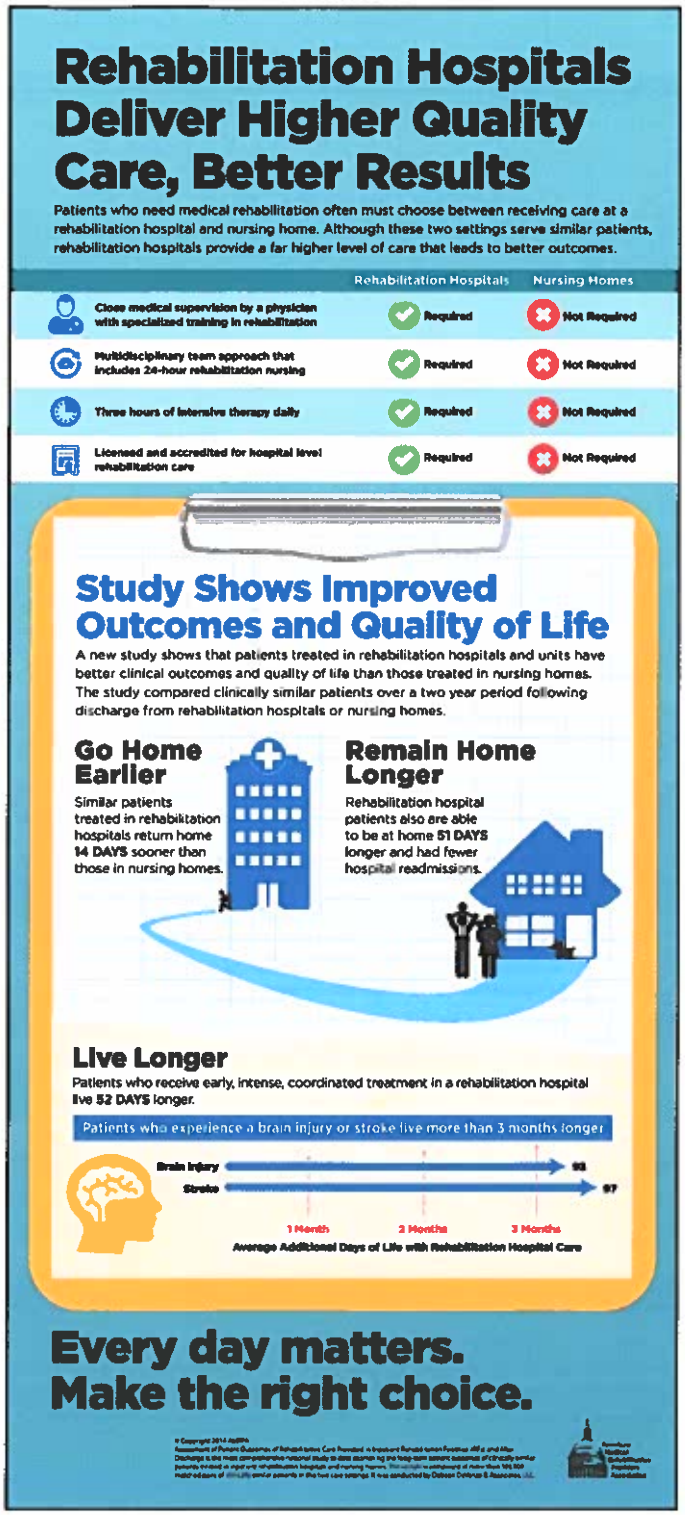
The Quad Cities Rehabilitation Institute, LLC

Exhibit A



Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

Exhibit A

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.
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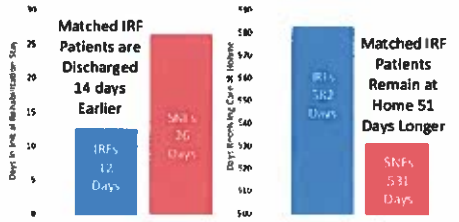
Synopsis of Key Findings

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*[3]

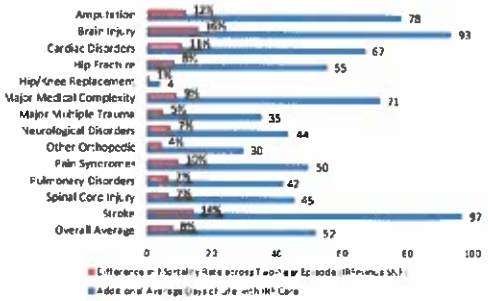


*Days treated in the home represents the average number of days per patient over two-year study period not spent in a hospital, IRF, SNF, or LTCH.

- 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[2] During Episode[4]



*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

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

Exhibit B

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.

Purpose of the Project
The Quad Cities Rehabilitation Institute, LLC

Exhibit B

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 Quad Cities Rehabilitation Institute, LLC

1. Renovate in-hospital space at Trinity Rock Island to expand the footprint of the inpatient rehab unit to space previously used for skilled nursing services.

This option was considered and rejected for a number of reasons. One such reason was that when you consider the overall facility space and infrastructure limitations of the 5th floor of the main hospital tower (a building that was originally designed and constructed for general medical/surgical patients more than 50 years ago) it is clear that this option would be less efficient and, ultimately, more costly. The use of renovated, outdated space to house specialty inpatient rehab services contrasts dramatically with the proposed construction of a new state-of-the-art freestanding rehab hospital designed and built solely to care for patients in need of inpatient rehab services. The potential impact or limitations on patient care, as well as the secondary impact of not being able to reallocate and utilize that space to meet other facility needs, undermined the attractiveness of this alternative.

Consider that the proposed new inpatient rehab hospital will not only provide needed services to HSA10 patients, but the closing of the Trinity Rock Island inpatient rehab unit will free up much-needed space for the hospital to use as it modernizes and renovates its existing patient units, with the vacated rehab unit providing 'flex space' to temporarily house med/surg rooms during the hospital-wide renovation. For these reasons, this alternative was rejected.

2. "Do nothing". Instead, maintain status quo and limit availability and accessibility to adult inpatient rehab beds despite Trinity's recognition (as the sole provider in HSA10) that there is a gap in care for HSA10 patients as well as Illinois patients beyond the HSA who currently rely on Trinity Medical Center for their healthcare needs.

There is an unquestionable need for access to these services. Maintaining the status quo would result in no enhanced access for patients currently foregoing rehab services post-discharge; choosing to utilize less intensive services such as SNF in lieu of rehab, when needed; or traveling outside their home community for inpatient rehab care (either to distant Illinois rehab hospitals or out-of-state to Iowa). The abysmally low utilization of inpatient rehab services for HSA10 residents compared to residents statewide was previously documented. Similarly, the benefits of inpatient rehab services compared to less-intensive SNF care was previously documented. In both instances, it is clear that HSA10 residents and Illinois residents outside the HSA who depend on Trinity for their healthcare needs need access to, and will benefit from, the proposed project.

For the few patients who are able and willing to travel outside their local community for inpatient rehab care, the status quo is not a viable option either. The closest provider, geographically, is in Iowa, and that provider focuses on a limited number of rehab services. Notably, when assessing whether this should be considered a viable option for the Illinois residents requiring access to this care, for the limited services offered, the Iowa hospital's outcomes have dropped below national rates in recent months. For the patients remaining in Illinois for inpatient rehab care, they are forced to travel significant distances which limits the participation of their family in their rehab and recovery process. As previously documented, the role of the patient's family is a critical component of the rehab inpatient stay. (*See* Attachment 12, item 4b. Applicant's existing inpatient rehab programs are too distant.)

Conversely, the approval of the proposed freestanding rehab hospital 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 Trinity and Encompass, bringing the strength and support of two health care entities to the proposed project, one of which is a national leader in the quality provision of this important care. The proposed project will be supported and strengthened by the proven policies, procedures, infrastructure, expertise, and commitment to local communities provided by both Trinity and Encompass. For these reasons, this alternative was rejected.

3. Submit a CON Application for the Establishment of a Smaller Facility.

The applicants considered the establishment of a facility of less than 40 beds, but 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 11-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, Trinity and Encompass did not consider a facility of less than 40 beds to be a viable option, particularly considering the quantified need for 41 beds in the analyses presented previously. Developing a quality rehabilitation hospital within the identified cost per square foot standards established by Illinois is already incredibly difficult and to build a smaller facility that included all of the space and equipment that is clinically necessary to provide the positive outcomes for which we strive would further exacerbate the delta between the standard and the expense.

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 comprehensive inpatient rehab beds, and that the proposed joint venture hospital between Trinity and Encompass is best positioned to address the residents' needs. For these reasons, this alternative was rejected.

4. 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 inpatient rehab services. Consistent with Ill. Admin. Code Section 1110.110 (d)(1)(b), this project will be a joint venture that brings together two 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. Moreover, this Project will ultimately allow for better utilization of the existing facility (another core tenet of the CON program) and meaningfully increase access to necessary and quality care, especially for underserved and indigent communities. This is the best project to meet the needs of the community, as a whole.

Size of the Project
The Quad Cities Rehabilitation Institute, LLC

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	606.6	24,264	525-660 GSF	26,400	Yes
Pharmacy	1	22.1	884	N/A	N/A	N/A
PT/OT/ST	N/A	N/A	6,306	N/A	N/A	N/A
Reviewable Space Total			31,454			
Non-Reviewable Space			16,368			
Total Proposed GSF			47,822			

Attachment 14
Page 1

Encompass Health Hospital of Moline, IL		11/25/2019
Room Name	**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	345	
a) 2) Lobby	628	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		Lobby includes Reception desk. Those waiting will have access to the receptionists telephone as needed.
Waiting		Provided in Lobby
WC Storage	83	
Men's Public Restroom	228	
Women's Public Restroom	213	
a) 3) Interview Space	232	Interviews will take place in Family Conference Room.
a) 4) General or Individual Office		The Admin. Suite is located adjacent to the Lobby and provides offices for administrative personnel.
HR Office	112	
HR Storage	66	
Admissions Office	122	
Admissions Office	101	
Admin. Assistant and Waiting	139	
Admissions Work Area	195	
CEO	172	
CFO	110	
Business Development	110	
Medical Director	108	
Marketing Dir	108	
Director of Quality	110	
Controller	130	
PASC	95	
a) 5) Multipurpose Room	448	The Admin multipurpose room is designated for conferences, meetings and education purposes including a TV for visual aid.
a) 6) Medical Library Facilities	130	Medical Resources are located in the Admin. Suite
a) 7) Storage Areas	36	Admin. Storage is located adjacent to Admin. Suite
b) Medical Records Unit (HIMS)	258	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	82	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
c) 3) Radiology Suite		N/A
c) 4) Pharmacy Suite	485	Pharmacy provided in the nursing unit.
c) 4) A) Administrative functions		Work space is provided for administrative functions, including requisitioning, recording and reporting, receiving, storage (including refrigeration) and accounting.
c) 4) B) Quality Control Area		No bulk compounding or packaging functions are performed.

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
c) 5) Physical Therapy Suite		
c) 5) A) Shared Spaces		Physical Therapy and Occupational Therapy share the use of the ADL suite.
c) 5) B) I) Office Space	96	A director of therapy office is provided within the Therapy Gym
c) 5) B) ii) Waiting Space		All patient rooms are private patient rooms, patients will wait in their rooms until their pre- scheduled time.
c) 5) B) iii)Treatment Areas	80 / each Area 123 / Room	3 Treatment Areas are provided; 2 curtained Treatment Areas and 1 Treatment Room. Hand washing station are easily located to the curtained Treatment Areas and a handwask sink is provided in the Treatment Room
c) 5) B) iv) Wet and Soiled Linen	69	A soiled linen room is provided for the collection of wet and soiled linen and other material.
c) 5) B) v) Exercise Area	3634	An exercise area is provided in the therapy gym and the therapy yard.
c) 5) B) vi) Storage for Clean Linen, Supplies, Equipment	26	Clean linen cabinets are provided for linen, supplies and equipment.
c) 5) B) vii) Patient Dressing Area and Toilet Rooms	50	This is an inpatient only hospital and therefore patients will dress in their private rooms. Patients have an assigned schedule time and will be ready ahead of arriving at the Therapy Gym. A toilet room is provided in the Gym
c) 5) B) viii) Wheelchair and Stretcher Storage	93	Wheelchair and stretcher storage is provided outside charting.
c) 5) B) ix) Showers, Lockers, Service Sinks		Showersand lockers are not provided in the Therapy gym due to this being an inpatient only hospital and each patient has their own private shower and wardrobe storage in their room.
c) 6) Occupational Therapy Suite		An ADL Suite is provided within the Therapy Gym
c) 6) A) Shared spaces		Physical Therapy and Occupational Therapy share the use of the ADL suite.
c) 6) B) I) Office Space (Charting)	96 Dir Office 379 Charting	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	320	Kitchen, bathroom, bedroom, and laundry spaces are provided
c) 6) B) iv) Patient Toilet Room	89	Provided adjacent to the ADL suite.
d) Nursing Unit		
d) 1) Patient Rooms	219 / 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 164 sq. ft.
d) 1) C) Minimum 3 feet clear at foot and sides of each bed		4 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
d) 2) Nurses' Service Center		

d) 2) A) Nurses' Station	354	A nurses' station with a work counter, storage areas, and communications equipment is provided.
d) 2) B) Nurses' Office	159	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	145	Charting facilities are provided for nurses and doctors, including a work counter and charting racks.
d) 2) E) Staff Lounge	400	Staff lounge with a bathroom is provided. Men's and Women's toilet rooms are provided.
d) 2) E) Men's Staff Tlt Room	60	Men's Locker Room and Shower Room provided central to both Nursing Units
d) 2) E) Women's Staff Tlt Room	60	Women's Locker Room and Shower Room provided central to both Nursing Units
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 and locker rooms.
d) 2) G) Multipurpose Room	231	A multipurpose room is provided for conferences, demonstrations, and consultation. This room is located within the bed wing of the nursing unit.
d) 2) H) Exam room		This room is omitted because all patient rooms are single bedrooms.
d) 2) I) One tub or shower for each 12 beds		Not applicable as each patient room has a private toilet/shower room within their private patient room.
d) 2) J) Nourishment Station	117	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)	119, 140	Within this secured access room there are self-contained Pyxis units. The first meds room is under the nursing staff's visual control due to its adjacent location to the main nurse station. The second Meds room is video monitored; both have access controls.The Meds room contains a work counter, refrigerator, and locked storage for biologicals and drugs.
d) 3) Service Area		
d) 3) A) Clean Workroom	143	A clean work room is provided in each 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
d) 3) B) Clean Linen Storage	89, 61	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	48, 28, 39	Parking is provided in alcoves for stretchers and wheelchairs out of the path of normal traffic.
d) 3) D) Soiled Workroom	213	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
Soiled Hold	69, 85	A Soiled Hold room is provided in the Therapy Gym, Back-of-House
d) 3) E) Equipment Storage	162, 170	Rooms for the storage of equipment such as IV stands, inhalators, mattresses and walkers is provided.
d) 3) F) Emergency Equipment Storage	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. Sitz baths are not required by the program narrative.
d) 4) Isolation Room	310	1 room is 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. All isolations rooms are private rooms and are otherwise planned as required for a standard patient room

Isolation Room Ante Rooms	51	4 Isolation Ante Rooms are provided 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	219	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 room is located in a private room adjacent to
e) Intensive Care Units		N/A
f) Pediatric Nursing Unit		N/A
g) Psychiatric Nursing Unit		N/A
h) Newborn Care Unity		N/A
I) Surgical Suite		N/A
j) Obstetrics and Neonatal Suite		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.)	233	Emergency Exam room is provided in the Nursing Unit for emergency care.
k) (1) entrance		A sheltered entrance at grade level is provided with pedestrian and ambulance access.
k) (4) treatment area		The treatment area contains a handwashing sink trimmed with valves that are aseptically operated (knee or 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	42	Provided adjacent to the Exam room
l) Outpatient Department		N/A
m) Service Departments		
m) 1) Dietary Facilities		
m) 1) A) General		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
m) 1) B) Functional Elements		
m) 1) B) i) Control Station for Receiving Food Supplies		Area in Kitchen dry strorage used for receiving and unpacking.
m) 1) B) ii) Storage Space	219, 184	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	682	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	1600	Dining space provided for ambulatory patients, staff, and visitors.
m) 1) B) vii) Warewashing Space	250	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	74	
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		Waste is not stored, close proximity to dumpsters outside facilitate immediate disposal. Collection of waste is not part of the functional program.

m) 1) B) xi) Offices or Desk Spaces	97	An office is provided for the dietary service manager.
m) 1) B) xii) Men's and Women's Toilets Accessible to Dietary Staff	67, 69	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	18	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		A receiving area included in Central Supply per functional program
m) 2) C) General Storage Rooms	466	General storage rooms meet the needs of the hospital located in back of house and throughout facility.
m) 2) D) Office Space		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		Off-site processing is used.
m) 3) B) I) Soiled Linen Holding Room w/ Hand-Washing Facilities	85	A soiled linen holding room with facilities for hand-washing is provided.
m) 3) B) ii) Clean Linen, Receiving, Inspection and Storage Rooms	89	Clean linen, receiving, inspection and storage rooms are provided.
m) 3) B) iii) Cart Storage		Cart Storage in Clean Linen in bedwing
m) 3) B) iv) Office Space	133	
m) 4) Facilities for Cleaning and Sanitizing Carts		Provided in Service Yard
m) 5) Employees' Facilities	82	Locker Room provided with lockers. Locker room adjacent to Men's and Women's Toilets. Showers not required with functional program.
m) 6) Janitors' Closets	121	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 [illegible]
m) 7) Engineering Service and Equipment Areas		
m) 7) A) Rooms or separate buildings for boilers, mechanical equipment, and electrical equipment	170, 188, 207, 572	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	321	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	35	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		N/A
m) 9) Storage	106	Suitable storage is provided per functional program.
Spaces Not Listed in Administrative Code 250:		
Dialysis Suite	696	Consisting of 4 Treatment Areas, Nurse Station, two handwashing sinks (one upon entry and another at the nurse station), Equipment Storage, and a linen distribution system are provided within the suite. Easily accessible Wheelchair Storage, Janitors Closet, and Staff Toilet are across the hall.
Dialysis Patient Toilet		included in suite

Dialysis Clean and Soiled Carts		Provided within the suite as part of a distribution system.
Speech Rooms	130	3 Provided
Bariatric Rooms	310 /Each	2 Bariatric Patient Rooms are provided with FGI 2018 spacing accommodations.

Project Services Utilization
The Quad Cities Rehabilitation Institute, LLC

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1	Rehab Hospital	N/A	9,490 Days, 65.0% Occ.	85%	No
YEAR 2	Rehab Hospital	N/A	12,425 Days, 85.1% Occ.	85%	Yes

The projected utilization is based on the need for 40 additional beds to be located in and primarily serve residents of HSA10, and further supported by the physician and patient letters attached and also to be provided under separate cover.

UnityPoint Health

Dee Ahuja, MD
Chief Medical Officer
Regional Vice President Medical Director

UnityPoint Health® – Quad Cities Trinity
2701 17th Street
Rock Island, IL 61201
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Deepak.Ahuja@unitypoint.org
unitypoint.org

December 9, 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 Quad Cities Rehabilitation Institute, LLC's Proposal to Establish a 40-bed Comprehensive Physical Rehabilitation Hospital in Rock Island County, HSA10

Dear Ms. Avery,

I am the Chief Medical Officer for UnityPoint Health–Trinity, Regional Vice President /Medical Director of the UnityPoint Clinics Quad Cities/Muscatine, and the Regional Medical Director for Accountable Care and Utilization. I represent and serve affiliated physicians, ancillary providers, inpatient and outpatient facilities, and employers on a daily basis to provide clinical leadership and administrative oversight and support. My focus, in collaboration with all of my healthcare partners, is to ensure quality, positive patient experiences, and affordable care.

In all of my professional capacities I am writing to express my support for The Quad Cities Rehabilitation Institute's proposal to build a 40-bed Comprehensive Physical Rehabilitation Hospital in Rock Island County. UnityPoint Health-Trinity is committed to building an integrated health delivery system in the Quad Cities market to continuously improve population health. We have made considerable progress towards that goal by integrating physicians and advanced practice providers in our accountable care organization, as well as growing our network of inpatient and outpatient facilities and practice locations throughout the area.

We strive for active communication and collaboration between all practitioners, regardless of their location or specialty to ensure we provide highly coordinated care is achieved for every patient across the continuum. Whether the physician is office-based or hospital-based, primary care or specialist, the entire team strives to assure the best possible course of care and treatment

for all patients and their families, inclusive of the post-acute discharge plan. The lack, however, of adequate, state of the art comprehensive rehabilitation beds in the Quad Cities market is a significant gap in our delivery system. Those patients who would benefit from comprehensive inpatient rehabilitation have very limited options to receive such care, and as a result are discharged to a skilled nursing facility, home health, or other less adequate locations for post-acute care. While the existing inpatient rehabilitation program at UnityPoint Health-Trinity Rock Island hospital provides excellent care, the unit is small, outdated, and in dire need of space for the advanced equipment technologies and private rooms for all patients needing inpatient rehabilitation. The existing inpatient rehab space could be used for other necessary services or to accommodate the hospital's med/surg patients during phased renovations once the new inpatient rehabilitation hospital is built.

All of our physician and advanced clinicians endorse and promote evidence-based clinical practices for all of their patients. For example, it is widely recognized that the best opportunity to achieve optimal physical and cognitive function and recovery for stroke patients is the provision of advanced, comprehensive inpatient rehabilitation. The interdisciplinary team approach in a comprehensive inpatient rehab hospital surpasses all other post-acute delivery models for optimal outcomes for patients suffering from traumatic brain injuries, neurological conditions, spinal cord injuries, amputations, hip fractures and so many other conditions. This interdisciplinary team includes physical, occupational and speech therapists (who provide three hours of therapy per day), along with physical medicine rehabilitation physicians (physiatrists) and rehab specialty trained nurses.

The proposed Quad Cities Rehabilitation Institute, a joint venture partnership between UnityPoint Health-Trinity Medical Center in the Quad Cities, the major healthcare leader in the region, and Encompass Health, the nation's leader in comprehensive inpatient rehabilitation, will undoubtedly provide a solution to the existing gap in the continuum of care for all the citizens who reside in this market. My colleagues and I strongly support and encourage the Health Facilities and Services Review Board of the Illinois Department of Public Health to approve this Certificate of Need to build a new free-standing comprehensive inpatient rehabilitation facility. We look forward to serving the needs of all patients who would benefit from this level of advanced rehabilitation care in our community.

Sincerely yours,

Deepak Ahuja, MD
Chief Medical Officer
UnityPoint Health-Trinity
Regional Vice President
UnityPoint Clinic - Quad Cities/Muscatine

UnityPoint Health
Trinity

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December 3, 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 Quad Cities Rehabilitation Institute, LLC's Proposal to Establish a 40-bed Comprehensive Physical Rehabilitation Hospital in Rock Island County, HSA10

Dear Ms. Avery,

I am a Board-Certified Internist and Medical Director of the UnityPoint Health – Trinity Hospitalist Group which includes 25 physicians and 5 Advanced Nurse Practitioners. We care for patients at UnityPoint Health – Trinity hospitals in the Quad-Cities area, including Trinity Rock Island and Trinity Moline in Illinois and Trinity Bettendorf and Trinity Muscatine in Iowa.

Our medical group cares for thousands of patients each year from Rock Island, Mercer, and Henry Counties, the three counties that comprise HSA10 in the State of Illinois. Additionally, we care for patients from contiguous Iowa counties and surrounding Illinois counties as well since residents of the greater Quad Cities area rely on UnityPoint Health hospitals for their healthcare needs.

In our role as Hospitalists for the UnityPoint Health – Trinity hospitals, we are involved in the care and treatment for the vast majority of patients admitted to our four Trinity hospitals. We collaborate with other physician specialists such as neurologists, cardiologists, surgeons, and pulmonologists who provide consultative coverage and coordination of the overall plan of care for every patient. While we admit and discharge the majority of patients hospitalized at UnityPoint Health - Trinity facilities, the entire multi-disciplinary team of specialists works together to assure the continuum of care is established for every patient, including the post-acute plan of care which is required for all patients. The post-acute plan of care often includes comprehensive inpatient rehabilitation, skilled nursing care, home-health care, or outpatient services to meet the patients' ongoing medical needs.

Unfortunately, however, too few of the patients we see who are in need of, and would benefit from, intensive inpatient therapy do not receive that level of care. A primary reason is that there are too few inpatient rehab beds available and accessible close to our patients' homes. Therefore, all too often patients needing the intensity of therapy and nursing care that inpatient rehab

hospitals provide are instead discharged to a skilled nursing facility, nursing home, or home care where intensive rehab and recovery therapy services are simply not provided. Additionally, numerous patients unfortunately forego needed rehab care altogether.

This gap in care adversely impacts the patient's outcome and ability to fully recover. Examples of the adverse impact on patients in need of intensive inpatient rehab but who do not receive that level of care is a much slower recovery; the inability to return to the highest level of cognitive and physical functioning; increased risk of complications including infections and falls; and higher rates of readmission back to the acute care hospital, to name just a few.

As I'm sure you're aware, it is important for patients and families to have needed health care services close to home, particularly the type of inpatient rehab service proposed in this instance. Our patients want to remain in their community and close to home so their family and friends can visit and participate in their rehab therapy, which is a vitally important component of inpatient rehab that supports the overall goal of a patient's return to their highest level of functionality and independence.

Currently we have limited comprehensive inpatient rehab capabilities for our patients, even within Trinity Rock Island's own inpatient hospital-based unit. The existing unit at Rock Island is outdated, with the majority of the patient beds in semi-private rooms where space is limited. Additionally, the therapy gym is small and the unit's overall footprint does not easily allow for expansion of the gym or the addition of new and advanced equipment and technology. Because of these facility limitations and the need for private rooms for optimal patient care and recovery, Rock Island's inpatient rehab program has had declining admissions despite the unmet need for inpatient rehab care for residents of the Quad-Cities communities.

I'm proud of UnityPoint Health – Trinity for partnering with Encompass Health to ensure that a new, state-of-the-art freestanding hospital will be built in our local community to care for local residents. The new hospital will not only provide needed services to our patients, but the closing of the Rock Island inpatient rehab unit will free up much-needed space for the hospital to use as it modernizes and renovates its existing patient units which currently include semi-private rooms.

For all of these reasons, I strongly support and recommend the approval of this CON request to build a dedicated, comprehensive inpatient rehab hospital in Rock Island County, Illinois to better serve the residents of our community.

Sincerely yours,

Toyosi T. Olutade, MD
Medical Director, Hospitalist Group
UnityPoint Health – Trinity

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

Applicable service-specific criteria follow. The relevant criteria are presented in **bold font** for ease of review.

a) 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 calculated need for 11 beds in HSA10; and
- Provide a dedicated rehab hospital as a local service for Illinois residents so that residents do not continue foregoing needed inpatient rehab care in the future, *i.e.*, close the identified gap in care for HSA10 and surrounding areas' residents.

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.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

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 HSA10. Letters of support and the bed need analysis evidence that the vast majority of discharges (approximately 65%) will come from HSA10. The need for the new facility and the support for the proposed project are documented in the letters of support provided by physicians and community leaders living and practicing within HSA10.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

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 HSA10 and the Quad Cities area support the proposed project and intend to refer patients to the project, as shown in the following letter of support and letters that will be provided under separate cover.

Due to the limitations of Trinity's existing facility, patients are currently foregoing rehab services post-discharge, choosing to utilize less intensive (and therefore less optimal) services such as SNF or home health care in lieu of rehab, when needed; or, leaving their home community to receive rehab care. For those reasons, data documenting the number of rehab-appropriate HSA10 residents by ZIP Code follows, further supporting the need for the proposed project and the expected high utilization by Project Year 2.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

HSA10 Rehab-Appropriate Discharges by ZIP Code January 2018 - December 2018	
Resident ZIP Code	**Rehab-Appropriate Discharges**
61201 - ROCK ISLAND	1,338
61204 - ROCK ISLAND	20
61231 - ALEDO	236
61232 - ANDALUSIA	34
61233 - ANDOVER	13
61234 - ANNAWAN	37
61235 - ATKINSON	49
61238 - CAMBRIDGE	87
61239 - CARBON CLIFF	21
61240 - COAL VALLEY	206
61241 - COLONA	237
61242 - CORDOVA	38
61244 - EAST MOLINE	895
61254 - GENESEO	367
61256 - HAMPTON	53
61257 - HILLSDALE	47
61258 - HOOPPOLE	5
61259 - ILLINOIS CITY	37
61260 - JOY	30
61262 - LYNN CENTER	30
61263 - MATHERVILLE	17
61264 - MILAN	366
61265 - MOLINE	1,465
61266 - MOLINE	7
61272 - NEW BOSTON	63
61273 - ORION	116
61274 - OSCO	13
61275 - PORT BYRON	124
61276 - PREEMPTION	4
61278 - RAPIDS CITY	15
61279 - REYNOLDS	38
61281 - SHERRARD	80
61282 - SILVIS	326
61284 - TAYLOR RIDGE	79

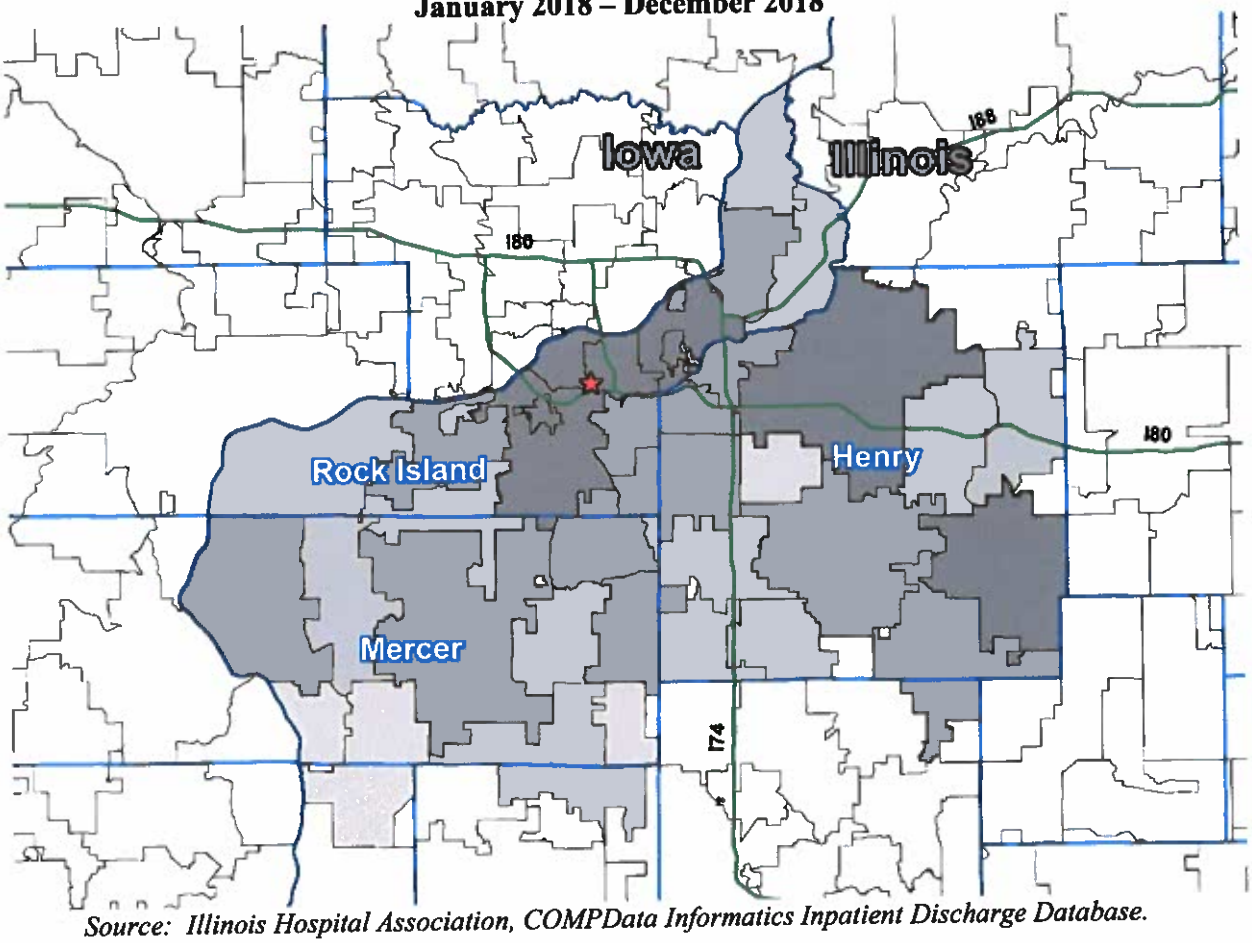
Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

HSA10 Rehab-Appropriate Discharges by ZIP Code January 2018 - December 2018	
Resident ZIP Code	**Rehab-Appropriate Discharges**
61412 - ALEXIS	40
61413 - ALPHA	40
61419 - BISHOP HILL	8
61434 - GALVA	99
61442 - KEITHSBURG	22
61443 - KEWANEE	420
61465 - NEW WINDSOR	61
61466 - NORTH HENDERSON	11
61468 - OPHIEM	2
61476 - SEATON	14
61486 - VIOLA	45
61490 - WOODHULL	39
Total	**7,294**
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 HSA10 residents. (*Please note*: The darker the color, the greater the number of rehab-appropriate discharges in that ZIP Code.)

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

HSA10 Rehab-Appropriate General Acute Care Discharges by ZIP Code
January 2018 – December 2018



Source: Illinois Hospital Association, COMPData Informatics Inpatient Discharge Database.

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;

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

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 Quad Cities Rehabilitation Institute, LLC is being proposed to improve access to needed rehab services for planning area residents. HFSRB has identified a need for eleven (11) beds based solely on the historically-low utilization of Trinity Rock Island's current unit. However, as discussed previously, the HFSRB methodology projects future need based solely on historical utilization of inpatient rehab beds in the state. Thus, the HFSRB bed need methodology understates actual demand for the service because there is no way for HFSRB to identify the 'gap in care' that exists in each planning region. Rather, HFSRB relies on providers, with knowledge of the individual market dynamics, to determine if there is a gap in care, and if so, to quantify that gap in care.

This application does just that. As documented in Attachment 12, HSA10 residents face a significant and long-term gap in inpatient rehab care that is worsening as the population ages.

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:

- Utilization rates of inpatient rehab services for Medicare beneficiaries in HSA10 are significantly below state and national averages and are trending downward compared to state and national rates that have remained relatively flat over the past decade. (*See* Figure 4, Attachment 12.)

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

- The population in HSA10 ages 65 and older is increasing significantly in the service area, projected to increase by 21% from 2015 to 2024. (*See* Table 2, Attachment 12.) This trend will continue to increase the need for inpatient rehab services as Medicare recipients, consisting mainly of residents ages 65 and older, are the leading patient population requiring inpatient rehabilitation services

- All existing providers of inpatient rehab services that could be considered alternatives to UnityPoint's existing inpatient rehabilitation unit are located either an hour or more away in Peoria or Rockford, or out-of-state in Iowa. While the Iowa facility is the geographically closest alternative provider of inpatient rehabilitation services to HSA10 residents, the facility there (Genesis Medical Center) reportedly focuses on a limited number of services, and for those limited services offered has experienced a lower rate of successful return to home and the community than the national average in recent years according to Medicare's Inpatient Rehabilitation Facility (IRF) Compare site.

- The above statistics and facts 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 Quad Cities Rehabilitation Institute, 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 as the Trinity Rock Island inpatient rehab unit is the only provider of inpatient rehab services in the entirety of HSA10. All other existing providers are located either an hour away or out-of-state in Iowa.

Trinity Medical Center's proposed freestanding inpatient rehab hospital, in partnership with Encompass Health, will expand upon the foundation of Trinity's existing inpatient rehab service in order to provide locally accessible and available services for HSA10 residents, as well as meeting the need for intensive inpatient rehab services for the patient population that Trinity currently serves from surrounding areas, including the greater Quad Cities area.

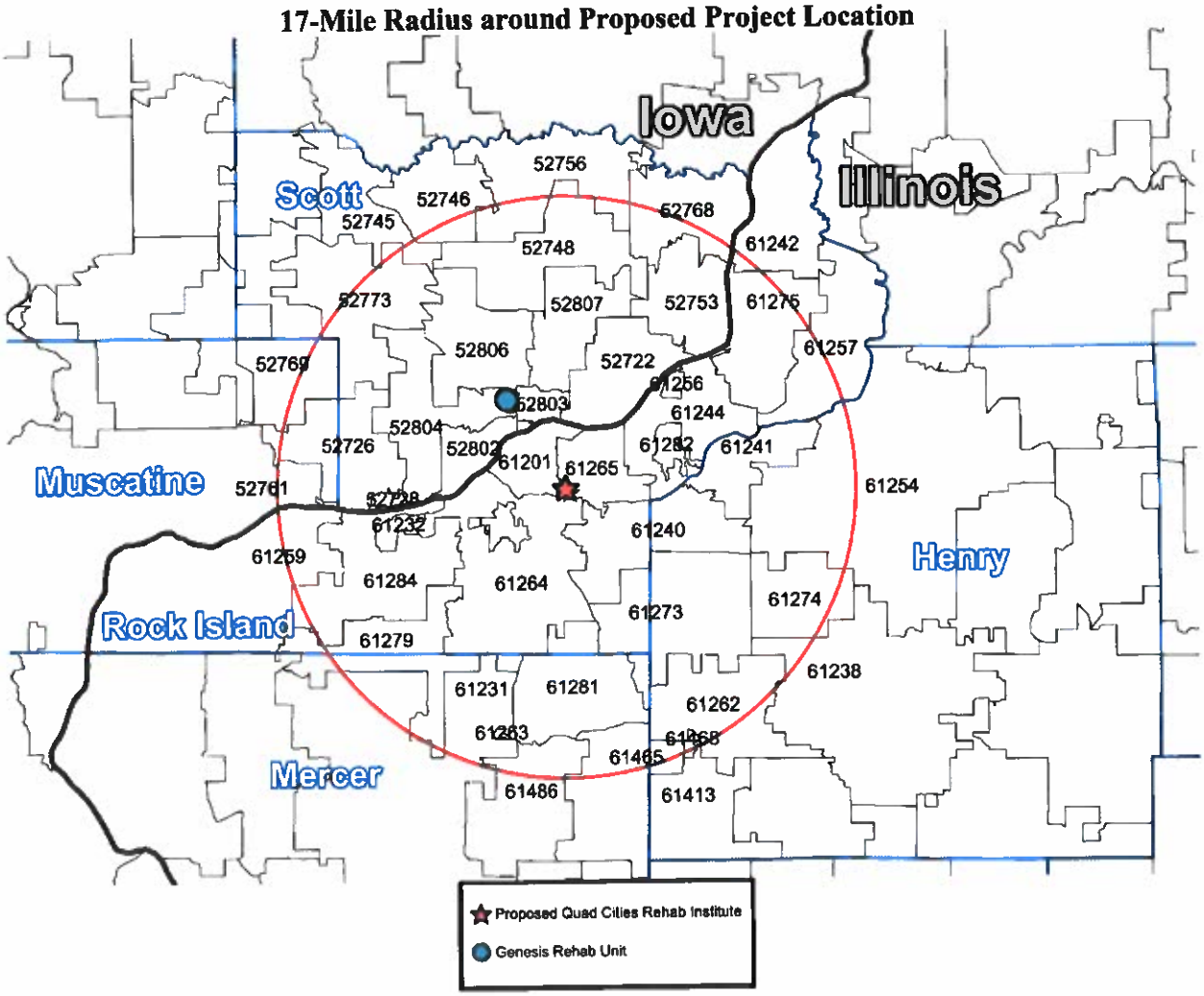
The following ZIP Code map shows the proposed new hospital that will be located adjacent to Trinity Moline. Only one other provider of inpatient rehab services is located within the 17-mile radius, which is the Genesis Medical Center rehab in-hospital unit in Davenport, Iowa.

Notably, the population within the 17-mile radius of the proposed The Quad Cities Rehabilitation Institute is representative of the patient population that Trinity Medical Center current serves at its four hospitals in the Quad Cities area, comprised of nearly 400,000 residents.

Trinity Medical Center will file at a later date a Certificate of Exemption for the discontinuation of its existing 22-bed inpatient rehabilitation service contingent upon the approval and opening of the proposed The Quad Cities Rehabilitation Institute project.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

17-Mile Radius around Proposed Project Location



ZIP Codes within 17-Mile Radius of Proposed Rehab Hospital Site					
ZIP Code	State	County	City	2019 Population	2024 Population
52722	IA	Scott	Bettendorf	38,327	39,677
52726	IA	Scott	Blue Grass	4,653	4,772
52728	IA	Scott	Buffalo	1,093	1,147
52745	IA	Scott	Dixon	588	590
52746	IA	Scott	Donahue	1,053	1,071
52748	IA	Scott	Eldridge	10,150	10,796
52753	IA	Scott	Le Claire	5,943	6,236

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

ZIP Codes within 17-Mile Radius of Proposed Rehab Hospital Site					
ZIP Code	**State**	**County**	**City**	**2019 Population**	**2024 Population**
52756	IA	Scott	Long Grove	2,057	2,086
52761	IA	Muscatine	Muscatine	30,736	31,045
52768	IA	Scott	Princeton	1,388	1,404
52769	IA	Muscatine	Stockton	674	680
52773	IA	Scott	Walcott	2,395	2,425
52802	IA	Scott	Davenport	10,497	10,551
52803	IA	Scott	Davenport	22,170	22,258
52804	IA	Scott	Davenport	26,627	27,078
52806	IA	Scott	Davenport	29,387	30,173
52807	IA	Scott	Davenport	14,945	15,599
61201	IL	Rock Island	Rock Island	37,835	37,349
61231	IL	Mercer	Aledo	5,112	5,000
61232	IL	Rock Island	Andalusia	1,310	1,306
61238	IL	Henry	Cambridge	3,331	3,285
61240	IL	Rock Island	Coal Valley	5,812	5,785
61241	IL	Henry	Colona	6,921	6,874
61242	IL	Rock Island	Cordova	1,132	1,108
61244	IL	Rock Island	East Moline	23,960	23,609
61254	IL	Henry	Geneseo	11,179	11,120
61256	IL	Rock Island	Hampton	1,746	1,757
61257	IL	Rock Island	Hillsdale	1,120	1,090
61259	IL	Rock Island	Illinois City	1,223	1,199
61262	IL	Henry	Lynn Center	1,016	1,005
61263	IL	Mercer	Matherville	665	648
61264	IL	Rock Island	Milan	10,281	10,190
61265	IL	Rock Island	Moline	43,886	43,440
61273	IL	Henry	Orion	3,289	3,275
61274	IL	Henry	Osco	339	334
61275	IL	Rock Island	Port Byron	4,707	4,770
61279	IL	Rock Island	Reynolds	1,040	1,024
61281	IL	Mercer	Sherrard	2,530	2,490
61282	IL	Rock Island	Silvis	7,645	7,618
61284	IL	Rock Island	Taylor Ridge	2,354	2,334
61413	IL	Henry	Alpha	1,043	1,029
61465	IL	Mercer	New Windsor	1,161	1,139
61468	IL	Henry	Ophiem	94	93

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

ZIP Codes within 17-Mile Radius of Proposed Rehab Hospital Site					
ZIP Code	**State**	**County**	**City**	**2019 Population**	**2024 Population**
61486	IL	Mercer	Viola	1,473	1,447
Total				**384,887**	**387,906**

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. Rather, HSA10 residents will have the appropriate number of inpatient rehab beds per population following opening of the 40-bed hospital. As shown below, the HSA10 beds per 1,000 population for ages 65 and older will be only slightly above the statewide rate in 2025 with the statewide rate experiencing a decrease over time due to the aging of the population statewide and only the addition of the new beds associated with this project.

Beds per 1,000 Population Ages 65+		
Geographic Region	**2020 (Current Beds)**	**2025 (With 18 New Beds)**
HSA10	0.504	0.827
Statewide	0.714	0.625

Sources: Inventory of Health Care Facilities and Services and Need Determinations, HFSRB 9/1/2019 and 10/23/2019 Update and Illinois Department of Public Health Certificate of Need Population Projections, 2014.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

The proposed Year 2 85.1% occupancy of The Quad Cities Rehabilitation Institute further demonstrates that the proposed project will not result in maldistribution of services, but instead will ensure that HSA10 residents and residents in the greater Quad Cities area who currently rely on UnityPoint for their healthcare needs have needed inpatient rehab services locally available and accessible.

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.

The proposed 40-bed freestanding hospital will take the place of, and expand, the inpatient rehab services of the sole inpatient rehab unit in the defined HSA10 service area, Trinity Rock Island. Thus, the project will not and cannot lower the utilization of any other area provider in Illinois, because there is not one.

Absent the addition of beds, HSA10 residents will continue to either forego needed rehab services altogether or, alternatively, travel outside their local community for care, neither of which are viable options for patients in a community with an increasing population ages 65+.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

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.

Trinity Medical Center and Encompass Health both have in place numerous innovative approaches to recruit and retain staff members at their hospital facilities, thus The Quad Cities Rehabilitation 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. Additionally, existing Trinity inpatient rehab unit staff will also have the opportunity to transition over to the new The Quad Cities Rehabilitation Institute. As well, Trinity's own College of Nursing and Health Sciences is a resource for developing and training clinical staff. Moreover, because of the significant resources associated with Trinity's affiliation with UnityPoint and Encompass' ability 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

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

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.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

Trinity College of Nursing & Health Sciences
Established in 1898, the College's long history of preparing health care professionals for clinical careers has established the Quad Cities area as a dynamic medical community. The College, affiliated with Trinity Regional Health System, offers four academic degree programs; Nursing (Bachelor and Master degrees), Health Sciences, Radiography and Respiratory Care. Trinity College of Nursing & Health Sciences, situated on a 4.5-acre campus in Rock Island, houses the Harriet Olson Learning Lab which utilizes simulation mannequins to best prepare students for real-life, dynamic clinical situations. Encompass Health will have the opportunity to collaborate with Trinity College to meet staffing needs and also develop continuing education opportunities.

Comprehensive Physical Rehabilitation Service Specific Criteria
The Quad Cities Rehabilitation Institute, LLC

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 Quad Cities Rehabilitation Institute's 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.

#19-059

Walter C. Smith
Director, State Regulatory
Affairs - Legal Services
9001 Liberty Parkway
Birmingham, AL 35242
205.970.7926
walter.smith@encompasshealth.com

Encompass Health

The Quad Cities Rehabilitation Institute, LLC
9001 Liberty Parkway
Birmingham, AL 35242

December 12, 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 Quad Cities Rehabilitation Institute, 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

Availability of Funds
The Quad Cities Rehabilitation Institute, LLC

The total estimated project cost is $33,812,822. The Applicant/Licensee will fund the project costs with cash and cash equivalents obtained from Encompass Health, the co-applicant. Encompass Health's existing internal resources are more than adequate funds for the proposed project as demonstrated in its letter of proof of funding and its most recent audited financial statements, which follow.

UnityPoint Health (ultimate parent to Trinity Rock Island) has sufficient internal resources to fund its share of necessary working capital as demonstrated in its letter of proof of funding and its most recent audited financial statements, which follow.

Please see the following letters confirming proof of project funding and most recent audited financial statements for Unity Point and Encompass Health.

#19-059

UnityPoint Health
Trinity

Katie Marchik
Senior VP/Chief Financial Officer
2701 17th Street
Rock Island, IL 61201
309-779-2218
Fax: 309-779-2399
E-Mail: Katie.Marchik@unitypoint.org

December 10, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: The Quad Cities Rehabilitation Institute, 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 Quad Cities Rehabilitation Institute, LLC Project costs will be entirely funded by Encompass Health Corporation, an Applicant, from internal cash resources including cash and equivalents.

2. Iowa Health System d/b/a UnityPoint Health, an Applicant, will fund a portion of the project until it achieves the target utilization of 85% of average annual occupancy as outlined in the application.

3. Iowa Health System d/b/a UnityPoint Health, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. 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,

Katie Marchik
Chief Financial Officer
UnityPoint Health - Trinity

#19-059

Encompass Health

9001 Liberty Parkway
Birmingham, AL 35242

205.967.7116
encompasshealth.com

December 12, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: The Quad Cities Rehabilitation Institute, 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 Quad Cities Rehabilitation Institute, LLC Project costs will be entirely funded by Encompass Health Corporation, an Applicant, from internal cash resources including cash and equivalents.

2. Encompass Health Corporation, an Applicant, will fund the necessary working capital and operating deficits through the first full fiscal year by which time the Project is expected to achieve the target utilization of 85% of average annual occupancy.

3. Encompass Health Corporation, 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 $1 Billion Revolving Credit Facility, of which more than $900 Million was available as of November 30, 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 revolving credit facility borrowings is the lowest cost option.

#19-059

9001 Liberty Parkway
Birmingham, AL 35242

205.967.7116
encompasshealth.com

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,

Edmund Fay
Senior Vice President and Treasurer
Encompass Health Corporation

Subscribed and sworn to before me this 12th day of December 2019.

Notary Public

CASSIE D. REED
MY COMMISSION EXPIRES
DECEMBER 20, 2020
NOTARY PUBLIC
STATE OF ALABAMA

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Consolidated Financial Statements

December 31, 2018 and 2017

(With Independent Auditors' Report Thereon)

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Table of Contents

KPMG LLP
4200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402

Independent Auditors' Report

To the Board of Directors
Iowa Health System and Subsidiaries
d/b/a UnityPoint Health:

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Iowa Health System and its subsidiaries d/b/a UnityPoint Health (the System), 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 consolidated financial statements in accordance 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Iowa Health System and its subsidiaries d/b/a UnityPoint Health as of December 31, 2018 and 2017, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in Note 1(v) to the consolidated financial statements, the System adopted new accounting guidance for ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, and ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*. Our opinion is not modified with respect to this matter.

Other Matter

Report on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The 2018 consolidating balance sheets and statements of operations and Affiliated Colleges' balance sheet and statement of operations are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Minneapolis, Minnesota
April 29, 2019

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Consolidated Balance Sheets

December 31, 2018 and 2017

(In thousands)

	2018	2017
Current assets:		
Cash and cash equivalents	$ 251,006	251,656
Short-term investments	21,782	19,528
Assets limited as to use – required for current liabilities	16,721	14,681
Patient accounts receivable, net	557,280	584,903
Other receivables	100,496	96,806
Inventories	83,889	77,618
Prepaid expenses	48,085	48,288
Total current assets	1,079,249	1,093,480
Assets limited as to use, noncurrent:		
Held by trustee under bond indenture agreements	2,171	1,162
Internally designated	1,204,365	1,263,275
Total assets limited as to use, noncurrent	1,206,536	1,264,437
Property, plant, and equipment, net	1,843,907	1,868,779
Other long-term investments	958,201	1,022,219
Investments in joint ventures and other investments	152,773	147,638
Contributions receivable, net	89,047	94,753
Other	91,826	80,176
Total assets	$ 5,421,539	5,571,482
Current liabilities:		
Current maturities of long-term debt	$ 62,658	154,574
Accounts payable	198,681	179,047
Accrued payroll	210,985	218,975
Accrued interest	8,752	10,215
Estimated settlements due to third-party payors	92,810	91,992
Other current liabilities	77,897	71,057
Total current liabilities	651,783	725,860
Long-term debt, net	1,042,488	1,046,036
Other long-term liabilities	382,076	420,664
Total liabilities	2,076,347	2,192,560
Net assets:		
Without donor restrictions:		
Attributable to UnityPoint Health	3,125,454	3,151,608
Attributable to noncontrolling interest	31,852	36,002
Total without donor restrictions	3,157,306	3,187,610
With donor restrictions:		
Attributable to UnityPoint Health	187,042	190,410
Attributable to noncontrolling interest	844	902
Total with donor restrictions	187,886	191,312
Total net assets	3,345,192	3,378,922
Total liabilities and net assets	$ 5,421,539	5,571,482

See accompanying notes to consolidated financial statements.

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2018 and 2017

(In thousands)

	2018	2017
Unrestricted revenue:		
Net patient service revenue	$ 4,075,430	3,816,086
Other operating revenue	324,611	329,798
Net assets released from restrictions used for operations	11,420	11,315
Total unrestricted revenue	4,411,461	4,157,199
Expenses:		
Salaries and wages	1,570,724	1,513,446
Physician compensation and services	662,784	618,991
Employee benefits	420,498	429,942
Supplies	725,630	662,072
Other expenses	707,691	667,124
Depreciation and amortization	241,334	247,005
Interest	38,754	38,234
Provision for uncollectible accounts	3,275	1,882
Total expenses	4,370,690	4,178,696
Operating income (loss)	40,771	(21,497)
Nonoperating gains (losses):		
Investment income (loss)	(87,642)	242,197
Contribution received in affiliations	34,806	41,771
Other, net	10,636	(119)
Total nonoperating gains (losses), net	(42,200)	283,849
Revenue over expenses before loss on bond refinancing transactions	(1,429)	262,352
Loss on bond refinancing transactions	(2,558)	—
Excess (deficiency) of revenue over expenses from continuing operations	(3,987)	262,352
Gain (loss) on discontinued operations	539	(32,840)
Excess (deficiency) of revenue over expenses	(3,448)	229,512
Less net income (loss) attributable to noncontrolling interest	5,979	(3,701)
Excess (deficiency) of revenue over expenses attributable to UnityPoint Health	(9,427)	233,213

(Continued)

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2018 and 2017

(In thousands)

	2018	2017
Net assets without donor restrictions:		
Excess of revenue over expenses	$ (9,427)	233,213
Change in the fair value of interest rate swaps	1,360	2,340
Net assets released from restrictions used for capital expenditures	10,120	11,782
Change in defined benefit pension plan gains and losses and prior costs and credits	(28,895)	44,795
Contributions of or for acquisition of property and equipment	261	159
Other, net	427	2,615
Increase (decrease) in net assets without donor restrictions, UnityPoint Health	(26,154)	294,904
Net assets without donor restrictions, noncontrolling interest:		
Excess (deficit) of revenue over expenses	5,979	(3,701)
Distributions of capital	(6,337)	(7,986)
Contributions of capital	(286)	—
Net assets released from restrictions used for capital expenditures	58	58
Other	(3,564)	—
Decrease in net assets without donor restrictions, noncontrolling interests	(4,150)	(11,628)
Net assets with donor restrictions:		
Contributions	16,901	15,243
Contribution received in affiliations	2,499	1,059
Investment income	2,042	6,545
Government grants	23	162
Net assets released from restrictions used for operations	(11,420)	(11,315)
Net assets released from restrictions used for capital expenditures	(10,120)	(11,782)
Change in net unrealized gains on investments	(6,909)	6,040
Change in beneficial interest in net assets of affiliate	(1,454)	12,010
Other, net	5,070	1,730
Increase (decrease) in net assets with donor restrictions, UnityPoint Health	(3,368)	19,692
Net assets with donor restrictions, noncontrolling interest:		
Net assets released from restrictions used for capital expenditures	(58)	(52)
Decrease in net assets with donor restrictions, noncontrolling interests	(58)	(52)
Increase (decrease) in net assets	(33,730)	302,916
Net assets, beginning of year	3,378,922	3,076,006
Net assets, end of year	$ 3,345,192	3,378,922

See accompanying notes to consolidated financial statements.

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Consolidated Statements of Cash Flows

Years ended December 31, 2018 and 2017

(In thousands)

	2018	2017
Operating activities:		
Increase (decrease) in net assets	$ (33,730)	302,915
Adjustments to increase (decrease) in net assets:		
Net (gain) loss on investments	128,398	(205,132)
Net unrealized gains on swaps	(13,887)	(7,845)
Restricted contributions, investment income, and government grants received	(7,546)	(10,635)
Contributions of or for acquisition of property and equipment	(251)	(159)
Depreciation and amortization	241,334	247,005
Change in defined pension plans' liability	28,895	(44,795)
Contribution received in affiliations	(37,305)	(42,830)
Amortization of bond premium and debt issuance costs, net	6,415	(1,988)
Gain on disposition of assets	(9,020)	(1,236)
Equity in earnings of joint ventures	(27,116)	(30,006)
Change in beneficial interest in net assets of affiliates	1,454	(12,010)
Provision for uncollectible accounts	3,275	1,882
Changes in:		
Receivables	34,449	(63,651)
Inventories, prepaid expenses, and other assets	1,781	19,279
Accounts payable, accrued liabilities, and other liabilities	(41,551)	9,668
Due to third-party payors	102	10,849
Net cash provided by operating activities	275,577	170,310
Investing activities:		
Capital expenditures	(161,349)	(215,719)
Proceeds from sale of assets	3,381	1,643
Decrease in assets limited as to use, net	(8,546)	(29,486)
Cash acquired in affiliations	9,949	13,589
Acquisitions, net of cash acquired	—	(39,564)
Increase in loans receivable	(14,304)	(205)
Increase in short-term investments	(2,144)	(2,804)
Decrease in other long-term investments	13,082	55,212
Investments in joint ventures	(7,019)	(2,543)
Distributions received from joint ventures	30,425	26,959
Net cash used in investing activities	(136,525)	(192,909)
Financing activities:		
Proceeds from issuance of long-term debt	380,819	75,730
Payments of debt	(217,411)	(56,190)
Payments of financing costs	(2,162)	(188)
Payments on early extinguishment of debt	(308,755)	(12,995)
Proceeds from restricted contributions, investment income, and government grants	7,546	10,635
Proceeds from contributions for acquisition of property and equipment	251	159
Net cash provided by (used in) financing activities	(139,702)	17,150
Decrease in cash and cash equivalents	(650)	(5,449)
Cash and cash equivalents, beginning of year	251,656	257,105
Cash and cash equivalents, end of year	$ 251,006	251,656

(Continued)

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Consolidated Statements of Cash Flows

Years ended December 31, 2018 and 2017

(In thousands)

	2018	2017
Supplemental cash flow information:		
Interest paid (net of amount capitalized)	$ 40,218	39,340
Capital lease obligations incurred for property and equipment	9,122	2,631
Property and equipment purchases in accounts payable	7,929	15,526
Affiliations:		
Assets acquired, less cash	75,810	92,976
Liabilities assumed	48,456	60,076
Acquisitions:		
Assets acquired, less cash	—	49,615
Liabilities assumed	—	10,052

See accompanying notes to consolidated financial statements.

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Notes to Consolidated Financial Statements

December 31, 2018 and 2017

(Dollars in thousands)

(1) Nature of Operations and Summary of Significant Accounting Policies

(a) Organization

Iowa Health System is an Iowa nonprofit corporation formed in December 1994. Iowa Health System and its subsidiaries provide inpatient and outpatient care and physician services from twenty-two hospital facilities and various ambulatory service and clinic locations in Iowa, Illinois and Wisconsin. Primary, secondary, and tertiary care services are provided to residents of Iowa, Illinois, Wisconsin, and adjacent states.

Iowa Health System publicly operates as UnityPoint Health (the System). The legal name of the parent remains Iowa Health System, with the UnityPoint Health name reflecting a doing business as (d/b/a). This "d/b/a" name reflects the transformation of clinical processes underway within the System and the adaptation to better address the healthcare needs of communities, including building a model of delivering healthcare that coordinates care around the patient while focusing on improving the quality of care and reducing costs.

(b) Basis of Presentation

The consolidated financial statements include the accounts of UnityPoint Health and its subsidiaries listed below:

- Central Iowa Health System and Subsidiaries (d/b/a UnityPoint Health – Des Moines) (Des Moines)
- Methodist Health Services Corporation and Subsidiaries (Peoria)
- Trinity Regional Health System and Subsidiaries (Rock Island)
- Meriter Health Services, Inc. and Subsidiaries (Madison)
- St. Luke's Healthcare and Subsidiaries (Cedar Rapids)
- Allen Health Systems, Inc. and Subsidiaries (Waterloo)
- St. Luke's Health System, Inc. and Subsidiaries (Sioux City)
- Trinity Health Systems, Inc. and Subsidiaries (Fort Dodge)
- Finley Tri-States Health Group, Inc. and Subsidiaries (Dubuque)
- Memorial Hospital Association (Carthage; affiliated as of July 1, 2018)
- Keokuk Health Systems and Subsidiaries, Inc. (Keokuk; affiliated as of January 1, 2017)
- Iowa Physicians Clinic Medical Foundation (d/b/a UnityPoint Clinic)
- UnityPoint at Home

All significant intercompany balances and transactions have been eliminated in consolidation.

On January 1, 2017, the System's subsidiary, Methodist Health Services Corporation, became the sole corporate member of Progressive Health Systems, Inc. with assets and liabilities of $82,512 and $42,080, respectively. Included in assets is cash of $4,351.

On January 1, 2017, the System became the sole corporate member of Keokuk Health Services, Inc. with assets and liabilities of $16,616 and $18,142, respectively. Included in assets is cash of $548.

On January 1, 2017, the System's subsidiary, St. Luke's Healthcare, became the sole corporate member of Abbe, Inc. with assets and liabilities of $31,123 and $9,848, respectively. Included in assets is cash of $8,598.

On May 1, 2017, the System's subsidiary, Allen Health Systems, Inc., acquired the assets of Central Iowa Healthcare out of bankruptcy for $39,571 and assumed certain liabilities as part of the transaction.

On July 1, 2017, the System's subsidiary, Trinity Regional Health System, became the sole corporate member of Center for Alcohol and Drug Services, Inc. with assets and liabilities of $6,796 and $857, respectively. Included in assets is cash of $59.

Physicians Plus Insurance Company (PPIC) had net assets of $16,366, which were contributed to Quartz Holding Company as of July 1, 2017 as part of an Exchange Agreement. The operating results of PPIC are reported in discontinued operations in the accompanying consolidated statements of operations and changes in net assets for the years ended December 31, 2018 and 2017. PPIC had unrestricted revenue of $122,214 and expenses of $130,721 through June 30, 2017.

On January 1, 2018, the System's subsidiary, Central Iowa Health System, became the sole corporate member of Grinnell Regional Medical Center (GRMC) with assets and liabilities of $32,284 and $11,699, respectively. Included in assets is cash of $4,983.

On January 1, 2018, the System's subsidiary, Central Iowa Health System, became the sole corporate member of Eyerly-Ball Community Mental Health Services (Eyerly-Ball) with assets and liabilities of $2,900 and $1,386, respectively. Included in assets is cash of $195.

On July 1, 2018, the System became the sole corporate member of Memorial Hospital Association with assets and liabilities of $50,487 and $35,371, respectively. Included in assets is cash of $4,771.

These transactions were accounted for as acquisitions in accordance with Accounting Standards Codification (ASC) Topic 958-805, *Business Combinations – Not-for-Profit Entities* and assets and liabilities were recorded at fair value.

(c) *Noncontrolling Interests*

The consolidated financial statements include all assets, liabilities, revenue, and expenses of entities that are controlled by the System and, therefore, consolidated. Noncontrolling interests in the consolidated balance sheets and statements of operations and changes in net assets represent the portion of net assets owned by entities outside the System and the portion of operating results attributed to the noncontrolling ownership interest.

(Continued)

(d) Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (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 and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

(e) Cash, Cash Equivalents, and Short-Term Investments

Cash equivalents consist of demand deposits, money market funds, and other debt securities with original maturities of three months or less at the date of purchase, other than those included in assets limited as to use or held in brokerage accounts. A portion of these balances are held in a pooled cash management account, with the balances and activity remaining within the respective subsidiaries. Short-term investments consist of debt securities with weighted average maturities between 91 and 365 days of the consolidated balance sheet date, and other debt securitized products, and other investments held as part of deferred compensation arrangements whose distributions will occur within one year.

At times, the System's cash accounts exceeded federally insured limits. Management believes that the institutions where cash accounts are maintained are financially stable and that the credit risk related to deposits is minimal.

(f) Assets Limited as to Use

Assets limited as to use include amounts held by trustees under bond indenture agreements and related documents and assets internally designated by the Board of Directors for identified purposes and over which the Board of Directors retains control and may, at its discretion, subsequently use for other purposes. Amounts required to meet current liabilities are classified as current assets.

(g) Inventories

Inventories consist of supplies and are stated at the lower of cost or market.

(h) Short-Term Investments, Other Long-Term Investments, Investments in Joint Ventures, and Investment Income

Investments in equity securities with readily determinable fair values and all investments in fixed-income securities are measured at fair value in the consolidated balance sheets. The fair values are based on quoted market prices or dealer quotes.

Investments in joint ventures and other affiliates, which are more than 20% and not more than 50% owned, are recorded using the equity method. Other investments are reported at cost, as adjusted for permanent impairment in value, if any.

(Continued)

Realized gains and losses from the sale of investments, interest and dividends (except those earned as a function of operations) and unrealized gains and losses on investments classified as trading securities and those carried at fair value pursuant to ASC Topic 825 are reported as nonoperating gains (losses) unless restricted by a donor. Income from investments restricted by donors is included as a component of the change in net assets based upon the nature of the restriction.

The System elected the net asset value as practical expedient option for its alternative investments (including hedge funds and private equity funds) that are primarily limited liability corporations and partnerships. Management has elected this option for the alternative investments because it more accurately reflects the portfolio returns and consolidated financial position of the System. Gains and losses on investments subject to the net asset value option are reported in investment income in nonoperating gains (losses) in the accompanying consolidated statements of operations and changes in net assets.

Refer to notes 5 and 12 for additional disclosures regarding balance sheet line items and fair value of those investments carried under Financial Accounting Standards Board (FASB) ASC Topic 825.

Transfers in and out of Level 1 (quoted market prices), Level 2 (other significant observable inputs), and Level 3 (significant unobservable inputs) are recognized on the actual transfer date.

(i) Property, Plant and Equipment

Property, plant and equipment acquisitions are recorded at cost, less accumulated depreciation. Depreciation is provided primarily using the straight-line method over the estimated useful lives of the assets. Depreciation of assets under capital lease is provided using the straight-line method over the shorter of the lease term or the estimated useful life of the assets. Donated property, plant and equipment are recorded at fair value at the date of donation.

Property, plant, and equipment assets are depreciated on the straight-line method over the following estimated useful lives:

Buildings	10–40 yrs.
Fixed equipment	5–15 yrs.
Moveable equipment	3–15 yrs.
Computer software	3–10 yrs.

(Continued)

Property, plant, and equipment are stated at cost and is summarized at December 31 as follows:

	2018	2017
Land	$ 196,472	195,782
Land improvements	71,405	68,361
Buildings, improvements, and fixed equipment	2,471,925	2,344,967
Moveable equipment	1,564,786	1,560,894
	4,304,588	4,170,004
Less accumulated depreciation and amortization	2,536,379	2,393,014
	1,768,209	1,776,990
Construction/information systems installation in progress	75,698	91,789
Net property, plant, and equipment	$ 1,843,907	1,868,779

Interest costs incurred on borrowed funds during the period of construction of capital assets are capitalized as a component of construction in progress, net of interest earned on investments acquired with the proceeds of the borrowing. During 2018 and 2017, the System capitalized $90 and $456 of interest expense, respectively.

As of December 31, 2018 and 2017, the System has committed $156,920 and $173,260, respectively, for costs related to various construction projects. The System plans to fund the majority of these projects through internal funds, with supplemental debt financing for certain projects.

(j) Asset Retirement Obligation

The System recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the consolidated statements of operations and changes in net assets. Liabilities for such obligations of $19,979 and $19,062 are recorded in other long-term liabilities as of December 31, 2018 and 2017, respectively. The year-over-year increase of $917 is primarily due to the accretion of the liability.

(k) Long-Lived Asset Impairment

The System evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset is less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value.

No asset impairment was recognized during the years ended December 31, 2018 and 2017.

(l) Other Assets

Other assets include certain intangible assets that are stated at cost less accumulated amortization. In addition, other assets include goodwill. The System follows ASU 2014-04, which simplifies the goodwill impairment test. Goodwill is an asset representing the future economic benefits arising from other assets acquired as part of business combinations that are not individually identified and separately recognized. The System has $37,064 and $38,437 of goodwill at December 31, 2018 and 2017, respectively. If necessary based on qualitative factors, the System will perform an impairment test of its goodwill and intangible assets using a discounted cash flow method, and any identified impairment loss is recognized as expense. The analysis performed during 2018 and 2017 showed the carrying amount exceeded fair value for two of the System's subsidiaries, and $1,373 and $13,102 of impairment was recognized in depreciation and amortization expense in the accompanying consolidated statements of operations and changes in net assets in 2018 and 2017, respectively.

Other intangible assets at December 31, 2018 and 2017 were $4,205 and $5,002, respectively, which are subject to amortization.

(m) Net Assets

Net assets are classified into two mutually exclusive classes: without donor restrictions and with donor restrictions. The two classes are based on the presence or absence of donor-imposed restrictions. The release of net assets from donor restrictions is recorded in the period in which the restrictions are met. Contributions with donor-imposed restrictions that are met in the same reporting period are reported as without donor restriction.

Donor-imposed restrictions are generally restricted for capital expenditures, passage of time, or other donor-specified restrictions.

For entities in which the System has less than full ownership but has a controlling interest, a noncontrolling interest is recorded for the portion of net assets controlled by unrelated parties.

(n) Excess (Deficiency) of Revenues over Expenses

Excess (deficiency) of revenues over expenses transactions affecting net assets without donor restrictions are reflected in the consolidated statements of operations and changes in net assets. Consistent with industry practice, the effective portion of derivative instruments qualifying for hedge accounting carried at fair value, changes in defined benefit plans, and contributions of long-lived assets (including assets acquired with donor-restricted cash contributions) are excluded from determination of the excess (deficiency) of revenues over expenses. Transactions with donor restrictions are recorded as additions of operations or deductions to net assets with donor restrictions and are reflected in the consolidated statements of operations and changes in net assets.

(Continued)

(o) Patient Service Revenue and Accounts Receivable

Patient service revenue is reported at the amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care. These amounts, representing transaction price, are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the System bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the System. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The System believes that this method provides a reasonable depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services. The System measures the performance obligation from admission into the healthcare provider to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided and the System does not believe it is required to provide additional goods or services. Because all of its performance obligations relate to contracts with a duration of less than one year, the System has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to 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. 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.

The System 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. The System determines the transaction price associated with services provided to patients who have third-party payor coverage based on reimbursement terms per contractual agreements, discount policies, and historical experience. For uninsured patients who do not qualify for charity care, the System determines the transaction price associated with services on the basis of charges reduced by implicit price concessions. Implicit price concessions included in the estimate of the transaction price are based on historical collection experience for applicable patient portfolios. Patients who meet the System's criteria for free care "charity" are provided care without charge; such amounts are not reported as revenue. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are

included in the determination of the estimated transaction price for providing patient care using the most-likely-outcome method. These settlements are estimated based on the terms of the payment agreements with the payor, correspondence from the payor, and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as new information becomes available or as years are settled or are no longer subject to such audits, reviews, and investigations.

The System 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 major payor classes and types of services provided for outpatient revenue. Based on the historical collection trends and other analyses, the System believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

The percentage of patient service revenue by payor recognized in the years ended December 31 was as follows:

	2018	2017
Medicare	36 %	36 %
Medicaid	14	14
Wellmark/Blue Cross	22	22
Commercial and other	28	28
Self-pay	—	—
	100 %	100 %

The percentage of patient accounts receivable by payor at December 31 was as follows:

	2018	2017
Medicare	27 %	29 %
Medicaid	13	16
Wellmark/Blue Cross	22	19
Commercial and other	34	32
Self-pay	4	4
	100 %	100 %

(Continued)

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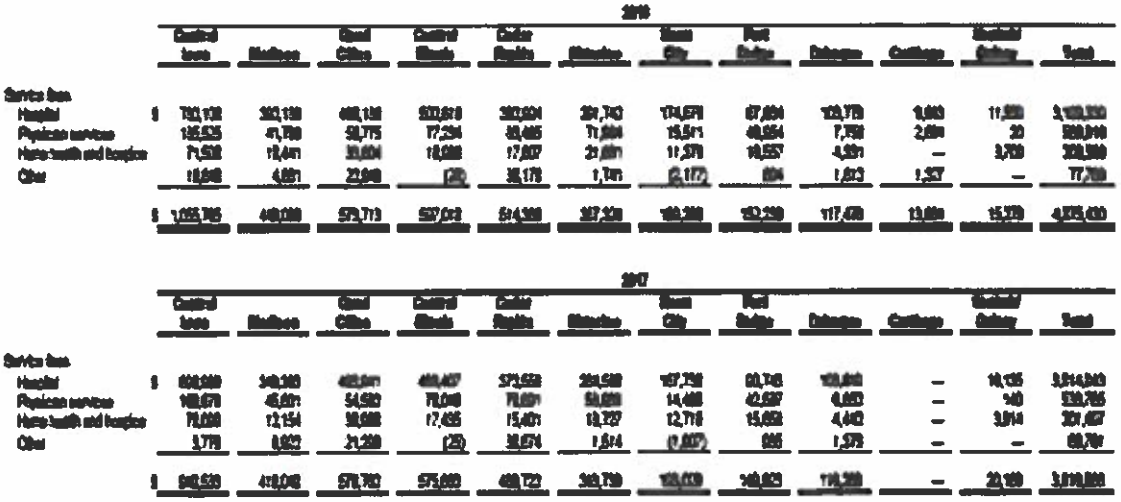
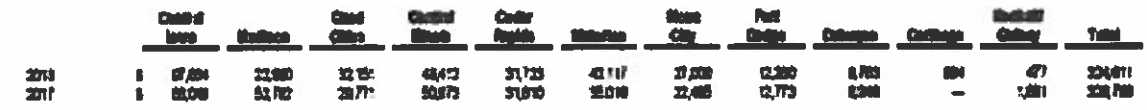
The sources of patient service revenue, disaggregated by lines of service, for the years ended December 31 were as follows:



Other operating revenue primarily includes income from joint ventures, reference lab, retail pharmacy and shared savings revenue from value based contracts with third party payors. Revenue from services recorded as other operating revenue is primarily recognized at the time of service rendered. Other operating revenue for the years ended December 31 was as follows:



(p) Charity Care

The System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Amounts determined to be charity care are not reported as revenue.

(q) Contributions and Beneficial Interest in Net Assets

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by the donor. Donor-imposed restrictions are considered fulfilled as soon as the stipulated time has expired or the qualifying expenditure has been made. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

Contributions not expected to be collected within a year are recorded at the present value of expected future cash flows using a risk-free interest rate over the term of the contribution. Contributions of property are recorded at fair value when received.

Interests in charitable trusts and perpetual trusts are carried at the present value of expected future cash flows, which approximates fair value. The System's interest in the net assets (the Interest) of certain foundations that raise and hold assets on behalf of the System is accounted for in a manner similar to the equity method. The Interest is recorded at its beneficial interest in the underlying assets, and changes in the Interest are included in the change in net assets. Transfers of assets between these foundations and the System are recognized as increases or decreases in the Interest.

(r) Estimated Malpractice Costs, Health Insurance, and Workers' Compensation

An annual estimated provision is accrued for the self-insured portion of medical malpractice, health insurance, and workers' compensation claims and includes an estimate of the ultimate costs for both reported claims and claims incurred but not reported.

Claims liabilities are recorded at the gross amount without consideration of insurance recoveries. Expected recoveries are presented separately as receivables in the consolidated balance sheets.

(s) Interest Rate Swap Agreements

The System has entered into various interest rate swap agreements (the Swaps) to reduce the effect of changes in cash flows primarily related to interest rate fluctuations on the System's various variable rate debt.

As described in note 7, the System no longer has any swaps that qualify for hedge accounting, so changes in fair value for all swap agreements are recorded as a component of nonoperating gains (losses) in excess of revenue over expense.

The Swaps are recognized on the consolidated balance sheets at fair value. The net cash payments or receipts under the Swaps are recorded as an increase or decrease to other nonoperating income (loss).

(t) Income Taxes

UnityPoint Health and most of its subsidiaries are classified as tax-exempt organizations as described in Sections 501(c)(3) and 501(c)(2) of the Internal Revenue Code (the Code). Tax-exempt organizations are not subject to federal and state income taxes on related income, pursuant to Section 501(a) of the Code. These organizations are subject to federal and state income taxes to the extent they have unrelated business income as described under provisions of Section 511 of the Code.

The System files Form 990 for substantially all of its operating entities in the U.S. federal jurisdiction and is no longer subject to examination by tax authorities for the years before 2015. The System has no material uncertain tax positions.

Certain subsidiaries are subject to federal and state income taxes. Some of these corporations have accumulated net operating loss carryforwards that are available to offset future taxable income, if any, during the carryforward period. Deferred tax assets and liabilities related to these subsidiaries were not material.

(u) Retirement Plans

Substantially all employees meeting age and length of service requirements participate in defined-contribution plans. Certain subsidiaries also have defined-benefit plans, most of which have been substantially frozen. Pension costs for the defined-benefit plans, which are composed of normal costs and amortization of prior service costs related to defined-benefit plans, are funded currently.

(v) Recently Issued Accounting Standards

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, which provides a single model for recognizing revenue arising from contracts with customers and supersedes current revenue recognition guidance. This ASU requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of goods or services and replaces existing revenue recognition guidance in U.S. GAAP when it becomes effective.

On January 1, 2018, the System adopted ASU 2014-09 following the modified retrospective method of application for the adoption of the guidance to all contracts existing on January 1, 2018, resulting in no impact to the System's existing revenue streams. At the adoption of ASU 2014-09, the majority of what was previously classified as the provision for bad debts (which would have approximated $127,415 for the year ended December 31, 2018) is now reflected as an implicit price concession (as defined in ASU 2014-09) and therefore is included as a reduction to patient service revenue in the accompanying consolidated statements of operations and changes in net assets. Such amounts were also reclassified in the consolidated statements of cash flows to the change in patient accounts receivable. For changes in credit issues not assessed at the date of service, the System will prospectively recognize those amounts as bad debt expense. Bad debt expense is now included as a component of operating expenses in the accompanying consolidated statements of operations and changes in net assets. For periods prior to the adoption of ASU 2014-09, the provision for bad debts has been presented consistent with the new revenue recognition standards that require it to be presented as a reduction to patient service revenue. Additionally, upon adoption of ASU 2014-09, the allowance for uncollectible accounts of approximately $86,632 as of December 31, 2017 was reclassified as a component of patient accounts receivable in the accompanying consolidated balance sheets.

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. As provided for under the guidance, the System does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less.

The System used a portfolio approach to apply the new model to classes of payors with similar characteristics and analyzed cash collection trends over an appropriate collection look-back period

 (Continued)

depending on the payor. The System also completed an initial assessment of the impact of the new standard on various reimbursement programs that represent variable consideration and concluded that accounting for these programs under the new standard is substantially consistent with the System's historical accounting practices.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, which requires lessees to recognize all leases with a term of more than one year on their balance sheet as well as disclose key information about leasing arrangements. The new standard establishes a right of use (ROU) model where a lessee will recognize a ROU asset and lease liability on the balance sheet. All leases will be classified as finance or operating, with classification affecting the pattern and classification of the expense recognition in the income statement. The new standard is effective for the System beginning January 1, 2019. The System continues to evaluate the standard and currently expects it will have a significant effect on the consolidated balance sheets but no material change to the consolidated statements of operations and changes in net assets.

In August 2016, the FASB issued ASU 2016-14, *Not-for Profit Entities (Topic 958)*, to change the way a not-for-profit entity (NFP) classifies and presents net assets on the face of the financial statements, as well as the information presented in the financial statements and notes about the NFP's liquidity, financial performance, and cash flows. The amendment changes the way an NFP reports classes of net assets, from three classes to two, by eliminating the distinction between resources with permanent restrictions and those with temporary restrictions. The amendment also requires the NFP to provide enhanced disclosure about the nature, amounts and effects of the various types of donor-imposed restrictions the NFP's management of its liquidity to meet short-term demands for cash and the types of resources used and how they are allocated to carrying out the NFP's activities.

On January 1, 2018, the System adopted ASU 2016-14, following the retrospective method of application for the adoption of the guidance. As a result, at the adoption of ASU 2016-14, net assets previously classified as temporarily restricted and permanently restricted (which would have approximated $112,008 and $75,878 respectively for the year ended December 31, 2018) are now reflected as net assets with donor restrictions (as defined in ASU 2016-14) in the accompanying consolidated balance sheets. For periods prior to the adoption of ASU 2016-14, net assets previously presented as temporarily restricted and permanently restricted, $117,169 and $74,143, respectively, as of December 31, 2017 have been presented as net assets with donor restrictions.

In March of 2017, the FASB issued ASU No. 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* (ASU 2017-07). ASU 2017-07 provides guidance on the presentation of the various components of net periodic pension and postretirement benefit cost (net benefit cost). The service cost component will be presented with other employee compensation costs in operating income on the statement of operations. All other components of net benefit cost will be reported separately outside of operating income. The provisions of ASU 2017-07 are effective for annual periods beginning after December 15, 2017. The adoption of the new guidance did not have a material impact on the consolidated financial statements.

(Continued)

In June 2018, the FASB issued ASU 2018-08, *Not-for-Profit Entities (Topic 958): Clarifying the Scope and Accounting Guidance for Contributions Received and Contributions Made*, to address consistency in determining whether a transfer of assets is an exchange transaction or a contribution and whether a contribution is conditional. The System will be required to adopt ASU 2018-08 as of January 1, 2019. The System does not expect the standard to have a material effect on the consolidated financial statements.

(2) Charity Care

The System provides charity care and financial assistance discounts for medically necessary healthcare services provided to persons who meet the System's policy. The policy provides a percentage discount to the patient that decreases at gradually higher income levels or higher levels of household net assets. The benchmark, which the income level is compared to, is the Federal Poverty Income Guideline and is updated annually. Patients who are already receiving benefits from certain identified government programs qualify for presumptive eligibility.

The availability of charity care is widely communicated to all patients, and patients are notified prior to receiving services if their treatment does not fall within the guidelines of the policy. Amounts charged for care that is provided to individuals eligible for charity may not be more than the amounts generally billed to individuals who have insurance covering such care. Amounts billed are based on either the best, or an average of the three best, negotiated commercial rates or Medicare rates.

Accounts that are classified by the System as charity care are not reported as patient service revenue. In some cases, the charity care is subsidized by contributions from volunteer organizations or other donors. Charity care subsidies are not material to the consolidated financial statements.

Cost of charity care is calculated by applying hospital specific cost-to-charge ratios to the total amount of charity care deductions from gross revenue. The cost-to-charge ratio is calculated by taking the hospital total expenses and gross charges and applying adjustments to remove the cost of nonpatient care activity, Medicaid provider taxes paid, identifiable community benefit expenses, as well as gross patient charges that are generated for identifiable community benefit services. The amount of charity care provided at cost was $26,912 and $22,521 for the years ended December 31, 2018 and 2017, respectively. The expansion of Medicaid coverage, under the provisions of the PPACA, for a large population of previously uninsured patients has had a significant impact on the amount of self-pay charges and resulting charity care provided.

Community benefit is also provided through reduced price services and free programs offered throughout the year. The System provides an array of uncompensated activities and services intended to meet the community health needs. These activities include wellness programs, community education programs and various health screening programs.

(3) Third-Party Reimbursement

As a provider of healthcare services, the System generally grants credit to patients without requiring collateral or other security. The System routinely obtains assignments of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies. These health insurance programs or providers are commonly referred to as third-party payors and include the Medicare and

Medicaid programs, Wellmark/Blue Cross and various health maintenance and preferred provider organizations.

A major portion of the System's revenue is derived from these third-party payers. Significant changes have been made, and may be made, in certain of these programs, which could have a material, adverse impact on the financial condition of the System. These changes include federal and state laws and regulations, particularly those pertaining to Medicare and Medicaid.

The System has agreements with certain third-party payers that provide for payment of services at amounts that differ from established rates. Third-party payer payment rates vary by payer and include established charges; contracted rates less than established charges; prospectively determined rates per discharge, bundled payment per episode of care, per procedure, or per diem; and retroactively determined cost-based rates.

(a) Medicaid State Plans

The System has operations within states that have enacted a Medicaid State Plan. Under each of these plans, a tax assessment is levied on certain hospital providers in order to provide funding for Medicaid to obtain federal matching funds. A portion of these additional federal funds are then redistributed to participating hospitals through increased Medicaid payments in order to help bring Medicaid reimbursement closer to the cost of providing care. The allocation of these funds to specific health care providers is based primarily on the amount of care provided to Medicaid recipients.

The System's aggregate tax assessment during 2018 and 2017 was $56,856 and $54,954, respectively, and is included in operating expenses in the consolidated statements of operations and changes in net assets. Additional Medicaid reimbursement in the same periods was $114,007 and $127,494, respectively, and is included in patient service revenue in the consolidated statements of operations and changes in net assets, resulting in a net increase in operating income of $57,153 and $72,540 for 2018 and 2017, respectively.

(Continued)

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(4) Functional Expenses

The System provides general health care services, including hospital, physician and home healthcare, and incurs related general and administrative expenses. Expenses related to providing these services for the years ended December 31 were as follows:

	2018					
	Hospital Services	Physician Services	Home Health and Hospice	Other	MGAA	Total
Salaries and wages	$ 729,079	152,509	53,284	80,786	555,066	1,570,724
Physician compensation and services	69,692	538,360	296	11,483	42,953	662,784
Employee benefits	181,393	47,540	12,542	22,880	156,143	420,498
Supplies	535,932	54,120	11,413	94,337	29,828	725,630
Other expenses	165,343	58,364	9,262	55,284	419,418	707,691
Depreciation and amortization	67,909	9,328	316	4,953	158,768	241,334
Interest	1	376	—	134	38,253	38,764
Provision for uncollectible accounts	—	—	960	2,244	471	3,275
	$ 1,749,409	860,597	87,693	272,091	1,400,900	4,370,690

	2017					
	Hospital Services	Physician Services	Home Health and Hospice	Other	MGAA	Total
Salaries and wages	$ 702,953	147,841	55,591	70,378	536,683	1,513,446
Physician compensation and services	68,087	496,438	(294)	11,753	43,007	618,991
Employee benefits	165,661	44,655	12,472	19,934	187,220	429,942
Supplies	494,917	54,242	10,255	81,971	20,687	662,072
Other expenses	142,038	54,518	9,681	49,378	411,509	667,124
Depreciation and amortization	63,099	9,000	390	17,834	156,682	247,005
Interest	9	406	20	109	37,690	38,234
Provision for uncollectible accounts	—	5	422	1,080	375	1,882
	$ 1,636,764	807,105	88,537	252,437	1,393,853	4,178,696

The consolidated financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function are allocated based on revenue.

(Continued)

(5) Investments

(a) Investment Summary

A summary of short-term investments at December 31 is as follows:

	2018	2017
Cash equivalents	$ 340	633
U.S. Treasury obligations	3,662	1,499
U.S. government agency obligations	200	—
Asset-backed securities:		
Home equity	53	—
Other	3,519	3,222
Mortgage-backed securities:		
Government	299	37
Nongovernment	348	837
Certificates of deposit	2,267	3,461
Corporate bonds	6,968	5,204
Municipal bonds	189	956
Mutual funds:		
Domestic	7	64
International	57	74
Index	279	224
Equity	294	272
Fixed income	166	428
Other	2,914	2,617
Total short-term investments	$ 21,782	19,528

A summary of investments reported as assets limited as to use at December 31 is as follows:

	2018	2017
Held by trustees under bond indenture agreements:		
Cash equivalents	$ 906	1,162
Certificates of deposit	1,265	—
Mortgage-backed securities	—	—
	2,171	1,162

(Continued)

	2018	2017
Internally designated:		
Cash equivalents	$ 2,266	1,919
U.S. Treasury obligations	3,616	4,341
Certificates of deposit	880	—
Corporate bonds	387	188
Equity securities:		
Domestic	13,221	13,619
International	902	675
Mutual funds:		
Domestic	7,694	7,582
International	306,417	346,713
Equity	230,465	255,577
Fixed income	330,485	341,778
Alternative funds	312,109	296,253
Hedge funds	—	2,123
Private equity funds	12,644	6,968
	1,221,086	1,277,956
Total assets limited as to use	1,223,257	1,279,118
Less amount required to meet current obligations	16,721	14,681
Noncurrent portion of assets limited as to use	$ 1,206,536	1,264,437

Assets held by trustee under bond indenture agreements are required to be held in separate trust accounts. A summary of these trust accounts aggregated by their required use at December 31 is as follows:

	2018	2017
Debt service accounts	$ 2,171	1,162

Internally designated assets are summarized below based on the designation at December 31:

	2018	2017
Capital improvements	$ 1,183,110	1,241,519
Self-insured reserves	37,976	36,437
	$ 1,221,086	1,277,956

(Continued)

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Investments presented as other long-term investments at December 31 are summarized as follows:

	2018	2017
Cash equivalents	$ 1,092	771
U.S. Treasury obligations	803	5,264
U.S. government agency obligations	998	881
Asset-backed securities:		
Home equity	4,001	—
Other	—	2,127
Mortgage-backed securities:		
Government	658	—
Nongovernment	1,574	1,447
Certificates of deposit	2,328	467
Corporate bonds	17,235	9,334
Municipal bonds	—	364
Equity securities:		
Domestic	2,826	3,208
International	79	—
Equity securities – PIF:		
Domestic	10,098	649
Mutual funds:		
Domestic	12,056	14,610
International	213,977	253,683
Emerging markets	—	758
Index	5,384	4,826
Equity	169,434	192,102
Fixed income	236,397	257,938
Other	48,050	49,615
Alternative funds	219,659	215,299
Hedge funds	—	1,543
Private equity funds	8,954	5,078
Insurance policies	1,756	1,727
Interest rate swaps (see note 7)	842	528
Total other long-term investments	$ 958,201	1,022,219

(Continued)

The following schedule summarizes the investment return and its classification in the consolidated statements of operations and changes in net assets for the years ended December 31:

	2018	2017
Investment return:		
Interest and dividends	$ 37,056	50,874
Realized gains on sales of investments	84,473	60,524
Unrealized gains on trading investments	(218,774)	103,931
Unrealized gains on other-than-trading investments	(6,909)	6,040
Equity in earnings of joint ventures	27,116	30,006
Change in fair value of investments accounted for under the fair value option of FASB ASC Topic 825	12,812	35,637
	$ (64,226)	287,012
Investment return classification:		
Net assets without donor restrictions:		
Other operating revenue	$ 28,283	32,230
Nonoperating gains – investment income	(87,642)	242,197
Net assets with donor restrictions	(4,867)	12,585
	$ (64,226)	287,012

(b) Alternative Investments

At December 31, 2018 and 2017, 25% and 23%, respectively, of the System's investments was invested in alternative investment vehicles. These investments are included in either internally designated or other long-term investments in the investment summary tables (previously presented) based on the underlying investments. Due to the nature of the alternative investments and the need for the fund managers to execute on long-term strategies, many of the vehicles contain specific lock-up periods, restricted redemption timing, as well as advanced notice of redemption requests.

(Continued)

Alternative investments that have been estimated using net asset value per share as a practical expedient consist of the following at December 31:

	December 31, 2018			
	Fair value	Unfunded commitments	Redemption frequency	Redemption notice period
Diversified property alternative fund	$ 125,770	—	Quarterly	95 Days
Structured credit alternative fund	96,243	—	Quarterly	65 Days
Diversified private equity alternative fund III	56,664	30,951	No specific lock-up provision	N/A
Diversified private equity alternative fund IV	11,820	62,325	No specific lock-up provision	N/A
Hedge fund segregated portfolio	166,537	—	Based on holdings***	N/A
Energy debt alternative fund	74,687	—	Semiannual, 3-year lockup*	95 Days
Healthcare private equity fund I	11,414	273	10-year lockup**	N/A
Healthcare private equity fund II	4,174	4,669	10-year lockup**	N/A
Health Catalyst	4,005	—	No specific lock-up provision	N/A
Health Velocity	1,952	8,059	No specific lock-up provision	N/A
	$ 553,366	106,278		

	December 31, 2017			
	Fair value	Unfunded commitments	Redemption frequency	Redemption notice period
Diversified property alternative fund	$ 114,007	—	Quarterly	65 Days
Structured credit alternative fund	94,254	—	Quarterly	65 Days
Diversified private equity alternative fund III	43,042	40,727	No specific lock-up provision	N/A
Diversified private equity alternative fund IV	716	73,271	No specific lock-up provision	N/A
Hedge fund segregated portfolio	169,033	—	Based on holdings***	N/A
Special situations alternative fund	10,510	—	Liquidation reserve***	N/A
Multi-strategy offshore hedge fund	3,666	—	Liquidation reserve***	N/A
Energy debt alternative fund	79,990	—	Semiannual, 3-year lockup*	95 Days
Healthcare private equity fund I	10,204	345	10-year lockup**	N/A
Healthcare private equity fund II	1,862	7,323	10-year lockup**	N/A
	$ 527,284	121,666		

* Subject to 3-year lockup based on initial subscriptions in the investment, which was set to expire in 2019 (50% available after lock-up period ends and 25% available for each of the following semiannual reporting periods); in 2018, the System recommitted to this fund, which extended the lock-up period. 50% is available at the next redemption window in June 2022, 25% in December 2022, and the remainder in June 2023.

(Continued)

** Subject to 10-year lockup based on initial subscriptions in the investment, which will expire between 2021 and 2025

*** Funds are held in escrow until July 2018; at that time they will be returned to the System.

**** The liquidity of the Segregated portfolio and the availability for redemptions will be determined based on the liquidity and redemption terms set forth in the underlying funds. As a result, the System's ability to obtain liquidity or redeem participating shares will be limited.

As of December 31, 2018, the alternative investment vehicles consist of six alternative funds and four private equity funds. The investment strategy of the diversified property alternative fund is to invest in income producing real estate properties utilizing a low level of leverage. The two diversified private equity alternative funds have an objective of investing in a diversified set of private equity real estate funds. The structured credit alternative fund is a fixed-income fund with an objective of generating high total returns using a strategy of investing in domestic credit markets, primarily through collateralized debt obligations and other structured credit instruments, such as loan participations and derivative instruments. The hedge fund segregated portfolio has an investment object to produce returns comparable to those of the equity markets over a full market cycle while targeting substantially less volatility than equities by investing in a diversified portfolio of hedge funds. The investment strategy of the energy debt alternative fund is to generate high absolute returns by taking advantage of the energy and related industries, market dislocation, and commodity price volatility, primarily by investing in debt securities, which are purchased or acquired at a significant discount to fair value and/or offer higher coupon rates. The private equity funds have a strategy of investing in early stage companies and entrepreneurs within the healthcare industry. There is no public market for shares in these alternative investment vehicles. The value of the investments in the funds is determined based on the fair values of the underlying investments, as determined by the net asset value per share. This includes Heritage I and II, along with Health Catalyst and Health Velocity, that the System initially invested during 2018. Health Velocity invests in private healthcare industry companies, similar to Heritage I and II. Health Catalyst is a direct investment in the company, which focuses on a data warehouse and analytics solutions.

In situations when investments do not have readily determinable fair values, the fund managers provide the net asset value (NAV) per share, or its equivalent, to the System. The NAV provided by the fund managers is supported by quoted market prices, operating results, balance sheet stability, growth, and other business and market sector fundamentals of the private investment funds. The System previously adopted ASU 2009-12, which provided a practical expedient for certain investments to use net asset value per share to measure fair value. Accordingly, the System uses the NAV as a practical expedient for fair value for each of its alternative investments.

(c) Investments in Joint Ventures

At December 31, 2018 and 2017, investments in joint ventures amounted to $141,636 and $138,088, respectively. Other investments also included in this line in the consolidated balance sheets consist primarily of investments reported at cost and real estate held for investment.

(Continued)

The joint ventures consist of 50 privately held healthcare organizations in which the System's ownership interest ranges from 20% to 50%. The collective financial position of the joint ventures as of and for the years ended December 31 were:

	2018 Unaudited	2017 Unaudited
Total assets	$ 388,645	363,418
Total equity	229,423	203,351
Net revenue	379,621	512,475
Net income	68,740	74,570

The System's share of earnings on the investments in joint ventures is included in other operating revenue in the consolidated statements of operations and changes in net assets. The System recorded activity related to joint ventures for the years ended December 31 as follows:

	2018	2017
Earnings on investments in joint ventures	$ 27,116	30,006
New investments in joint ventures	7,019	2,543
Distributions received from joint ventures	30,425	26,969

The System both purchases services and sells services and supplies to several joint ventures. In 2018 and 2017, services purchased from joint ventures totaled $20,526 and $17,517, respectively. Services and supplies sold to joint ventures in 2018 and 2017 were $2,207 and $1,824, respectively. The System has loaned $4,500 to a joint venture as of December 31, 2018 and 2017. This loan is interest bearing and carries a rate of interest commensurate with prevailing market rates.

(6) Long-Term Debt

Long-term debt at December 31, 2018 and 2017 is summarized as follows:

	Payable through	Issuance type (1)	Interest rate (2)	2018	2017
Hospital Facility Revenue Bonds:					
Series 2018A	2035	VRDB	2.17 %	$ 82,330	—
Series 2018B	2048	Fixed	5.00	72,980	—
Series 2018C	2041	VRDB	1.65	57,415	—
Series 2018D	2041	VRDB	1.65	57,415	—
Series 2018E	2041	VRDB	1.61	57,415	—
Series 2018F	2041	VRDB	1.60	57,415	—

(Continued)

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	Payable through	Issuance type (1)	Interest rate (2)	2018	2017
Series 2017A	2027	Fixed	3.15 %	$ 19,170	19,500
Series 2016A	2035	Variable	1.58	—	86,230
Series 2016	2036	Fixed	4.00	17,100	—
Series 2016B	2041	Variable	1.55	—	51,220
Series 2016C	2031	Variable	1.30	—	10,430
Series 2016D	2046	Fixed	4.00%–5.00%	42,305	44,100
Series 2016E	2046	Fixed	4.00%–5.00%	165,130	168,690
Series 2016F	2041	Variable	1.49	—	42,500
Series 2016G	2041	Variable	1.58	—	42,500
Series 2014A (WHEFA)	2029	Fixed	5.00	70,115	74,245
Series 2014A	2019	Fixed	3.25	6,990	7,447
Series 2014B	2018	Fixed	5.00	1,772	1,875
Series 2014C	2035	Fixed	4.47%–5.00%	69,145	69,145
Series 2013A	2044	Fixed	5.25	103,175	103,175
Series 2013B	2039	VRDB	1.61%, 1.26%	74,125	75,255
Series 2012A	2024	Fixed	2.15	9,300	10,850
Series 2012C	2037	Fixed	2.43	17,250	17,735
Series 2011A	2021	Fixed	3.29	19,350	25,415
Series 2011	2031	Fixed	4.40	404	446
Series 2009D	2035	Variable	1.65	—	46,045
Series 2009E	2039	Variable	1.67	—	38,100
Series 2005	2031	Fixed	1.45%–4.00%	2,745	2,890
Series 2005A	2029	Fixed	2.50%–5.625%	—	87,690
Series 1992A	2022	Fixed	6.00	3,880	4,720
Total hospital facility revenue bonds				1,006,946	1,030,203
Capital lease obligations net book value: 2018 – $2,655; 2017 – $4,256	2026	Fixed	0%–9.05%	16,334	15,432
Commercial paper	Ongoing	Variable	Various	22,857	80,153
Revolving lines of credit	2017	Variable	Various	—	29,500
Other notes and mortgages	2022	Fixed	1.00%–8.00%	25,853	18,419
				1,073,990	1,173,707
Current maturities				(62,658)	(154,574)
Unamortized bond issuance costs				(6,937)	(6,944)
Unamortized bond premium				36,093	33,847
Long-term portion				$ 1,042,488	1,046,036

(1) Fixed rate, variable rate, or variable rate demand bonds (VRDB)

(2) Variable rates shown as of December 31, 2018 and 2017, respectively, and do not include letter of credit and remarketing fees.

(Continued)

The Series 2011 Bonds are obligations of one of the System's subsidiaries that were issued prior to their affiliation. The proceeds were used to refund a prior outstanding bond, repay a construction line-of-credit, and fund the remainder of the facility addition. The bond is secured by a first mortgage lien on the facility and a security interest in certain personal property, machinery and equipment. The amount outstanding as of December 31, 2018 and 2017 was $404 and $446, respectively.

In August 2014, one of the System's subsidiaries issued tax-exempt Hospital Revenue Bonds, Series 2014A, with an aggregate principal amount not to exceed $8,250 and taxable Hospital Revenue Bonds, Series 2014B, with an aggregate principal not to exceed $2,750 through the City of Anamosa, Iowa, to finance a renovation and expansion capital project. Amounts are only reflected as a liability as funds are drawn down. The amounts outstanding at December 31, 2018 were $6,990 and $1,772, respectively. The amounts outstanding at December 31, 2017 were $7,447 and $1,875, respectively.

The Series 2016 Bonds are obligations of one of the System's subsidiaries that were issued prior to their affiliation with the System, and thus they were the sole obligor under the bond indenture. The debt agreement for the bonds contains loan covenants which require maintaining certain measures of financial performance as long as the bonds are outstanding.

On October 20, 2017, the System issued $19,500 of direct note obligations, Series 2017A, to retire existing taxable debt, pay costs for renovations and expansion capital projects in Pekin, Illinois, and pay costs of issuance of the bond.

On March 20, 2018, the System issued $82,330 of variable rate demand refunding revenue bonds, Series 2018A, to refund the Series 2016A bonds, which were direct note obligations.

On November 20, 2018, the System issued $72,980 of Iowa Finance Authority Revenue Bonds, Series 2018B, which included refinancing a portion of the Series 2005A bonds, and issued new money to finance various capital projects. A portion of the Series 2005A bonds were cash-defeased as a part of this transaction.

On November 20, 2018, the System also issued $229,680 of Iowa Finance Authority Revenue Bonds, Series 2018C, 2018D, 2018E, and 2018F to refund the Series 2009D, 2009E, 2016B, 2016C, 2016F, and 2016G bonds. The purpose of this deal was to enter into more favorable interest rate terms and refinance the Series 2009D and 2009E bonds, which had credit expirations in 2019.

The Series 2018B, 2018C, 2018D, 2018E, 2018F, 2016D, 2016E, 2014A, 2014C, 2013A, 2013B, and 1992A bonds (collectively, the Bonds) and the Series 2018A, 2017A, 2012A, 2012C, and 2011A direct note obligations (collectively, the Notes) are general obligations of the System and its affiliates. The System is required to meet certain operating and financial ratios contained in the master bond trust indenture, bond insurance agreements, and bank letter of credit agreements (related to the variable rate demand bonds). The Bonds and Notes are subject to the provisions of amended and restated master trust indentures, which generally require monthly or quarterly deposits for principal and interest payments be made and certain funds be maintained by the trustee for interest payment and bond retirement purposes. The Bonds and the Notes are secured by the System's revenue.

(Continued)

The variable interest rates on substantially all of the bonds are adjusted daily or weekly by remarketing agents. The bonds may be tendered by the bond holders each interest rate period. The System maintains letters of credit that can be drawn on should the Series 2013B, 2018C, 2018D, 2018E, or 2018F variable rate demand bonds not be remarketed. These letters of credit have varying expiration dates with the earliest expiration being 2020 and are renewable, subject to approval and at the option of the providers, through the term of the bonds. Outstanding amounts under the letters of credit are due at the earlier of expiration of the agreement or over a period of three years, commencing after an initial outstanding period of 366 days or more.

On December 1, 2014, the System established a $200,000 taxable commercial paper program, which had $22,857 drawn on it as of December 31, 2018 and $80,153 as of December 31, 2017. During 2018 the System drew down no additional amounts from the commercial paper program and paid down a portion of the amount outstanding. The System's commercial paper program is sold in tranches, with varying maturities of 1 to 270 days so that no more than $25,000 will mature in any 5-business-day period.

The System maintains separate revolving line-of-credit facilities that provide for revolving credit in an aggregate principal amount of up to $50,000 each. The interest rates applicable to loans under the credit agreements are based on LIBOR plus certain margins, as defined in the agreements. Additionally, the facilities carry a commitment fee, which is charged on the average daily undrawn portion of the facilities. Both of these credit facilities matures in 2020. These agreements contain various financial covenants that mirror those in the System's master bond trust indenture.

Aggregate annual maturities of long-term debt during the years ending December 31 are as follows:

	Accelerated maturities with letter of credit expirations	Scheduled maturities based on loan agreements
2019	$ 62,658	62,658
2020	113,491	40,916
2021	148,422	41,962
2022	33,965	37,255
2023	137,726	37,301
Thereafter	577,728	853,898
	$ 1,073,990	1,073,990

(7) Interest Rate Swaps

The System uses interest rate swap agreements as a risk management strategy to maintain acceptable levels of exposure to the risk of changes in future cash flows due to interest rate fluctuations.

(Continued)

The system has no swaps that are currently designated as hedging instruments, and all changes in fair values are recorded as a component of nonoperating gains (losses) in excess (deficiency) of revenue over expenses. Effective January 1, 2018, one Swap that was previously designated as hedged was deemed to no longer be effective. As a result, the cumulative change in fair value of the hedge previously deemed effective of $(15,036) is being amortized into income over the remaining life of the swap agreement. As of December 31, 2018, $(14,156) of net unrealized losses remains in net assets to be amortized, and $880 was amortized into other loss in 2018.

In prior years, other swap agreements previously designated as hedges by the System were deemed to be ineffective. The ineffective portion of these changes in fair value, previously deemed effective, is being amortized into other income (loss) over the remaining life of the swap. As of December 31, 2018 and 2017, $(272) and $(333), respectively, of net unrealized losses remain in net assets to be amortized and $61 and $61 was amortized into other loss in 2018 and 2017, respectively.

In previous years, the System reduced the notional amount of certain swap agreements by $58,395 by paying $8,450 as of the date of the transactions to the counterparty. This fair value remains a component of unrestricted net assets and will be amortized into interest expense over the remaining life of the swap. As of December 31, 2018 and 2017, $6,745 and $7,164, respectively, remains in unrestricted net assets to be amortized and $419 was amortized into interest expense in 2018 and 2017.

The System has provisions within certain interest rate swap agreements that would require it to post collateral should the negative fair value of the agreements exceed certain thresholds that are dependent on the System's credit rating. As of December 31, 2018, the System has not been required to post collateral under these agreements.

The respective fair values of interest rate swaps in an asset-and-liability position for the System were as follows:

Trade date	Maturity date	Notional amount	System pays	System receives	Fair value 2018	Fair value 2017
2006	2030	$ 60,000	100% of SIFMA*	68.0% of 10Y LIBOR + 14.3 bps	$ 842	529
2005	2035	99,960	3.5 %	62.4% of 3m LIBOR + 29 bps	(11,810)	(15,036)
2006	2037	129,100	3.8	61.9% of 1m LIBOR + 31 bps	(25,875)	(31,050)
2006	2023	37,800	3.5	61.9% of 1m LIBOR + 31 bps	(2,221)	(3,140)
2005	2035	49,980	3.3	62.4% of 1m LIBOR + 29 bps	(5,272)	(5,669)
2008	2025	16,100	3.5	63.0% of 1m LIBOR + 30 bps	(1,139)	(1,563)
2008	2024	9,300	3.5	63.0% of 1m LIBOR + 30 bps	(504)	(761)
2005	2032	22,450	3.5	67.0% of 1m LIBOR	(3,385)	(4,161)
					$ (49,364)	(61,891)

* Through February 15, 2017, the System paid 68% of 10Y LIBOR + 14.3 bps. After that date, payment reverted back to the contracted terms, which are stated in the table above.

(Continued)

The aggregate fair value of the unhedged swap agreements is recorded as long-term investments of $842 and $529 and long-term liabilities of $(50,206) and $(62,420), including the swap that previously qualified for hedge accounting, as of December 31, 2018 and 2017, respectively. The change in fair value of $12,527 and $5,505 is included as a component of other income as of December 31, 2018 and 2017, respectively. The net of what the System pays and receives, is settled monthly or quarterly on each swap agreement and is reported as other income (loss).

The table below presents certain information regarding the System's interest rate swap agreements:

	2018	2017
Other long-term investments:		
Fair value of interest rate swap agreement	$ 842	529
Other long-term liabilities:		
Fair value of interest rate swap agreements	(50,206)	(62,420)
Net assets without donor restrictions:		
Gain recognized in changes in unrealized gains and losses on interest rate swaps (effective portion)	—	1,660
Change in unrestricted net assets amortizing into other, net	941	61
Operating expenses:		
Loss recognized in interest expense	—	419
Nonoperating other, net:		
Gain recognized in income from changes in fair value of interest rate swaps	12,527	5,505
Loss recognized in income from amortization of unrecognized losses in unrestricted net assets	(941)	(61)

(Continued)

(8) Liquidity

As part of the System's cash management policy, cash and investments feature a high degree of safety and liquidity to support general expenditures and debt service within one year in the normal course of operations.

The following table represents financial assets available for general expenditures within one year at December 31:

		2018	2017
Financial assets at December 31:			
Cash and cash equivalents	$	251,006	251,656
Short-term investments		21,782	19,526
Patient accounts receivable, net		557,280	584,903
Assets limited as to use – required for current liabilities		16,721	14,681
Assets limited as to use, noncurrent:			
Held by trustee under bond indenture agreements		2,171	1,162
Internally designated		1,204,365	1,263,275
Other long-term investments		958,201	1,022,219
Contribution receivable, net		89,047	94,753
Total financial assets		3,100,573	3,252,177
Less amounts not available to be used within one year:			
Funds held by trustee under bond indenture agreements		2,171	1,162
Assets internally designated for self-insured reserves		37,976	36,437
Assets internally designated for capital improvements with liquidity horizons greater than one year		96,668	78,653
Other long-term investments with liquidity horizons greater than one year		67,848	57,161
Assets attributable to noncontrolling interest		31,852	36,002
Donor restricted assets		187,886	191,312
Financial assets not available to be used within one year		424,401	400,727
Financial assets available to meet general expenditures within one year	$	2,676,172	2,651,450

(Continued)

The System has certain board-designated and donor-restricted assets limited to use which are available for general expenditure within one year in the normal course of operations. Accordingly, these assets have been included in the table above representing financial assets to meet general expenditures within one year. The System has other assets limited to use under bond indenture agreement, for self-insurance reserves, and for capital expenditures. These assets are limited to use, which are more fully described in notes 5 and 12, and are not available for general expenditure within the next year. The assets internally designated for capital improvements could be made available, if necessary.

As part of the System's pooled cash management plan, cash in excess of daily requirements are invested in short-term investments and money market funds.

The System maintains a $200 million commercial paper program, as discussed in more detail in note 6. As of December 31, 2018 and 2017, $177 million and $120 million remained available on the System's commercial paper program, respectively.

The System maintains separate revolving line of credit facilities that provide for revolving credit in aggregate principal amount of up to $50,000 each, as discussed in more detail in note 6. As of December 31, 2018 and 2017, $50 million and $21 million remained available on the System's revolving line of credit facilities, respectively.

As of December 31, 2018, the System was in compliance with bond covenants. Long-term debt is discussed in more detail in note 6.

(9) Retirement Benefit Plans

(a) Defined-Contribution Retirement Plans

The System has several defined-contribution benefit plans, which are available to substantially all employees meeting age and length of service requirements. Participating employers annually determine the amount, if any, of the System's contributions to the plans. Total benefit expenses under the defined-contribution plans were approximately $79,012 and $79,124 for 2018 and 2017, respectively. The System also has deferred compensation plans for certain employees. Total expenses under the deferred compensation plans were $2,879 and $3,971 for 2018 and 2017, respectively.

(b) Defined-Benefit Plans

Prior to 2001, substantially all employees of four of the System's subsidiaries were covered by noncontributory defined-benefit pension plans, all of which have subsequently been frozen to new participants or terminated. The System's funding policy is to make the minimum annual contribution that is required by applicable regulations, plus such amounts as the System may determine to be appropriate from time to time.

(Continued)

The noncontributory defined-benefit plan for Methodist Health Services, Inc. (Methodist Peoria) has been frozen to new participants since 2007. As of December 31, 2012, Methodist Peoria froze its defined-benefit pension plan with regard to accrual of additional benefits by participants in the plan. The noncontributory defined-benefit pension plan for Proctor Health Care (Proctor Peoria) has been frozen with regard to the accrual of additional benefits and new participants since 2008. The unrecognized pension benefit costs in unrestricted net assets were eliminated prior to affiliation for both the Methodist Peoria and Proctor Peoria plans as part of the accounting for the affiliation with the System. Progressive Health Systems, Inc. (Pekin Peoria) has a defined-contribution plan that covers nearly all hospital employees. The board of trustees determines the amount, if any, of contributions to the plan annually. In addition, Pekin Peoria has a noncontributory defined-benefit plan covering all employees who met eligibility requirements. This plan has been curtailed since 2008 and was replaced by the defined-contribution plan. Effective December 31, 2018, the defined-benefit plans for Methodist Peoria and Proctor Peoria were merged into the Pekin Peoria plan and are now referred to as the Central Illinois plan.

Upon the affiliation with Meriter Health Services, Inc. (Madison) during 2014, the System inherited their defined-benefit pension plan. Substantially all of the employees of Madison are eligible to participate in the plan. Benefits under this plan are based primarily on years of service and employees' compensation. As of December 31, 2014, Madison froze the plan for all nonunion-and service union – covered employees. As of December 31, 2015, Madison froze the plan for all nurses' union participants. Subsequent to these dates, no additional benefits will be accrued by the frozen participants in the plan.

During 2017, the plan for UnityPoint Health-Des Moines was terminated and participants received either a lump-sum payment or had annuities purchased on their behalf. As a result of the plan terminating, a settlement expense of $41,209 was recognized in the consolidated statements of operations and changes in net assets for the year ended December 31, 2017.

The System expects to contribute $13,304 to the plans in 2018. The System uses a December 31 measurement date for the plans.

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The following tables set forth information about each defined benefit plan:

	December 31, 2018					
	Methodist Peoria	Proctor Peoria	Pekin Peoria	Madison	Cedar Rapids	Waterloo
Change in benefit obligation:						
Benefit obligation, beginning of year	$ 253,354	72,051	32,868	241,273	130,808	13,044
Service cost	—	—	—	—	—	655
Interest cost	10,186	2,874	1,320	9,568	5,223	527
Actuarial (gain) loss	(18,735)	(5,763)	(3,390)	(10,155)	(4,609)	(1,156)
Benefits paid	(10,433)	(3,809)	(5,979)	(3,882)	(6,603)	(242)
Effect of settlement	—	—	—	(12,945)	—	—
Effect of plan restatement	(233,299)	(64,343)	297,642	—	—	—
Benefit obligation, end of year	1,053	—	322,461	223,858	124,619	12,829
Change in fair value of plan assets:						
Fair value of plan assets, beginning of year	188,496	54,150	26,464	188,382	129,667	11,764
Actual return on plan assets	(14,341)	(4,259)	(1,924)	(11,447)	(4,675)	(552)
Employer contributions	9,987	4,176	285	32,500	5,004	300
Benefits paid	(10,433)	(3,809)	(5,979)	(3,882)	(6,603)	(242)
Effect of settlement	—	—	—	(12,945)	—	—
Effect of plan restatement	(173,709)	(50,258)	228,957	—	—	—
Fair value of plan assets, end of year	—	—	242,813	192,607	123,393	11,270
Funded status, end of year	(1,053)	—	(79,648)	(31,251)	(1,226)	(1,559)
Accumulated benefit obligation	$ 1,053	—	322,461	223,858	124,619	12,829

(Continued)

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH
Notes to Consolidated Financial Statements
December 31, 2018 and 2017
(Dollars in thousands)

	December 31, 2018					
	[illegible] Peoria	Proctor Peoria	Pekin Peoria	Madison	Other Peoria	Waterloo
Assets and liabilities recognized in the consolidated balance sheets:						
Noncurrent liabilities	$ (1,053)	—	(79,648)	(31,251)	(1,226)	(1,559)
	$ (1,053)	—	(79,648)	(31,251)	(1,226)	(1,559)
Amounts recognized in unrestricted net assets but not yet recognized as components of net periodic benefit cost:						
Net loss	$ 50	—	55,644	27,911	43,496	2,569
Net prior service credit	—	—	—	1,409	—	29
	$ 50	—	55,644	29,320	43,496	2,598
Amounts expected to be recognized within one year:						
Net loss	$ —	—	1,102	—	4,310	141
Net prior service credit	—	—	—	—	—	12
	$ —	—	1,102	—	4,310	153
Other changes in plan assets recognized in changes in net assets:						
Net (gain) loss	$ (1)	—	13,551	10,654	9,222	359
Amount recognized due to curtailment	—	—	318	—	—	—
Amount recognized due to settlement	—	—	—	(1,515)	—	—
Amortization of:						
Net loss	—	—	(431)	—	(3,312)	(118)
Prior service credit	—	—	—	(190)	—	(12)
Total recognized in changes in net assets	$ (1)	—	13,438	9,049	5,910	229

(Continued)

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH
Notes to Consolidated Financial Statements
December 31, 2018 and 2017
(Dollars in thousands)

	December 31, 2018					
	[illegible] Peoria	Proctor Peoria	Pekin Peoria	Madison	Cedar Rapids	Waterloo
Weighted average assumptions used to determine benefit obligations for the year ended December 31, 2018:						
Discount rate	4.67 %	NA	4.59 %	4.55 %	4.69 %	4.62 %
Rate of compensation increase	NA	NA	NA	NA	NA	NA
Weighted average assumptions used to determine benefit costs for the year ended December 31, 2018						
Discount rate	4.10 %	NA	4.10 %	4.10 %	4.10 %	4.10 %
Expected return on plan assets	NA	NA	7.00	6.90	7.10	8.20
Rate of compensation increase	NA	NA	NA	NA	NA	NA
Components of net periodic benefit cost:						
Service cost	$ —	—	—	—	—	655
Interest cost	41	—	14,319	9,556	5,223	527
Expected return on plan assets	—	—	(21,933)	(9,562)	(9,156)	(962)
Amortization of prior service credit	—	—	—	190	—	12
Amortization of net (gain)/loss	—	—	431	—	—	—
Recognized net actuarial loss	—	—	—	—	3,312	118
Effect of settlement	—	—	—	1,615	—	—
Curtailment gain from freezing benefits	—	—	(318)	—	—	—
Net periodic benefit cost (benefit)	$ 41	—	(7,501)	1,811	(621)	351

(Continued)

The service cost component of $153 is presented with other employee compensation costs in Employee benefits within operating income on the consolidated statement of operations and changes in net assets for the year ended December 31, 2018. All other components of net benefit cost, which total $(6,072), are reported separately outside of operating income in Other, net for the year ended December 31, 2018 in the accompanying consolidated financial statements.

	December 31, 2017						
	Des Moines	Methodist Peoria	Proctor Peoria	Pekin Peoria	Madison	Cedar Rapids	Waterloo
Changes in benefit obligation							
Benefit obligation, beginning of year	$ 199,567	247,266	70,200	31,899	229,946	123,943	11,559
Service cost	—	—	—	—	—	—	858
Interest cost	5,929	11,239	3,174	1,375	10,309	5,537	518
Actuarial (gain) loss	(10,083)	14,915	5,211	880	12,670	7,918	750
Benefits paid	(192,453)	(19,788)	(8,623)	(1,253)	(13,145)	(8,250)	(200)
Effect of settlement	—	—	—	—	1,500	—	(250)
Benefit obligation, end of year	—	253,354	72,061	32,869	241,279	130,808	13,044
Changes in fair value of plan assets							
Fair value of plan assets, beginning of year	200,200	172,932	50,409	23,502	170,826	117,677	11,340
Actual return on plan assets	4,929	28,708	7,248	4,215	22,401	13,438	1,581
Employer contributions	(21,794)	8,623	3,026	—	8,500	5,004	400
Benefits paid	(192,454)	(19,788)	(8,623)	(1,253)	(13,145)	(8,250)	(200)
Effect of settlement	—	—	—	—	—	—	(1,357)
Fair value of plan assets, end of year	—	190,409	54,160	26,464	188,582	128,867	11,764
Funded status, end of year	—	(62,945)	(17,911)	(6,404)	(52,691)	(941)	(1,280)
Accumulated benefit obligation	$ —	253,354	72,061	32,869	241,279	130,808	13,044

(Continued)

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Notes to Consolidated Financial Statements

December 31, 2018 and 2017

(Dollars in thousands)

	December 31, 2017						
	Des Moines	Methodist Peoria	Proctor Peoria	Pekin Peoria	Madison	Cedar Rapids	Waterloo
Liabilities recognized in the consolidated balance sheets:							
Noncurrent liabilities	$ —	(84,859)	(17,911)	(9,404)	(52,891)	(941)	(1,280)
	$ —	(84,859)	(17,911)	(9,404)	(52,891)	(941)	(1,280)
Amounts recognized in unrestricted net assets but not yet recognized as components of net periodic benefit cost:							
Net loss	$ —	24,778	19,252	(1,733)	18,671	37,586	2,328
Net prior service credit	—	—	—	—	1,600	—	42
	$ —	24,778	19,252	(1,733)	20,271	37,586	2,370
Amounts expected to be recognized within one year:							
Net prior service credit	$ —	—	431	—	—	3,312	118
	$ —	—	431	—	—	3,312	118
Other changes in plan assets recognized in changes in net assets:							
Net (gain) loss	$ —	2,540	2,381	—	(1,031)	2,946	(13)
Amount recognized due to settlement	—	—	—	—	1,600	—	—
Amortization of:							
Net loss	—	(20)	(201)	—	—	(3,192)	(155)
Prior service credit	—	—	—	—	—	—	(12)
Total recognized in changes in net assets	$ —	2,520	2,180	—	569	(246)	(180)

(Continued)

IOWA HEALTH SYSTEM AND SUBSIDIARIES
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Notes to Consolidated Financial Statements
December 31, 2018 and 2017
(Dollars in thousands)

	December 31, 2017						
	Des Moines	Methodist Peoria	Proctor Peoria	Pekin Peoria	Madison	Cedar Rapids	Waterloo
Weighted average assumptions used to determine benefit obligations for the year ended December 31, 2017							
Discount rate	4.10 %	4.10 %	4.10 %	4.10 %	4.10 %	4.10 %	4.10 %
Rate of compensation increase	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Weighted average assumptions used to determine benefit costs for the year ended December 31, 2017							
Discount rate	4.64 %	4.64 %	4.64 %	4.40 %	4.64 %	4.64 %	4.64 %
Expected return on plan assets	7.00	8.50	8.00	7.00	7.00	7.10	8.20
Rate of compensation increase	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Components of net periodic benefit cost							
Service cost	$ —	—	3,174	—	—	—	858
Interest cost	5,029	11,299	(4,397)	1,375	10,309	5,597	518
Expected return on plan assets	(9,537)	(14,690)	—	(1,802)	(8,501)	(8,764)	(815)
Amortization of prior service credit	—	—	201	—	—	—	12
Recognized net actuarial loss	1,784	20	—	—	—	3,192	155
Effect of settlement	40,991	—	—	—	—	—	—
Net periodic benefit cost (benefit)	$ 38,167	(3,371)	(1,022)	(227)	1,808	25	823

The System has estimated the long-term rate of return on plan assets based primarily on historical returns on plan assets, adjusted for changes in target portfolio allocations and recent changes in long-term interest rates based on publicly available information.

Plan assets are held by bank-administered trust funds, which invest each plan's assets in accordance with the provisions of the plan agreements. The plan agreements permit investment in common stocks, corporate bonds and debentures, U.S. government securities, and other specified investments based on certain target allocation percentages.

Asset allocation is primarily based on a strategy to provide stable earnings while still permitting the plans to recognize potentially higher returns through investment in equity securities and limited exposure to alternative investments. Target asset allocation percentages for 2018 and 2017 were as follows:

	2018					
	Methodist Peoria	Proctor Peoria	Pekin Peoria	Madison	Cedar Rapids	Waterloo
Equity securities	100 %	100 %	100 %	45 %	23 %	34 %
Fixed income	—	—	—	40	77	51
Alternative investments	—	—	—	15	—	15

(Continued)

	2017					
	Methodist Peoria	Proctor Peoria	Pekin Peoria	Madison	Cedar Rapids	Waterloo
Equity securities	56 %	55 %	60 %	45 %	22 %	38 %
Fixed income	29	30	40	40	78	48
Alternative investments	15	15	—	15	—	14

Plan assets are re-balanced quarterly. At December 31, 2018 and 2017, plan asset allocations are as follows:

	2018				2017					
	Peoria	Madison	Cedar Rapids	Waterloo	Methodist Peoria	Proctor Peoria	Pekin Peoria	Madison	Cedar Rapids	Waterloo
Cash equivalents	— %	2 %	— %	— %	— %	— %	— %	2 %	— %	— %
US Treasury obligations	—	—	18	9	—	—	—	9	15	9
Corporate bonds	—	5	—	—	—	—	—	21	—	—
Equity securities										
Domestic	—	7	—	—	—	—	—	9	—	—
Mutual funds										
Domestic	35	—	9	29	34	31	50	—	8	27
International	20	—	13	11	23	23	13	—	14	13
Equity	—	20	—	—	—	—	—	22	—	—
Fixed income	10	12	40	42	28	32	37	9	42	38
Other	—	5	—	—	—	—	—	5	—	—
Alternative investments	12	14	—	15	6	6	—	16	1	13
Hedge funds	5	37	—	—	9	10	—	9	—	—
	100 %	100 %	100 %	100 %	100 %	100 %	100 %	99 %	100 %	99 %

(c) Defined Benefit Plan Assets

The valuation methodologies and inputs used for pension plan assets measured at fair value on a recurring basis, as well as the general classification of pension plan assets pursuant to the valuation hierarchy, are described below. There have been no significant changes in the valuation techniques during the year ended December 31, 2018 or 2017.

Where quoted market prices are available in an active market, plan assets are classified within Level 1 of the valuation hierarchy. Level 1 plan assets include exchange traded equities and mutual funds as well as cash equivalents held in money market accounts. If quoted market prices are not available, then fair values are estimated by using quoted prices of securities with similar characteristics or independent asset pricing services and pricing models, the inputs of which are market based or independently sourced market parameters, including, but not limited to, yield curves, interest rates, volatilities, prepayments, defaults, cumulative loss projections, and cash flows. Such securities are classified within Level 2 of the valuation hierarchy. Level 2 plan assets include U.S. Treasury obligations and corporate debt. In certain cases where Level 1 or Level 2 inputs are not available, plan assets are classified within Level 3 of the hierarchy. There are no Level 3 plan assets.

The value of certain plan assets classified as alternative investments is determined using net asset value (or its equivalent) as a practical expedient.

(Continued)

The following table presents the fair value measurements of the System's pension plans' assets measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at December 31, 2018 and 2017:

		Fair value measurements using		
	Fair value	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
2018:				
Cash equivalents	$ 2,480	2,480	—	—
U.S. Treasury obligations	20,201	20,201	—	—
Corporate bonds	8,954	—	8,954	—
Equity securities:				
Domestic	14,200	14,200	—	—
International	672	672	—	—
Mutual funds:				
Domestic	92,174	92,174	—	—
International	65,194	65,194	—	—
Equity	37,862	37,862	—	—
Fixed income	174,728	174,728	—	—
Other	9,895	—	9,895	—
Alternative funds *	58,631	—	—	—
Hedge funds*	84,409	—	—	—
Accrued income	683	—	—	—
	$ 570,083	407,511	18,849	—

(Continued)

	Fair value	Fair value measurements using: Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
2017:				
Cash equivalents	$ 3,888	3,888	—	—
U.S. Treasury obligations	31,168	31,168	—	—
Corporate bonds	40,481	—	40,481	—
Equity securities:				
Domestic	17,344	17,344	—	—
International	857	857	—	—
Mutual funds:				
Domestic	107,382	107,382	—	—
International	79,014	79,014	—	—
Equity	41,163	41,163	—	—
Fixed income	180,764	180,764	—	—
Other	9,395	—	9,395	—
Alternative funds *	49,113	—	—	—
Hedge funds*	38,552	—	—	—
Accrued income	2	—	—	—
	$ 599,123	461,580	49,876	—

* Certain investments that are measured at fair value using the net asset value per share (or its equivalent) as a practical expedient have not been classified in the fair value hierarchy. The fair value amounts included above are intended to permit reconciliation of the fair value hierarchy to amounts presented in the change in fair value of plan assets above.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as of December 31, 2018:

2019	$ 40,904
2020	43,761
2021	43,252
2022	44,785
2023	45,397
2024–2028	224,099

(Continued)

(10) Risk Management

The System's hospitals are primarily self-insured for professional and general liability for amounts of $5,000 per claim ($3,000 per claim for Methodist Health Services Corporation) and $30,000 in the aggregate annually. Other entities of the System maintain their professional and general liability coverage primarily on a claims-made basis with no significant deductibles.

The System is primarily self-insured for workers' compensation and employee healthcare claims. Workers' compensation claims individually and in the aggregate that exceed certain amounts are covered by insurance.

Property insurance is maintained with at least 90% replacement value coverage and minimal deductibles. Network security and information privacy insurance as well as business interruption insurance coverage is also maintained by the System.

The System has accrued as other liabilities $122,742 and $109,858 for self-insured losses at December 31, 2018 and 2017, respectively. These liabilities are presented on a gross basis, and the expected offsetting insurance recoveries are reported as a receivable. The accrued liabilities are based on management's evaluation of the merits of various claims, historical experience, and consultation with external insurance consultants and actuaries, and these liabilities include estimates for incurred but not reported claims. There can be no assurance that the accrued liabilities will be sufficient for the ultimate amounts that will be paid for claims and settlements. Also, in the ordinary course of business, the System is involved in other litigation and claims, none of which management believes will ultimately result in losses that will adversely affect the System's consolidated net assets or results of operations to a material degree.

Cash and investments have been internally designated to be held for payments of claims, if any, which may result from the self-insured or uninsured portion of liability insurance and workers' compensation claims. At December 31, 2018 and 2017, cash and investments designated for this purpose amounted to $37,978 and $36,437, respectively.

(11) Lease Commitments

Certain property and equipment is being leased under long-term noncancelable operating leases. In most cases, management expects that, in the normal course of operations, the leases will be renewed or replaced by other leases. The total rent expense under operating leases for 2018 and 2017 was $80,410 and $80,323, respectively.

(Continued)

The following is a schedule by year of future minimum rental payments required under noncancelable operating leases that have initial or remaining noncancelable lease terms in excess of one year as of December 31, 2018:

2019	$	62,568
2020		49,416
2021		42,705
2022		37,813
2023		33,111
Thereafter		125,143
Total minimum payments required	$	350,756

(12) Disclosures about Fair Value of Assets and Liabilities

Fair value is defined as 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. An entity must maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. There is a hierarchy of three levels of inputs that may be used to measure fair value:

Level 1 Quoted prices in active markets for identical assets or liabilities

Level 2 Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in active markets that are not active, or other inputs, that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities

Level 3 Unobservable inputs supported by little or no market activity and are significant to the fair value of the assets or liabilities

(a) Financial Instruments Measured at Fair Value on a Recurring Basis

The valuation methodologies and inputs used for assets and liabilities measured at fair value on a recurring basis and recognized in the accompanying consolidated balance sheets, as well as the general classification of such assets and liabilities pursuant to the valuation hierarchy, are described below. There have been no significant changes in the valuation techniques during the years ended December 31, 2018 or 2017. For assets classified within Level 3 of the fair value hierarchy, the process used to develop the reported fair value is described below.

(Continued)

(b) Investments

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Level 1 securities include exchange traded equities and mutual funds, certificates of deposit and cash equivalents held in money market accounts. If quoted market prices are not available, then fair values are estimated by using quoted prices of securities with similar characteristics or independent asset pricing services and pricing models, the inputs of which are market-based or independently sourced market parameters, including, but not limited to, yield curves, interest rates, volatilities, prepayments, defaults, cumulative loss projections, and cash flows. Such securities are classified within Level 2 of the valuation hierarchy. Level 2 securities include U.S. Treasury obligations, U.S. government agency obligations, municipal bonds, collateralized mortgage and other collateralized asset obligations, corporate debt, and certain beneficial interest in perpetual trusts. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy. Level 3 financial instruments include beneficial interest in perpetual trusts, which are discussed below. Inputs and valuation techniques used for these Level 3 interests are described below.

Fair value determinations for Level 3 measurements of securities are the responsibility of management. Management contracts with a pricing specialist to generate fair value estimates on a monthly or quarterly basis. Management challenges the reasonableness of the assumptions used and reviews the methodology to ensure the estimated fair value complies with accounting standards generally accepted in the United States.

(c) Interest Rate Swap Agreements

The fair value is estimated using forward-looking interest rate curves and discounted cash flows that are observable or can be corroborated by observable market data and, therefore, are classified within Level 2 of the valuation hierarchy.

(d) Beneficial Interest in Perpetual Trusts

The fair value is estimated at the present value of the future distributions expected to be received over the term of the agreement. Trusts that have a definite duration based on the terms of the trust document, and where the System has the ability to redeem the investment for the underlying assets at some future point, are classified within Level 2 of the valuation hierarchy due to the nature of the valuation inputs. For trusts that are perpetual in nature in which the underlying assets will never be available to the System, the interest is classified within Level 3 of the hierarchy.

(Continued)

(e) Fair Value Measurements

The following tables present the fair value measurements of assets and liabilities recognized in the accompanying consolidated balance sheets measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at December 31, 2018 and 2017:

	2018			
		Fair value measurements using		
	Fair value	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Investments:				
Cash equivalents	$ 4,604	4,604	—	—
U.S. Treasury obligations	8,281	—	8,281	—
U.S. government agency obligations	1,198	—	1,198	—
Municipal bonds	189	—	189	—
Asset-backed securities:				
Home equity	4,054	—	4,054	—
Other	3,519	—	3,519	—
Mortgage-backed securities:				
Government	957	—	957	—
Nongovernment	1,922	—	1,922	—
Certificates of deposit	5,740	5,740	—	—
Corporate bonds	24,510	—	24,510	—
Equity securities:				
Domestic	15,047	15,047	—	—
International	981	981	—	—
Equity securities – PIF:				
Domestic	10,098	10,098	—	—
Mutual funds:				
Domestic	19,757	19,757	—	—
International	520,451	520,451	—	—
Emerging markets	—	—	—	—
Index	5,663	5,663	—	—
Equity	400,193	400,193	—	—
Fixed income	567,048	567,048	—	—
Other	50,964	50,964	—	—

(Continued)

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		2018			
		Fair value measurements using			
	Fair value	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Alternative investments*	$ 531,768	—	—	—
Hedge funds*	—	—	—	—
Private equity funds*	21,598	—	—	—
Interest rate swap agreements	842	—	842	—
Other items at cost**	1,756	—	1,756	—
Total short-term investments, assets limited as to use and other long-term investments	$ 2,203,240	1,602,545	47,328	—
Beneficial interests in perpetual trusts included in contributions receivable	$ 19,051	—	11,897	7,154
Interest rate swap agreements included in other long-term liabilities	(50,206)	—	(50,206)	—

(Continued)

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December 31, 2018 and 2017

(Dollars in thousands)

		2017			
		Fair value measurements using			
	Fair value	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Investments:					
Cash equivalents	$ 4,485	4,485	—	—
U.S. Treasury obligations	11,104	—	11,104	—
U.S. government agency obligations	881	—	881	—
Municipal bonds	1,320	—	1,320	—
Asset-backed securities:				
Other	5,349	—	5,349	—
Mortgage-backed securities:				
Government	37	—	37	—
Nongovernment	2,284	—	2,284	—
Certificates of deposit	3,928	3,928	—	—
Corporate bonds	14,726	—	14,726	—
Equity securities:				
Domestic	16,827	16,827	—	—
International	875	875	—	—
Mutual funds:				
Domestic	22,256	22,256	—	—
International	600,470	600,470	—	—
Emerging markets	758	758	—	—
Index	5,050	5,050	—	—
Equity	447,951	447,951	—	—
Fixed income	600,144	600,144	—	—
Other	52,232	52,232	—	—
Alternative funds*	511,552	—	—	—
Hedge funds*	3,656	—	—	—
Private equity funds*	12,066	—	—	—
Interest rate swap agreements	528	—	528	—
Other items at cost**	6,668	—	1,727	—
Total short-term investments, assets limited as to use and other long-term investments	$ 2,325,157	1,754,975	37,956	—
Beneficial interests in perpetual trusts included in contributions receivable	$ 20,985	—	13,529	7,456
Interest rate swap agreements included in other long-term liabilities	(62,419)	—	(62,419)	—

(Continued)

* Certain investments that are measured at fair value using the net asset value per share (or its equivalent) as a practical expedient have not been classified in the fair value hierarchy. The fair value amounts included above are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

** Other items at cost primarily includes insurance policies and accrued interest.

(f) Level 3 Reconciliation

The following is a reconciliation of the beginning and ending balances of recurring fair value measurements recognized in the accompanying consolidated balance sheets using significant unobservable (Level 3) inputs:

	Beneficial interest in Perpetual Trusts
Balance, December 31, 2016	$ 7,063
Change in beneficial interest in perpetual trusts	393
Balance, December 31, 2017	7,456
Change in beneficial interest in perpetual trusts	(302)
Balance, December 31, 2018	$ 7,154

(g) Goodwill

Goodwill is evaluated for impairment when qualitative events indicate goodwill might be impaired. If the System performs an impairment test, any impairment loss is recognized as expense when it is determined that the carrying amount of the goodwill exceeds its implied fair value. The key inputs used to assess for potential impairment are a qualitative analysis of the applicable reporting unit and a quantitative discounted cash flow analysis. These inputs are classified within Level 3 of the fair value hierarchy.

(Continued)

(h) Unobservable (Level 3) Inputs

The following table presents quantitative information about unobservable inputs used in recurring and nonrecurring Level 3 fair value measurements:

	Fair value	Valuation technique	Adjustment to NAV
Recurring:			
Beneficial interests in perpetual trusts	$ 7,154	Present value of future distributions expected to be received over term of agreement	N/A
Nonrecurring:			
Goodwill	$ 37,064	Discounted cash flow	N/A

(13) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes or periods as of December 31:

	2018	2017
Purchase of equipment	$ 25,849	28,869
Indigent care/operations	60,091	47,207
Health education	12,686	16,052
For use in future periods	13,402	25,041
Investments (generally including net investment appreciation and depreciation) to be held in perpetuity (income is unrestricted)	4,233	9,260
Investments (generally including net investment appreciation and depreciation) to be held in perpetuity (income is restricted for various purposes as directed by the donors)	71,645	64,883
Total with donor restrictions	$ 187,886	191,312

The portion of restricted net assets that have restrictions on the usage of income include restrictions for the support of operations, capital and equipment, education, patient assistance and research.

Net assets released from restrictions were $21,540 and $23,097 in 2018 and 2017 respectively. Net assets were released from restriction by incurring expenses satisfying the restricted purposes or by occurrence of other events specified by donors including support of operations, capital and equipment, education, patient and employee assistance, and research.

(Continued)

(14) Related-Party Transactions

The System purchases a variety of services and products, including leases, from companies affiliated with members of the Boards of Directors of the System and/or its subsidiaries. Services and products purchased from these affiliated companies during 2018 and 2017 totaled $21,587 and $22,898, respectively. In addition, the System purchases services from several joint ventures and sells services and supplies to several joint ventures in which the System is also an investor.

The System has recorded receivables for amounts held by nonconsolidated foundations on behalf of the System of $50,700 and $54,932 as of December 31, 2018 and 2017, respectively. Contributions received from nonconsolidated foundations and other related parties were $4,654 and $7,219 in 2018 and 2017, respectively.

The System believes these transactions are consummated under commercially reasonable business arrangements.

(15) Commitments and Contingencies

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Government activity has increased with respect to investigations and allegations concerning possible violations of regulations by health care providers, which could result in the imposition of significant fines and penalties as well as significant repayments of previously billed and collected revenues for patient services. The System has a corporate compliance plan intended to meet federal guidelines. As a part of this plan, the System performs periodic internal reviews of its compliance with laws and regulations. As part of the System's compliance efforts, the System investigates and attempts to resolve and remedy all reported or suspected incidents of material noncompliance with applicable laws, regulations or policies on a timely basis. The System believes that these compliance programs and procedures lead to substantial compliance with current laws and regulations.

The System is in various stages of responding to inquiries and investigations by regulators. These various inquiries and investigations could result in fines and/or financial penalties, which could be material. At this time, the System is unable to estimate the possible liability, if any, that may be incurred as a result of these inquiries and investigations, but the System does not believe it would materially affect the financial position of the System.

Guarantees

The System has guaranteed $21,798 and $27,507, which is outstanding at December 31, 2018 and 2017, respectively, relating to long-term debt for the construction of a family practice residency program education facility, a managed facility's building project, and debt related to joint ventures. For 2018 and 2017, no payments on these guarantees were made.

(Continued)

(16) Subsequent Events

Subsequent events have been evaluated through April 29, 2019, which is the date the consolidated financial statements were issued.

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

UnityPoint Health – Des Moines and Subsidiaries (Des Moines)

Consolidating Statement of Operations

Year ended December 31, 2018

(In thousands)

	UPH-DM	CHC	UPHF	CHP	EB	GRMC	UPC	UP At	Eliminations	Consolidated
Unrestricted revenue:										
Net patient service revenue	$ —	774,459	—	—	11,936	45,560	153,938	69,695	(15)	1,055,769
Other operating revenue	—	64,475	1,210	9,172	1,045	2,010	22,421	3,048	(11,001)	92,480
Net assets released from restrictions used for operations	—	4,955	276	—	—	178	2	217	—	5,630
Total unrestricted revenue	—	843,889	1,486	9,172	12,981	47,750	176,361	73,131	(11,016)	1,153,822
Expenses:										
Salaries and wages	—	274,544	1,997	70	7,807	17,050	45,069	30,031	—	377,094
Physician compensation and services	—	97,575	—	—	127	6,540	68,884	310	(3,755)	169,680
Employee benefits	—	70,949	342	24	2,004	5,104	13,339	7,035	(14)	100,889
Supplies	—	169,360	852	4	203	10,095	19,007	25,047	(1)	211,997
Other expense	—	143,457	1,133	2,308	2,418	7,765	38,165	10,454	(8,115)	199,671
Depreciation and amortization	—	33,934	5	1,005	131	2,251	3,134	721	—	39,931
Interest	—	4,724	—	—	39	182	383	61	(27)	5,361
Provision for uncollectible accounts	—	215	—	—	1	—	—	1,003	—	1,219
Total expenses	—	779,765	4,049	3,979	12,888	51,195	216,084	75,662	(11,916)	1,131,254
Operating income (loss)	—	65,124	(2,563)	2,193	415	(3,335)	(39,723)	(2,531)	—	19,568
Nonoperating gains (losses):										
Investment income (loss)	—	(25,434)	(6,000)	—	2	(283)	(110)	(91)	—	(33,982)
Contribution received institutions	—	(1)	—	—	1,803	16,380	—	—	—	18,082
Other, net	—	—	(3)	—	—	(20)	—	—	—	(23)
Total nonoperating gains (losses), net	—	(25,435)	(6,003)	—	1,805	16,072	(110)	(91)	—	(14,662)
Excess (deficiency) of revenue over expenses	$ —	39,689	(10,649)	2,193	2,220	14,747	(39,813)	(2,612)	—	4,905

Definitions:

UPH-DM – UnityPoint Health – Des Moines
CHC – Central Iowa Hospital Corporation
UPHF – UnityPoint Health Foundation
CHP – Central Iowa Health Properties Corporation
EB – Every Bill Mental Health Services
GRMC – Grinnell Regional Medical Center
UPC – UnityPoint Clinic, UPH-DM portion
UP At – UnityPoint at Home, UPH-DM portion

See accompanying independent auditors' report

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Trinity Regional Health System and Subsidiaries (Rock Island)

Consolidating Statement of Operations

Year ended December 31, 2018

(In thousands)

	TRHS	TMC	THF	THE	TM	UPC	UPAH	Eliminations	Consolidated
Unrestricted revenue:									
Net patient service revenue	$ —	432,857	—	3,284	47,085	89,089	33,307	(48)	573,713
Other operating revenue	(783)	28,198	21	(123)	2,934	6,472	334	(3,871)	33,439
Net assets released from restrictions used for operations	—	319	109	—	18	3	8	—	459
Total unrestricted revenue	(783)	461,081	130	3,161	50,037	95,564	33,737	(3,720)	634,577
Expenses:									
Salaries and wages	—	142,310	622	780	15,004	20,628	15,693	—	195,014
Physician compensation and services	—	42,699	—	—	7,699	33,733	119	(1,332)	87,778
Employee benefits	—	34,944	136	202	3,691	6,199	4,093	(218)	49,017
Supplies	—	65,167	42	2,002	5,002	6,109	10,012	(16)	108,497
Other expenses	—	69,259	418	267	9,041	19,278	4,191	(2,699)	129,419
Depreciation and amortization	—	20,850	—	33	2,481	693	149	—	24,341
Interest	—	6577	—	—	648	3	35	(1)	7,462
Provision for uncollectible accounts	—	(16)	—	—	—	—	208	—	208
Total expenses	—	430,770	1,220	3,834	45,813	86,693	34,699	(4,454)	603,555
Operating income (loss)	(783)	27,263	(1,090)	(783)	5,344	(29,789)	(1,071)	784	3,918
Nonoperating gains (losses):									
Investment income (loss)	(728)	(3,837)	(340)	20	(311)	(45)	(38)	—	(5,099)
Contribution received in affiliations	—	1	—	—	—	—	—	—	1
Other, net	—	(22)	—	—	—	—	—	—	(22)
Total nonoperating gains (losses), net	(728)	(3,858)	(340)	20	(311)	(45)	(38)	—	(5,120)
Excess (Deficiency) of revenue over expenses	(1,501)	23,525	(1,430)	(763)	5,033	(29,811)	(1,107)	784	(4,184)
Less net loss attributable to noncontrolling interest	—	(3,851)	—	—	—	—	—	—	(3,851)
Excess (Deficiency) of revenue over expenses attributable to UnityPoint Health	$ (1,501)	19,774	(1,430)	(763)	5,033	(29,811)	(1,107)	784	(8,035)

Definitions
TRHS – Trinity Regional Health System
TMC – Trinity Medical Center
THF – Trinity Health Foundation
THE – Trinity Health Enterprises, Inc
TM – Trinity Muscatine
UPC – UnityPoint Clinic, TRHS portion
UPAH – UnityPoint at Home, TRHS portion

See accompanying independent auditors' report

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Mercy Health System, Inc. and Subsidiaries (Medicare)

Consolidating Statement of Operations

Year ended December 31, 2018

(In thousands)

	MHS	MH	MF	MMS	UPAH	Eliminations	Consolidated
Unrestricted revenue							
Net patient service revenue	$ —	433,650	—	16,942	10,440	(11,952)	449,080
Other operating revenue	3,459	23,951	1,478	9,304	243	(17,283)	21,152
Net assets released from restrictions used for operations	—	190	25	—	—	—	215
Total unrestricted revenue	3,459	457,801	1,503	26,246	10,683	(29,235)	470,447
Expenses							
Salaries and wages	2,220	148,835	411	9,694	5,203	—	166,363
Physician compensation and services	—	41,764	—	3	—	—	41,767
Employee benefits	511	47,008	129	3,004	1,924	—	52,576
Supplies	1	66,485	8	3,476	3,492	—	73,462
Other expenses	806	113,869	1,112	8,519	980	(29,999)	95,087
Depreciation and amortization	—	21,049	—	351	54	—	21,454
Interest	—	7,588	—	—	12	—	7,600
Provision for uncollectible accounts	—	—	—	—	231	—	231
Total expenses	3,538	446,428	1,660	25,047	11,896	(29,999)	459,820
Operating income (loss)	(79)	11,373	(157)	1,199	(1,153)	(209)	10,627
Nonoperating gains (losses):							
Investment income (loss)	194	(14,466)	(603)	101	(19)	—	(14,822)
Other, net	40	(2,039)	(5)	(238)	—	—	(2,242)
Total nonoperating gains (losses), net	234	(16,534)	(608)	(137)	(19)	—	(17,064)
Excess (Deficiency) of revenues over expenses	$ 155	(5,161)	(765)	1,062	(1,172)	(209)	(6,097)

Definitions
MHS – Mercy Health Services, Inc.
MH – Mercy Hospital, Inc.
MF – Mercy Foundation, Inc.
MMS – Mercy Management Services
UPAH – UnityPoint at Home, MHS portion

See accompanying independent auditors' report

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

St. Luke's Healthcare and Subsidiaries (Cedar Rapids)

Consolidating Statement of Operations

Year ended December 31, 2018

(in thousands)

	SLMH	CARE	JRMC	ABBE	UPC	UPAH	Eliminations	Consolidated
Unrestricted revenue:								
Net patient service revenue	$ 372,448	11,809	34,833	34,873	53,178	16,005	(886)	514,388
Other operating revenue	29,334	218	666	3,049	11,691	176	(15,832)	29,090
Net assets released from restrictions used for operations	787	—	54	—	49	169	—	1,059
Total unrestricted revenue	402,567	12,217	35,342	29,519	64,778	17,180	(16,668)	544,916
Expenses:								
Salaries and wages	125,324	6,439	10,162	16,883	20,223	6,441	(80)	184,410
Physician compensation and services	34,352	34	6,843	—	38,127	113	(4,126)	75,043
Employee benefits	34,588	1,108	3,832	5,089	8,407	1,775	—	54,833
Supplies	68,449	1,782	3,132	788	6,333	7,006	(63)	84,822
Other expense	60,088	2,838	7,448	5,748	10,781	3,407	(12,387)	113,353
Depreciation and amortization	18,043	348	1,709	688	778	148	—	21,787
Interest	3,414	—	333	27	3	17	(63)	3,751
Provision for uncollectible accounts	37	—	—	84	—	214	—	335
Total expenses	372,170	12,009	33,659	29,234	85,652	19,182	(16,668)	535,031
Operating income (loss)	30,397	178	2,683	285	(22,180)	(1,672)	1	9,915
Nonoperating gains (losses):								
Investment income (loss)	(8,128)	11	269	(374)	(62)	(13)	—	(8,271)
Other, net	621	—	—	—	—	—	—	621
Total nonoperating gains (losses), net	(7,505)	11	269	(374)	(62)	(13)	—	(7,650)
Excess (Deficiency) of revenues over expenses	22,892	189	2,952	(89)	(22,242)	(1,685)	1	1,265
Less net income attributable to noncontrolling interest	65	—	—	—	—	—	—	65
Excess (Deficiency) of revenues over expenses attributable to UnityPoint Health	$ 22,847	189	2,952	(89)	(22,242)	(1,685)	1	1,200

Definitions:
SLMH – Mercy Health Services, Inc
MH – Mercy Hospital, Inc
MF – Mercy Foundation, Inc
MMS – Mercy Management Services
UPAH – UnityPoint at Home, MHS portion

ABBE – Abbe, Inc
UPC – UnityPoint Clinic, SLMC portion
UPAH – UnityPoint at Home, SLMC portion

See accompanying independent auditors' report

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[illegible] UNITYPOINT HEALTH

Allen Health Systems, Inc. and Subsidiaries (Waterloo)

Consolidating Statement of Operations

Year ended December 31, 2019

(In thousands)

	AHS	AMH	MFAH	AC	Marshalltown	BHKMHC	UPC	UPAH	Eliminations	Consolidated
Unrestricted revenue										
Net patient service revenue	$ —	281,779	—	—	63,439	4,094	43,559	21,803	(742)	397,329
Other operating revenue	1,356	19,462	6	11,822	5,081	663	6,602	666	(10,166)	37,021
Net assets released from restrictions used for operations	—	497	6	573	—	38	2	83	—	1,199
Total unrestricted revenue	1,356	301,738	12	12,395	68,519	4,795	50,163	22,552	(10,908)	435,549
Expenses										
Salaries and wages	—	73,993	426	6,254	24,269	2,130	16,363	8,576		132,942
Physician compensation and services	—	29,466		67	18,189	1,731	31,239	70	(3,474)	76,288
Employee benefits	—	19,975	99	1,472	6,573	725	4,749	2,386	(99)	35,810
Supplies	—	57,070	6	135	9,193	32	4,828	7,329	(61)	77,262
Other expenses	—	53,499	211	2,937	14,208	302	10,629	3,402	(6,884)	68,304
Depreciation and amortization	—	16,412	—	—	4,145	103	1,003	150		21,813
Interest	1,356	3,357	—	—	1,397	10	2	34	(1,356)	4,799
Provision for uncollectible accounts	—	2	—	93	59	—	—	249	—	353
Total expenses	1,356	253,824	742	10,958	74,123	5,137	72,491	22,196	(10,854)	419,373
Operating income (loss)	—	47,914	(730)	1,769	(5,604)	(194)	(22,328)	356	—	16,176
Nonoperating gains (losses)										
Investment income (loss)	—	(8,020)	(110)	—	94	(21)	(39)	(17)	—	(8,112)
Other, net	—	304	(7)	—	—	—	—	—	—	297
Total nonoperating gains (losses), net	—	(8,716)	(117)	—	94	(21)	(39)	(17)	—	(8,815)
Excess (Deficiency) of revenues over expenses	$ —	39,198	(847)	1,769	(5,510)	(215)	(22,367)	339	—	7,361

Definitions

AHS – Allen Health System
AMH – Allen Memorial Hospital Corporation
MFAH – Memorial Foundation of Allen Hospital
AC – Allen College
Marshalltown – Marshalltown Hospital
BHKMHC – Black Hawk-Grundy Mental Health Center
UPC – UnityPoint Clinic, AHS portion
UPAH – UnityPoint at Home, AHS portion

See accompanying independent auditors' report

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

St. Luke's Health System, Inc. and Subsidiaries (Sioux City)

Consolidating Statement of Operations

Year ended December 31, 2016

(In thousands)

	SLHS	SLRMC	SLHR	PACE	UPC	UPAH	Eliminations	Consolidated
Unrestricted revenue:								
Net patient service revenue	$ —	174,578	4,149	—	11,352	11,378	(2,177)	199,280
Premium revenue	—	—	—	—	—	—	—	—
Other operating revenue	2,997	5,321	615	16,999	2,073	99	(2,699)	25,405
Total unrestricted revenue	2,997	179,897	4,764	16,999	13,425	11,477	(4,788)	224,750
Expenses:								
Salaries and wages	—	59,900	1,720	3,214	3,926	3,656	—	71,216
Physician compensation and services	—	19,849	1,594	667	8,045	—	(840)	29,505
Employee benefits	—	14,640	488	694	1,006	1,047	—	18,285
Supplies	2	30,335	318	151	1,010	4,009	—	35,825
Other expenses	1,012	39,478	648	10,776	2,884	1,363	(4,128)	51,672
Depreciation and amortization	1,107	7,401	132	141	116	139	—	9,036
Interest	336	1,823	—	—	1	12	—	2,172
Provision for uncollectible accounts	—	39	—	150	—	343	—	531
Total expenses	2,457	173,697	4,870	16,093	16,400	10,664	(4,788)	218,523
Operating income (loss)	540	7,200	(106)	906	(2,975)	599	—	6,221
Nonoperating gains (losses):								
Investment income (loss)	14	(2,377)	5	16	(9)	(9)	—	(2,360)
Total nonoperating gains (losses), net	14	(2,377)	5	16	(9)	(9)	—	(2,360)
Excess (Deficiency) of revenues over expenses	554	4,823	(101)	922	(2,974)	594	—	3,863
Less net income (loss) attributable to noncontrolling interest	—	(2,147)	—	—	—	—	—	(2,147)
Excess (Deficiency) of revenues over expenses attributable to UnityPoint Health	$ 554	2,676	(101)	922	(2,974)	594	—	1,671

Definitions:
SLHS – St. Luke's Health System
SLRMC – St. Luke's Regional Medical Center
SLHR – St. Luke's Health Resources
PACE – Siouxland PACE
UPC – UnityPoint Clinic, SLHS portion
UPAH – UnityPoint at Home, SLH Sportion

See accompanying independent auditors' report.

[redacted]

Trinity Health System, Inc. and Subsidiaries (Fort Dodge)

Consolidating Balance Sheet

December 31, 2018

(in thousands)

Assets	THS	TRMC	THF	TBC	TPG	BMHC	TP ACO	UPC	UPAH	Eliminations	Consolidated
Current assets:											
Cash and cash equivalents	$ 377	1,488	101	1,412	60	1,247	—	—	—	—	4,685
Short-term investments	17	120	3	60	—	65	—	—	—	—	265
Assets limited as to use – required for current liabilities	—	450	—	—	—	—	—	—	—	—	450
Patient accounts receivable, net	—	14,480	—	—	(1)	644	—	—	—	—	15,123
Other receivables	100	1,840	—	—	—	1,504	—	—	—	—	3,444
Inventories	—	2,842	—	—	—	—	—	—	—	—	2,842
Prepaid expenses	—	303	—	—	—	5	—	—	—	—	308
Due from affiliates	1,826	6,237	—	10,894	1,277	169	66	—	—	(22,469)	1,454
Total current assets	2,320	30,966	104	12,366	1,436	3,760	66	—	—	(22,469)	28,951
Assets limited as to use, noncurrent:											
Internally designated	—	44,083	—	18,121	—	—	—	—	—	—	62,204
Total assets limited as to use, noncurrent	—	44,083	—	18,121	—	—	—	—	—	—	62,204
Property, plant, and equipment, net	149	99,499	—	—	—	453	—	—	—	—	99,084
Other long-term investments	454	368	2,225	140	12,537	107	—	—	—	—	15,831
Investments in joint ventures and other investments	39,491	31,160	—	—	—	13	—	2,401	3,704	(67,849)	9,120
Contributions receivable, net	—	—	3,164	—	—	—	—	—	—	—	3,164
Other	—	91	—	—	1	104	—	—	—	1	217
Total assets	$ 42,792	208,202	5,594	30,627	14,014	4,515	66	2,401	3,704	(90,473)	221,442
Liabilities and Net Assets											
Current liabilities:											
Accounts payable	$ 2	3,065	6	—	42	49	—	—	—	—	3,164
Accrued payroll	280	3,777	13	—	—	81	—	—	—	—	4,251
Refunds to patients due to third-party payers	—	1,029	—	—	142	451	—	—	—	—	1,621
Due to affiliates	212	18,844	188	70	7,171	1,249	109	—	—	(22,823)	4,921
Other current liabilities	14	1,703	(3)	—	—	2	—	—	1	1	1,720
Total current liabilities	508	28,507	177	70	7,355	1,829	109	—	1	(22,824)	14,632
Other long-term liabilities	483	1,278	—	—	12,527	34	—	—	—	—	14,322
Due to affiliates	—	11,200	—	—	—	—	—	—	—	—	11,200
Total liabilities	1,017	39,985	177	70	19,882	1,863	109	—	1	(22,824)	40,410
Net assets (deficit):											
Total without donor restrictions	39,158	118,229	15,080	12,462	(5,878)	2,642	(39)	2,401	3,250	(61,884)	124,439
Total with donor restrictions	—	7,715	5,348	—	—	12	—	—	473	(5,665)	7,883
Total net assets	39,158	125,944	21,437	12,462	(5,878)	2,654	(39)	2,401	3,703	(67,649)	132,322
Total liabilities and net assets	$ 42,792	208,202	21,614	12,532	14,004	4,515	66	2,401	3,704	(90,473)	172,732

Definitions:
THS – Trinity Health System
TRMC – Trinity Regional Medical Center
THF – Trinity Health Foundation
TBC – Trinity Building Corporation
TPG – Trinity Physicians Group

BMHC – Bonyfill Mental Health Clinic
TP ACO – Trinity Pioneer ACO
UPC – UnityPoint Clinic, THS portion
UPAH – UnityPoint at Home, THS portion

See accompanying Independent auditors' report

[redacted]

Trinity Health System, Inc. and Subsidiaries (Fort Dodge)

Consolidating Statement of Operations

Year ended December 31, 2018

(in thousands)

	THS	TRMC	THF	TBC	TPG	BBHC	TP ACO	UPC	UPAH	Eliminations	Consolidated
Unrestricted revenue:											
Net patient service revenue	$ —	118,387	—	—	845	4,300	—	14,453	18,857	(15)	163,256
Other operating revenue	3,250	6,150	320	(100)	69	1,260	—	2,197	162	(3,095)	8,059
Net assets released from restrictions used in operations	—	150	70	—	—	1	—	4	128	—	353
Total unrestricted revenue	3,250	124,559	394	(100)	740	5,561	—	16,654	19,019	(3,110)	171,718
Expenses:											
Salaries and wages	2,151	38,735	229	65	—	1,809	1	4,607	7,720	—	55,518
Physician compensation and services	—	23,757	—	—	—	1,916	—	6,291	159	(365)	31,457
Employee benefits	117	11,882	69	—	(1)	597	1	1,346	1,899	—	16,109
Supplies	4	15,388	11	1	(10)	24	—	825	4,759	—	21,001
Other expenses	116	39,137	355	21	255	745	—	5,250	3,060	(3,745)	45,354
Depreciation and amortization	69	8,345	—	—	—	68	—	312	359	—	9,055
Interest	—	662	—	—	—	—	—	1	21	—	714
Provision for uncollectible accounts	—	11	—	650	—	—	—	—	200	—	950
Total expenses	3,457	138,919	664	650	239	4,859	2	17,632	18,268	(3,110)	180,081
Operating income (loss)	(207)	(14,360)	(270)	(750)	501	702	(2)	(978)	751	—	(8,363)
Nonoperating gains (losses):											
Investment income (loss)	(9)	(1,815)	(917)	21	—	19	—	(13)	(28)	—	(2,742)
Total nonoperating gains (losses), net	(9)	(1,815)	(917)	21	—	19	—	(13)	(28)	—	(2,742)
Excess (deficiency) of revenue over expenses	$ (216)	(16,175)	(1,187)	(729)	501	(683)	(2)	(991)	723	—	(19,105)

Definitions:

THS – Trinity Health System
TRMC – Trinity Regional Medical Center
THF – Trinity Health Foundation
TBC – Trinity Building Corporation
TPG – Trinity Physicians Group
BBHC – Battelle Mental Health Clinic
TP ACO – Trinity Pioneer ACO
UPC – UnityPoint Clinic, THS portion
UPAH – UnityPoint at Home, THS portion

See accompanying independent auditor's report

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Finley 514 Allen Health Group, Inc. and Subsidiaries (Obligor)

Consolidating Balance Sheet

December 31, 2016

(In thousands)

	TRUST	Finley	VHA	Eliminations	Consolidated
Assets					
Current assets					
Cash and cash equivalents	$ —	$ 5,047	$ 241	$ —	$ 5,188
Short-term investments	—	340	—	—	340
Patient accounts receivable, net	—	17,819	33	—	17,852
Other receivables	—	778	279	—	1,057
Inventories	—	2,421	—	—	2,421
Prepaid expenses	—	949	—	—	949
Due from affiliates	—	2,179	1	(64)	2,116
Total current assets	—	29,073	553	(64)	29,917
Assets limited or held as long-term investment internally designated	—	60,843	—	—	60,843
Total assets limited or held as long-term investment	—	60,843	—	—	60,843
Property, plant and equipment, net	—	78,099	34	—	78,133
Other long-term investments	—	1,355	—	—	1,355
Investments in joint ventures and other investments	14	3,224	1,851	—	5,089
Cost in excess of net assets acquired, net	—	8,287	—	—	8,287
Other	—	65	1	—	66
Total assets	$ 14	$ 200,946	$ 2,438	$ (64)	$ 203,334
Liabilities and Net Assets					
Current liabilities					
Accounts payable	$ —	$ 4,090	$ 11	$ —	$ 4,101
Accrued payroll	—	4,017	84	—	4,101
Estimated settlements due to third-party payors	—	804	—	—	804
Due to affiliates	—	2,859	68	(68)	2,859
Other current liabilities	—	1,545	—	—	1,545
Total current liabilities	—	13,345	211	(68)	13,491
Other long-term liabilities	—	1,469	—	—	1,469
Due to affiliates	—	16,996	—	—	16,996
Total liabilities	—	31,470	211	(68)	31,673
Net assets					
Total without donor restrictions	14	169,333	302	—	169,679
Total with donor restrictions	—	8,143	1,925	—	10,068
Total net assets	14	177,476	2,227	—	179,697
Total liabilities and net assets	$ 14	$ 208,946	$ 2,438	$ (68)	$ 203,334

Definitions:
TRUST – Finley TRUSTees Health Group, Inc
Finley – The Finley Hospital
VHA – Valley Home Association

See accompanying Independent auditors' report

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Finley Tri-States Health Group, Inc. and Subsidiaries (Dubuque)

Consolidating Statement of Operations

Year ended December 31, 2018

(In thousands)

	TRI-ST	Finley	VNA	Eliminations	Consolidated
Unrestricted revenue					
Net patient service revenue	$ —	117,432	46	—	117,478
Other operating revenue	—	4,898	2,597	—	7,495
Net assets released from restrictions used for operations	—	260	150	—	410
Total unrestricted revenue	—	122,590	2,793	—	125,383
Expenses					
Salaries and wages	—	42,718	1,769	—	44,487
Physician compensation and services	—	11,166	—	—	11,166
Employee benefits	—	12,847	368	—	13,215
Supplies	—	15,743	64	—	15,807
Other expenses	—	33,337	339	—	33,676
Depreciation and amortization	—	7,747	10	—	7,757
Interest	—	907	—	—	907
Provision for uncollectible accounts	—	7	—	—	7
Total expenses	—	124,272	2,750	—	127,022
Operating income (loss)	—	(1,682)	43	—	(1,639)
Nonoperating gains (losses):					
Investment income (loss)	—	(3,491)	4	—	(3,487)
Other, net	—	(209)	—	—	(209)
Total nonoperating gains (losses), net	—	(3,700)	4	—	(3,696)
Excess (Deficiency) of revenues over expenses	$ —	(5,382)	47	—	(5,335)

Definitions:
TRI-ST – Finley Tri-States Health Group, Inc.
Finley – The Finley Hospital
VNA – Visiting Nurse Association

See accompanying independent auditors' report

DOVA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UofT YP-CSF HEALTH
Kodak Health Systems, Inc. and Subsidiaries (Kodak)
Consolidating Balance Sheet
December 31, 2018
(In thousands)

	KAH	TEMD	KHHS	KAH	Eliminations	Consolidated
Assets						
Current assets						
Cash and cash equivalents	$ 1,088	210	365	147	—	1,810
Assets limited as to use – restricted for current liabilities	7	—	—	—	—	7
Patient accounts receivable, net	2,435	—	453	—	—	2,888
Inventories	840	—	317	—	—	1,157
Prepaid expenses	90	—	17	—	—	107
Due from affiliates	4,277	—	—	—	(4,230)	46
Total current assets	8,852	210	1,152	147	(4,230)	6,147
Assets limited as to use, noncurrent	120	—	—	—	—	120
Internally designated	170	—	—	—	—	170
Total assets limited as to use, noncurrent	290	—	—	—	—	290
Property, plant, and equipment, net	3,388	445	1,767	—	—	5,595
Total assets	$ 12,530	655	2,919	147	(4,230)	11,912
Liabilities and Net Assets						
Current liabilities:						
Current maturities of long-term debt	4,000	0	155	—	—	4,167
Accounts payable	4,004	—	224	—	—	8,048
Accrued payroll	800	—	824	—	—	1,624
Accrued interest	40	—	(1)	—	—	(1)
Estimated settlements due to third-party payers	—	—	—	—	—	0
Due to affiliates	4,188	3,833	303	3	(4,230)	4,188
Other current liabilities	90	—	86	—	—	177
Total current liabilities	14,022	3,841	1,388	3	(4,230)	15,019
Long-term debt, net	(188)	—	530	—	—	372
Due to affiliates	8,428	—	—	—	—	8,428
Total liabilities	22,262	3,841	1,918	3	(4,230)	23,800
Net assets (deficit):						
Total without donor restrictions	(9,982)	(3,186)	1,044	123	—	(12,000)
Total with donor restrictions	11	—	—	21	—	32
Total net assets (deficit)	(9,971)	(3,186)	1,044	144	—	(11,968)
Total liabilities and net assets	$ 12,292	655	2,959	147	(4,230)	11,912

Definitions:
KAH – Kodak Area Hospital
TEMD – TriState Medical Group, Inc.
KHHS – Kodak Area Medical Equipment and Supply Inc.
KAH – Kodak Area Hospital Foundation

See accompanying independent auditors' report

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Keokuk Health Systems, Inc. and Subsidiaries (Keokuk)

Consolidating Statement of Operations

Year ended December 31, 2018

(in thousands)

	KAH	TSMG	KAME	KAHF	Eliminations	Consolidated
Unrestricted revenue:						
Net patient service revenue	$ 12,209	(16)	1,342	—	—	13,535
Other operating revenue	256	112	12	10	—	390
Net assets released from restrictions used for operations	53	—	—	—	—	53
Total unrestricted revenue	12,518	96	1,354	10	—	13,978
Expenses:						
Salaries and wages	8,142	—	375	13	—	8,530
Physician compensation and services	1,893	(3)	—	—	—	1,890
Employee benefits	1,833	—	117	—	—	1,950
Supplies	2,881	2	518	—	—	3,391
Other expenses	5,557	4	274	4	—	5,839
Depreciation and amortization	815	30	89	—	—	934
Interest	551	—	14	—	—	565
Provision for uncollectible accounts	—	—	27	—	—	27
Total expenses	21,682	33	1,414	17	—	23,116
Operating income (loss)	(9,134)	63	(60)	(7)	—	(9,138)
Nonoperating gains:						
Investment income	5	—	—	—	—	5
Total nonoperating gains, net	5	—	—	—	—	5
Excess (Deficiency) of revenues over expenses	$ (9,129)	63	(60)	(7)	—	(9,133)

Definitions:
KAH – Keokuk Area Hospital
TSMG – Tri-State Medical Group, Inc.
KAME – Keokuk Area Medical Equipment and Supply Inc.
KAHF – Keokuk Area Hospital Foundation

See accompanying independent auditors' report

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IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Memorial Hospital Association and Subsidiaries (Carthage)

Consolidating Statement of Operations

Year ended December 31, 2018

(In thousands)

	MHA	HCSS	Eliminations	Consolidated
Unrestricted revenue				
Net patient service revenue	$ 12,537	1,328	—	13,865
Other operating revenue	785	109	—	894
Net assets released from restrictions used for operations	13		—	13
Total unrestricted revenue	13,335	1,437	—	14,772
Expenses				
Salaries and wages	4,695	600	—	5,295
Physician compensation and services	2,860	—	—	2,860
Employee benefits	1,314	59	—	1,373
Supplies	1,155	136	—	1,291
Other expenses	2,633	279	—	2,912
Depreciation and amortization	1,165	290	—	1,455
Interest	399	153	—	552
Total expenses	14,221	1,517	—	15,738
Operating loss	(886)	(80)	—	(966)
Nonoperating gains (losses)				
Investment loss	(51)	(12)	—	(63)
Contribution received in affiliations	11,760	3,083	—	14,843
Other, net	(38)	—	—	(38)
Total nonoperating gains, net	11,681	3,081	—	14,742
Excess of revenue over expenses	$ 10,775	3,001	—	13,776

Definitions:
MHA – Memorial Hospital Association
HCSS – Hancock County Senior Services

See accompanying independent auditors' report

DOWNHEALTH SYSTEM AND SUBSIDIARIES
dba UNITYPOINT HEALTH
Affiliated Colleges
Balance Sheet Information
December 31, 2018
(in thousands)

	NC	TCN	AC	SLC	Consolidated
Assets					
Current assets					
Cash and cash equivalents	$ 2,859	3,868	609	333	7,669
Short-term investments	—	188	—	—	188
Student loan and other receivables	552	2	(282)	105	376
Inventories	78	—	129	29	236
Prepaid expenses	78	9	129	29	245
Due from affiliate	—	71	6,122	—	6,193
Total current assets	3,561	3,938	6,488	504	17,231
Property, plant and equipment, net	1,065	66	—	90	1,221
Other long-term investments	6,731	333	—	—	7,064
Interest in net assets of foundation	3,952	3,411	10,697	2,318	20,478
Other	—	—	716	456	1,172
Total assets	$ 15,918	7,778	21,173	3,728	47,176
Liabilities and Net Assets					
Current liabilities					
Accounts payable	$ 16	25	62	13	116
Accrued payroll	71	10	212	153	452
Due to affiliates	—	134	166	—	322
Other current liabilities	188	492	2	247	929
Total current liabilities	276	677	454	393	1,819
Other long-term liabilities	—	—	782	10	792
Total liabilities	276	677	1,236	373	2,561
Net assets					
Total without donor restrictions	10,913	3,622	9,020	18	23,573
Total with donor restrictions	3,929	3,501	10,697	2,938	21,065
Total net assets	14,841	7,123	19,947	2,955	44,638
Total liabilities and net assets	$ 15,918	7,778	21,173	3,728	47,176

Definitions
NC – Methodist College (Peoria)
TCN – Trinity College of Nursing & Health Sciences (Quad Cities)
AC – Allen College (Waterloo)
SLC – S. Luke's College (Sioux City)

Note 1: Fiscal year of Unity AC belongs to their parent hospital corporation, Allen Memorial Hospital Corporation (AMHC), and thus are not reflected in the balance sheet of the College
AC receives the benefit of using cash since all the AMHC's liabilities but dividends/revenue and donated expense is not reflected within the income statement of AC.
Note 2: Certain assets and liabilities, such as accrued liabilities, are also not shown separately on the AC balance sheet but rather included in AMHC

See accompanying independent auditors' report

IOWA HEALTH SYSTEM AND SUBSIDIARIES
d/b/a UNITYPOINT HEALTH

Affiliated Colleges

Statement of Operations

Year ended December 31, 2018

(In thousands)

	MC	TCN	AC	SLC	Consolidated
Revenue					
Tuition and student revenue	$ 12,278	4,424	11,794	3,587	32,083
Government pass-through	—	—	—	843	843
Grant revenue	148	—	—	15	163
Other revenue	126	159	28	242	555
Net assets released from restrictions used for operations	—	127	573	—	700
Total revenue	12,552	4,710	12,395	4,687	34,344
Expenses					
Salaries and wages	6,015	2,221	6,254	2,556	17,046
Physician compensation and services	—	12	67	—	79
Employee benefits	1,483	497	1,472	628	4,080
Supplies	228	147	125	143	643
Other expenses	4,048	804	2,637	1,220	8,709
Depreciation and amortization	287	42	—	7	336
Provision for uncollectible accounts	40	(7)	50	25	108
Total expenses	12,101	3,716	10,605	4,579	31,001
Operating income (loss)	451	994	1,790	(192)	3,043
Nonoperating gains (losses)					
Investment income (loss)	(254)	59	—	—	(195)
Total nonoperating gains (losses), net	(254)	59	—	—	(195)
Excess (Deficiency) of revenue over expenses	$ 197	1,053	1,790	(192)	2,848

Definitions
MC – Methodist College (Peoria)
TCN – Trinity College of Nursing & Health Sciences (Quad Cities)
AC – Allen College (Waterloo)
SLC – St. Luke's College (Sioux City)

See accompanying independent auditors' report

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.

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 35

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 35

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)

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 Reported	Adjustment	As Revised
As of December 31, 2017		(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

	As Reported	Adjustment	As Revised
For the Year Ended December 31, 2017		(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

	As Reported	Adjustment	As Revised
For the Year Ended December 31, 2017		(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

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

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.

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Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

	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

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Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

	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

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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

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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

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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

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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

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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

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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	$ —	$ —

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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

Attachment 35

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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	$ —	$ —

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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).+

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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).

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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.

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+ 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 Quad Cities Rehabilitation Institute, LLC

The Income Statement for the Applicant entity, The Quad Cities Rehabilitation Institute follows.

	CON Year 1	CON Year 2
Revenue		
Gross Patient Revenue	$ 22,272,200	$ 29,742,600
Contractual Adjustments	7,959,000	10,679,400
Other Deductions from Revenue	547,200	729,900
Deductions from Revenue	8,506,200	11,409,300
Net Patient Revenue	$ 13,766,000	$ 18,333,300
Other Revenue	-	-
Total Revenue	**$ 13,766,000**	**$ 18,333,300**
Operating Expenses		
Salaries and Benefits	8,256,200	9,961,200
Supplies	707,100	944,300
Administrative Services	688,300	916,700
Depreciation and Amortization	1,668,200	1,673,200
Other Operating Expenses	2,653,800	2,937,500
Total Operating Expenses	13,973,600	16,432,900
Income from Project Operations	**$ (207,600)**	**$ 1,900,400**
Taxes		513,100
Net Income from Project Operations	$ (207,600)	$ 1,387,300

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Financial Viability
The Quad Cities Rehabilitation Institute, LLC

The Balance Statement for the Applicant entity, The Quad Cities Rehabilitation Institute follows.

	CON Year 1	CON Year 2
Cash	$ 2,321,488	$ 5,007,700
Accounts Receivable	3,168,065	3,867,579
Other Current Assets		
Total Current Assets	5,489,553	8,875,280
PP&E	33,812,822	33,862,822
Accumulated Depreciation	(2,502,237)	(4,175,395)
PP&E, net	31,310,585	29,687,427
Other Assets		
TOTAL ASSETS	$ 36,800,139	$ 38,562,707
CURRENT LIABILITIES		
Accounts Payable	307,399	366,353
Accrued Salaries	526,043	634,674
Other Current Liabilities		
TOTAL CURRENT LIABILITIES	833,441	1,001,027
L/T LIABILITIES		
EQUITY		
Partners Equity	36,174,334	36,174,334
Retained Earnings	(207,636)	1,387,347
NET EQUITY	$ 35,966,697	$ 37,561,681
TOTAL LIAB AND EQUITY	$ 36,800,139	$ 38,562,707

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Financial Viability
The Quad Cities Rehabilitation Institute, LLC

The Financial Viability Ratios for the Applicant entity, The Quad Cities Rehabilitation Institute follows.

	CON Year 1	CON Year 2
Current Ratio:	**6.59**	**8.87**
Current Assets /	5,489,553	8,875,280
Current Liabilities	833,441	1,001,027
Net Margin Percentage	**-1.5%**	**10.4%**
Income b/f Tax /	(207,636)	1,900,475
Net Patient Revenue	13,765,998	18,333,331
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	**68.9**	**123.8**
Total Expenses excl Depreciation	12,305,476	14,759,697
Expenses per Day	33,714	40,438
Cushion Ratio	**N/A**	**N/A**
Note: Licensee has no long term debt		

Financial Viability
The Quad Cities Rehabilitation Institute, LLC

The assumptions supporting the income statement for The Quad Cities Rehabilitation Institute follow.

Patient Utilization
As explained and supported throughout this application, patient days are projected to reach 12,425 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 Quad Cities Rehabilitation 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 Trinity Medical Center. Gross patient revenues include patient room, therapeutic, and ancillary service charges. Average charges per patient day are projected to be $2,394 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 UnityPoint experience, and is summarized below as follows:

Payor	Payor Mix
Medicare	62.0%
Medicaid	11.5%
BCBS	8.0%
Managed Care	16.2%
Self-Pay/Other (incl. Charity)	2.3%
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 Quad Cities Rehabilitation Institute's anticipated services and payor mix, as well as experiences in other Encompass and Trinity facilities.

Expenses
The Quad Cities Rehabilitation 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 Trinity 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 Trinity experience in recruiting employees.

Supplies and Drugs
Supplies and drugs expenses are based on The Quad Cities Rehabilitation Institute's projected patient case mix and Encompass and Trinity experience. Supplies and drug expenses for the proposed hospital will approximate $76 per patient day in CON Year 2.

Administrative Services
These expenses, estimated to be 5% of net patient revenues, represent service fees that will be paid by The Quad Cities Rehabilitation 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 Quad Cities Rehabilitation 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 UnityPoint 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%.

UnityPoint Health
Trinity

Katie Marchik
Senior VP/Chief Financial Officer
2701 17th Street
Rock Island, IL 61201
309-779-2218
Fax: 309-779-2399
E-Mail: Katie.Marchik@unitypoint.org

December 10, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: The Quad Cities Rehabilitation Institute, 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 Quad Cities Rehabilitation Institute, LLC Project costs will be entirely funded by Encompass Health Corporation, an Applicant, from internal cash resources including cash and equivalents.

2. Iowa Health System d/b/a UnityPoint Health, an Applicant, will fund a portion of the project until it achieves the target utilization of 85% of average annual occupancy as outlined in the application.

3. Iowa Health System d/b/a UnityPoint Health, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. 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,

Katie Marchik
Chief Financial Officer
UnityPoint Health - Trinity

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Encompass Health

9001 Liberty Parkway
Birmingham, AL 35242

205.967.7116
encompasshealth.com

December 12, 2019

Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

RE: The Quad Cities Rehabilitation Institute, 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 Quad Cities Rehabilitation Institute, LLC Project costs will be entirely funded by Encompass Health Corporation, an Applicant, from internal cash resources including cash and equivalents.

2. Encompass Health Corporation, an Applicant, will fund the necessary working capital and operating deficits through the first full fiscal year by which time the Project is expected to achieve the target utilization of 85% of average annual occupancy.

3. Encompass Health Corporation, 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 $1 Billion Revolving Credit Facility, of which more than $900 Million was available as of November 30, 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 revolving credit facility borrowings is the lowest cost option.

Encompass Health

9001 Liberty Parkway
Birmingham, AL 35242

205.967.7116
encompasshealth.com

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.

Edmund Fay
Senior Vice President and Treasurer
Encompass Health Corporation

Subscribed and sworn to before me this 12th day of December 2019.

Notary Public

CASSIE D. REED
MY COMMISSION EXPIRES
DECEMBER 20, 2020
NOTARY PUBLIC
STATE OF ALABAMA

Economic Feasibility
The Quad Cities Rehabilitation Institute, LLC

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	$416.15		47,822				$ 19,900,960		
Contingency	$36.85		47,822				$ 1,762,104		
TOTALS	$453.00		47,822				$ 21,663,064		
* Include the percentage (%) of space for circulation									

Projected Operating Costs

The projected operating costs for The Quad Cities Rehab Institute in the first full fiscal year when the Project achieves target utilization are as follows:

Factor	CON Year 2
Salaries and Benefits	$ 7,721,900
Benefits	2,239,400
Supplies	944,300
Total Operating Costs	$ 10,905,600
Patient Days	12,425
Cost per Day	$ 877.72

Total Effect of the Project on Capital Costs

The projected capital costs for The Quad Cities Rehabilitation Institute in the first full fiscal year when the Project achieves target utilization are as follows:

Factor	CON Year 2
Depreciation	$1,673,200
Total Capital Costs	$1,673,200
Patient Days	12,425
Cost per Day	$134.67

The Quad Cities Rehabilitation Institute, LLC

The proposed project is a new entity that will be a 50/50 joint venture between Trinity Medical Center and Encompass Health. 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 Moline will have a positive impact on community safety net services. Information was previously provided specific to the three hospitals of the applicants: Trinity Rock Island, Trinity Moline, and Van Matre Rehab Hospital. The following information provides an overview of the extensive safety net services provided by UnityPoint's Trinity Regional Health System.

Trinity Regional Health System has an established history of providing safety net services to its community. In 2018, Trinity provided nearly $32 Million in total community benefits including more than $16.4 Million in charity care and uncompensated Medicaid. In all, more than 5% of Trinity Regional Health System's total expenses were for community benefit.

Trinity's community involvement and mission are both priorities for the organization and its leadership team. This commitment served as the motivation behind the creation of Trinity's Mission Effectiveness Committee ("MEC"). The MEC brings together employees, senior members of the organization, and members of Trinity's Board of Directors to discuss the effectiveness with which Trinity is serving its community. Trinity also has a senior leader devoted to community advocacy and community health initiatives.

In addition to the MEC, the efforts and dedication of Trinity's community health improvement team and volunteers have been vital in this effort. The team draws on multiple disciplines, and individuals across the organization have gone through great lengths to aid in this effort. Members ranging from the executive level, to parish nurses, clinicians and student volunteers have all been integral in staffing and contributing to community events and planning initiatives.

Trinity is also a founding member of the Quad City Health Initiative ("QCHI"), established as a joint effort between Trinity and Genesis Health System in 1999 after they agreed that the community needed a single organization fully dedicated to its health needs. Because of QCHI, entities throughout the Quad-City community with similar goals are able to work in conjunction with one another despite their organizational differences and geographic barriers to achieve the same overarching goal. The organization was founded on the core values of coordination, collaboration, and creativity, operating across two states and counties, as well as five urban cities. Rock Island County Health Department, Scott Community Health Department and Community Health Care, a federally qualified health center, are also members of QCHI.

In 2018, QCHI completed its most recent community needs assessment. Trinity's Vice President of Patient and Community Advocacy and its Director of Community Engagement were on the steering committee. While there were many areas of opportunity identified in this study's findings, some of the most prevalent health issues in the community were identified as mental health, heart disease, and the accessibility of healthcare services in general. This aligns with what Trinity has been experiencing in terms of utilization of Emergency Department services, Cardiac and Mental Health services. It also confirms that Trinity has been focusing its efforts appropriately to be a safety net in the community.

Trinity developed a three-year Community Health Improvement Plan ("CHIP") to guide the organization in meeting these identified needs. The 2019-21 CHIP has five main areas of focus to include the following:

- Diabetes, Obesity, Nutrition, Physical Activity and Weight
- Heart Disease & Stroke
- Mental Health/Behavioral Health/Substance Abuse
- Cancer
- Access to Healthcare Services

It is Trinity's goal to bring awareness to these health risks, and provide education and services to the members of the community, with the end goal of delivering on the mission of "to improve the health of the people and the communities we serve".

In response, Trinity has actively participated in multiple community collaborations to address specific community health needs in the Quad-Cities and Western Illinois counties of Rock Island, Henry, Mercer, and Whiteside. While Trinity's Community Health Improvement Plan lays out specific strategies to meet our community health needs, the following examples demonstrate Trinity's commitment to filling healthcare gaps and providing much needed services to the residents of its service area and beyond.

Access

- Trinity provides obstetrical (OB) and neonatal care at its Moline campus. Trinity has 18 dedicated obstetrical beds, an OB Emergency Department, and a level II NSCU with neonatologists and neonatology nurse practitioners on call 24/7. The NSCU offers 11 rooms with the most technologically advanced equipment. Larger rooms also are available to accommodate twins and triplets. Trinity has a transfer agreement with OSF Healthcare/Children's Hospital of Illinois for more advanced neonatal care needs.

- Expand provider access and availability of care within the community through patient and community enrollment in health insurance plans offered through the Healthcare Exchange Marketplace and expanded Medicaid programs. Trinity employs certified application counselors (CACs) who participate in community events to educate about health care insurance options available through the Exchange and schedule appointments for confidential enrollment.

- Trinity's affiliated physician clinic network, UnityPoint Clinic, has two express care clinics in Rock Island County with extended hours on evenings and weekends. The clinics provide walk-in appointments when a patient's primary care physician is not available or for community members who do not have a physician. Express care clinics are visited often by pediatric patients and families when in need of care for minor injuries and common illnesses that are not life-threatening.

- Trinity has 47 nurses in its Parish Nursing program which reaches a number of individuals in churches and other community forums. They participate in health fairs, provide health education and assist with disease prevention programming.

- Expanded consumer access to specialty medicine, behavioral health and primary care through use of telemedicine.

Trauma Services

Trinity Rock Island is a Level II trauma center for Region 2 in the State of Illinois, as well as a designated Emergency Department Approved for Pediatrics ("EDAP"). At Trinity, patients seeking emergency care are treated by board certified emergency physicians who believe quality emergency care is a fundamental right and that unobstructed access to emergency services should be available to all patients who perceive the need for emergency services.

At Trinity Rock Island, the Emergency Department's payer mix is comprised of 33% Medicare, 36% Medicaid, 6% self-pay and just 25% commercially insured. With 33% of Rock Island County residents living in poverty, Trinity's Emergency Department acts as the safety net that its residents need. Emergency departments are often used by the uninsured or underinsured as an access point for primary care, minor injuries and low acuity illnesses such as ear aches, colds and sore throats.

Mental Health

Robert Young Center for Community Mental Health, a subsidiary of Trinity Regional Health System, provides a full continuum of behavioral health services for the greater Quad-Cities region and specifically for the catchment area of Rock Island and Mercer Counties in Illinois. The service continuum includes the Access Center which serves as a central intake site for behavioral health services. The Access Center also provides a 24/7 psychiatric crisis response system that functions as the primary provider of psychiatric crisis service in the Illinois Quad Cities and Eastern Iowa, including regional coverage for area hospital emergency departments through the use of telepsychiatry.

The continuum also includes a full range of outpatient behavioral health services for mental health and substance abuse for adult and children. Outpatient behavioral health services are also integrated into primary care practices including the local Federally Qualified Health Center. Behavioral health assessments are available in 19 area schools and Arrowhead Ranch, a residential treatment facility serving at-risk youth aged 12-21 through the use of telemedicine. Additionally, Robert Young Center provides inpatient behavioral health services with 54 licensed beds serving adults, adolescents and children on the Trinity Rock Island campus. Trinity has six designated pediatric inpatient beds for acute mental illness. In response to the need for more pediatric inpatient beds for behavioral health, Trinity recently added a swing door in its behavioral health unit that would allow for an additional eight beds to accommodate children and adolescents. Nearly two thirds of these patients are on Medicaid.

Health Outreach and Wellness

In addition to providing free or subsidized care in accordance with Trinity's financial assistance policy, the hospital also offers programs and services that respond to the community's unique healthcare needs. Trinity sponsors outreach efforts including health and disease prevention programs such as health fairs, risk assessments, and free or low-cost screenings. Trinity also provides corporate sponsorships to many health-related events to raise awareness and funds. For instance, Trinity provided more than $327,000 in sponsorships in 2018 to benefit non-profit organizations and other community programs and events. Many of these sponsorships directly benefited children and families including:

- March of Dimes
- Boys and Girls Club
- Family Resources
- Child Abuse Council
- Big Brothers Big Sisters
- Gilda's Club
- Make a Wish of Illinois
- Junior Achievement
- YMCA
- United Way
- Children's Therapy Center
- Skip-A-Long Child Development Center
- Girl Scouts & Boy Scouts

Projected Charity Care Information

The following table presents The Quad Cities Rehabilitation Institute'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.

Payor	Payor Mix
Medicare	62.0%
Medicaid	11.5%
BCBS	8.0%
Managed Care	16.2%
Self-Pay/Other (incl. Charity)	2.3%
Total	100.0%

The Quad Cities Rehab Institute Projected Charity Care	
	CON Year 2
Net Patient Revenue	$ 18,333,300
Amount of Charity Care (Charges)	$ 333,606
Cost of Charity Care	$ 184,318
Charity Care Cost % of Net Pat Rev	1.0%

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

Attachment 38

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

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UnityPoint Health Trinity

Encompass Health

and their Joint Venture Entity

The Quad Cities Rehabilitation Institute, LLC

Propose to Establish a New 40-Bed Comprehensive Physical Rehabilitation Hospital in Moline, Illinois (Rock Island County, HSA 10)

Applicant: **The Quad Cities Rehabilitation Institute, LLC**
A Joint Venture of Trinity Medical Center & Encompass Health
Intersection of 52nd Avenue and 7th Street - NW Parcel
Moline, Illinois 61265

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December 19, 2019