ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

25-035

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: The Rehabilitation Institute of Southern Illinois		
Street Address: 2351 Frank Scott Parkway East		
City and Zip Code: Shiloh 62269-7457		
County: St. Clair	Health Service Area: 11	Health Planning Area: N/A

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

Exact Legal Name: The Rehabilitation Institute of Southern Illinois, LLC
Street Address: 2351 Frank Scott Parkway East
City and Zip Code: Shiloh 62269-7457
Name of Registered Agent: Illinois Corporate Service Company
Registered Agent Street Address: 801 Adlai Stevenson Drive
Registered Agent City and Zip Code: Springfield 62703--4261
Name of Chief Executive Officer: Cassidy Hoelscher
CEO Street Address: 2351 Frank Scott Parkway East
CEO City and Zip Code: Shiloh 62269-7457
CEO Telephone Number: (618) 206-7600

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	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 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: Jacob M. Axel
Title: President
Company Name: Axel & Associates, Inc.
Address: 348 Chicory Lane, Buffalo Grove, IL 60089
Telephone Number: (312) 969-4759
E-mail Address: jacobmaxel@msn.com
Fax Number: n/a

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

Name: Juan Morado, Jr.
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: (312) 212-4967
E-mail Address: JMorado@beneschlaw.com
Fax Number: (312) 767-9192

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 Rehabilitation Institute of Southern Illinois
Street Address: 2351 Frank Scott Parkway East
City and Zip Code: Shiloh 62269-7457
County: St. Clair Health Service Area: 11 Health Planning Area: N/A

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 35242
Name of Registered Agent: Corporation Trust Center
Registered Agent Street Address: 1209 Orange Street
Registered Agent City and Zip Code: Wilmington 19801
Name of Chief Executive Officer: Mark J. Tarr
CEO Street Address: 9001 Liberty Parkway
CEO City and Zip Code: Birmingham 35242
CEO Telephone Number: (205) 967-7116

Type of Ownership of Applicants

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

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E-mail Address: jacobmaxel@msn.com
Fax Number: n/a

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

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Title: CON Counsel
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Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: (312) 212-4967
E-mail Address: JMorado@beneschlaw.com
Fax Number: (312) 767-9192

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 Rehabilitation Institute of Southern Illinois
Street Address: 2351 Frank Scott Parkway East
City and Zip Code: Shiloh 62269-7457
County: St. Clair Health Service Area: 11 Health Planning Area: N/A

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

Exact Legal Name: BJC Health System d/b/a BJC HealthCare
Street Address: 4901 Forest Park Avenue
City and Zip Code: St. Louis 63108
Name of Registered Agent: CSC-Lawyers Incorporating Service Company
Registered Agent Street Address: 2210 Bolivar Street
Registered Agent City and Zip Code: Jefferson City 63108
Name of Chief Executive Officer: Richard J. Liekweg
CEO Street Address: 4901 Forest Park Avenue
CEO City and Zip Code: St. Louis 63108
CEO Telephone Number: (314) 286-2030

Type of Ownership of Applicants

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

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- 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: Jacob M. Axel
Title: President
Company Name: Axel & Associates, Inc.
Address: 348 Chicory Lane, Buffalo Grove, IL 60089
Telephone Number: (312) 969-4759
E-mail Address: jacobmaxel@msn.com
Fax Number: n/a

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

Name: Juan Morado, Jr.
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: (312) 212-4967
E-mail Address: JMorado@beneschlaw.com
Fax Number: (312) 767-9192

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

Name: Cassidy Hoelschler
Title: Chief Executive Officer
Company Name: The Rehabilitation Institute of Southern Illinois, LLC
Address: 2351 Frank Scott Parkway East, Shiloh, IL 62269-7457
Telephone Number: (618) 206-7600
E-mail Address: cassidy.hoelscher@encompasshealth.com
Fax Number: N/A

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner: Progress East Healthcare (a wholly owned subsidiary of BJC Healthcare)
Address of Site Owner: 4901 Forest Park Avenue, St. Louis, Missouri 63108
Street Address or Legal Description of the Site: 2351 Frank Scott Parkway East, Shiloh, IL 62269 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee [Provide this information for each applicable facility and insert after this page]

Exact Legal Name: The Rehabilitation Institute of Southern Illinois, LLC

Address: 2351 Frank Scott Parkway East, Shiloh, IL 62269-7457

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	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)**. **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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 :

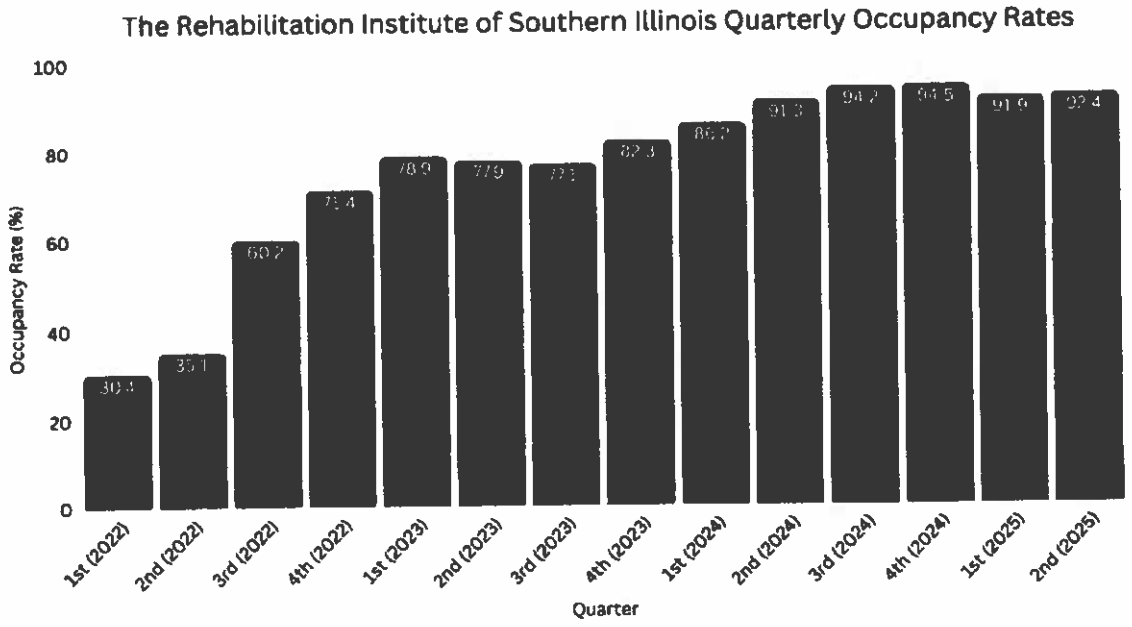
☒ Substantive

☐ 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 Applicants were granted a Certificate of Need Permit in September 2020 to establish The Rehabilitation Institute of Southern Illinois ("RISI") as a 40-bed comprehensive physical rehabilitation hospital, and an IDPH license for operation was granted in February 2022. The hospital, which consists of all private rooms, was designed to expand to 60 beds, and as a result of steadily increasing utilization and anticipated continuing increases, the Applicants propose to proceed with that expansion. The graph below documents the rapid growth in utilization experienced by RISI, reaching the HFSRB's target utilization level during its ninth quarter of operations, and has consistently remained at over 90% occupancy for the last year and a half.



Approximately 87% of the total space to be added to the hospital will be on the proposed new 20-bed patient unit (the remainder being therapy and family space).

The project addressed in this application is categorized as "substantive" because it involves the addition of more than the lesser of 20 beds or 10% of the hospital's licensed capacity.

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	$169,150	$850	$170,000
Site Survey and Soil Investigation	-	-	-
Site Preparation	$472,625	$2,375	$475,000
Off Site Work	-	-	-
New Construction Contracts	$8,754,240	$413,600	$9,167,840
Modernization Contracts	-	-	-
Contingencies	$520,000	$28,000	$548,000
Architectural/Engineering Fees	$820,875	$4,125	$825,000
Consulting and Other Fees	$530,833	$2,668	$533,500
Movable or Other Equipment (not in construction contracts)	$1,525,000	$300,000	$1,825,000
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	$290,640	$1,461	$292,100
Fair Market Value of Leased Space or Equipment	-	-	-
Other Costs to Be Capitalized	-	-	-
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	**$13,083,362**	**$753,078**	**$13,836,440**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	-	-	-
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	-	-	-
Leases (fair market value)	-	-	-
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	$13,083,362	$753,078	$13,836,440
TOTAL SOURCES OF FUNDS	**$13,083,362**	**$753,078**	**$13,836,440**
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: NOT APPLICABLE

Fair Market Value: NOT APPLICABLE

The project involves the establishment of a new facility or a new category of service

☐ Yes ☒ No

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

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

Project Status and Completion Schedules

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): November 1, 2029

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

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 departments or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Not Reviewable Space [i.e., non-clinical]: *means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.* [20 ILCS 3960/3]

	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							
Inpatient Unit	$12,560,028	25,948	37,440	11,492		25,948	
Therapy/Exercise Area	$523,334	3,673	4,633	960		3,673	
	$13,083,362	29,621	42,073	12,452		29,621	
NON-REVIEWABLE							
Family Area	$753,078	1,909	2,661	752		1,909	
PROJECTED TOTAL	**$13,836,440**	**31,530**	**44,734**	**13,204**		**31,530**	

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**.

FACILITY NAME: The Rehabilitation Institute of Southern Illinois		**CITY:** Shiloh			
REPORTING PERIOD DATES:	**From:** January 1, 2024		**To:** December 31, 2024		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation	40	1,074	13,366	+20	60
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other (identify)					
TOTALS:	40	1,074	13,366	+20	60

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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

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

SIGNATURE	SIGNATURE
Greg Bratcher	
PRINTED NAME	PRINTED NAME
Director, Government Relations	
PRINTED TITLE	PRINTED TITLE
Notarization:	Notarization:
Subscribed and sworn to before me this 18 day of July 2025	Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

ABBIE J FRINTRUP
Notary Public, Notary Seal
State of Missouri
St. Louis County
Commission # 15644744
My Commission Expires 04-23-2029

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

SIGNATURE

Carey B. McRae
PRINTED NAME
Vice President, Encompass Health
Southern Illinois Holdings, LLC
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8 day of July, 2025

Signature

Seal

Notary Public, Alabama State at Large
Kristy H. Horsley
Expires 2/28/2029

*Insert the EXACT legal name of the applicant

SIGNATURE

PRINTED NAME

PRINTED TITLE

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

Signature of Notary

Seal

CERTIFICATION

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

This Application is filed on the behalf of _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 E. Coltharp

PRINTED NAME
Executive Vice President & Chief Financial Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of June

Signature of Notary

Seal

SIGNATURE

Patrick Darby

PRINTED NAME
Executive Vice President, General Counsel, and Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of June

Signature of Notary

Seal

PATIENCE MACHAE HARRIS LAYTON MY COMMISSION EXPIRES JUNE 2, 2029 NOTARY PUBLIC STATE OF ALABAMA

*Insert the exact legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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

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

SIGNATURE	SIGNATURE
Greg Bratcher	
PRINTED NAME	PRINTED NAME
Director, Government Relations	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 16 day of July 2025	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

ABBIE J FRINTRUP
Notary Public, Notary Seal
State of Missouri
St. Louis County
Commission # 05807464
My Commission Expires 04/23/2029

* Insert the EXACT legal name of the applicant

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 can 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** the alternatives to the proposed project:

   Alternative options **must** include:

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

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

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

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

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality, and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

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

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

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

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
    c. The project involves the conversion of existing space that results in excess square footage.
    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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

SIZE OF PROJECT				
DEPARTMENT / SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
20 Bed Inpatient Unit	11,492	13,200	1,708	YES

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					
	DEPARTMENT / SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 2	Inpatient Rehab	13,366	18,363	>18,304	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.

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**	**60**

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 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

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

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
☒ **Physical Therapy**	**N/A**	**N/A**
☒ **Occupational Therapy**	**N/A**	**N/A**
☒ **Speech Therapy**	**N/A**	**N/A**

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 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

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)**

SECTION VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those 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]:**

	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 timetable 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 timetable of receipts. d) Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, 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.
$13,836,440	**TOTAL FUNDS AVAILABLE**

SECTION VIII. 1120.130 - FINANCIAL VIABILITY – NOT APPLICABLE

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

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

1. "A" Bond rating or better
2. All the project's 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 35, 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 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

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 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY – NOT APPLICABLE

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 the cash and equivalents must be retained in the balance sheet asset accounts 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	
	Cost/Sq. Ft. New	Cost/Sq. Ft. Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	Total Cost (G + H)
Contingency									
TOTALS									

* 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.

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.

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

SECTION X. 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, ***including the impact on racial and health care disparities 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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all 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 - NOT APPLICABLE

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2022**	**2023**	**2024**
Inpatient	0	1	1
Outpatient	0	0	0
Total	**0**	**1**	**1**
Charity (cost in dollars)			
Inpatient	$0	$20,262	$28,208
Outpatient	$0	$0	$0
Total	**$0**	**$20,262**	**$28,208**
MEDICAID			
Medicaid (# of patients)	**2022**	**2023**	**2024**
Inpatient	23	109	95
Outpatient	0	0	0
Total	23	109	95
Medicaid (revenue)			
Inpatient	$858,221	$3,906,610	$3,570,937
Outpatient	$0	$0	$0
Total	**$858,221**	**$3,906,610**	**$3,570,937**

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

SECTION XI. 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 - NOT APPLICABLE.

CHARITY CARE			
	2022	2023	2024
Net Patient Revenue	**$10,219,692**	**$17,698,316**	**$22,282,534**
Amount of Charity Care (charges)	$0	$24,720	$34,414
Cost of Charity Care	$0	$20,262	$28,208

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI. SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: The Rehabilitation Institute of Southern Illinois (Name) 2351 Frank Scott Parkway East (Address)

   Shiloh (City) Illinois (State) 62269-7457 (ZIP Code) (618) 206-7600 (Telephone Number)

2. Project Location: 2351 Frank Scott Parkway East (Address) Shiloh (City) Illinois (State)

   St. Clair (County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go to NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the icon in the top corner of the page. Select the pin tool icon and place a pin on your site. Print a FIRMETTE size image.
   If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes No X

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? NO

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.

If the determination is being made by a local official, please complete the following:

FIRM Panel Number: _____ Effective Date: _____

Name of Official: _____ Title: _____

Business/Agency: _____ Address: _____

_____ (City) (State) (ZIP Code) (Telephone Number)

Signature: _____ Date: _____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

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

INDEX OF ATTACHMENTS

ATTACHMENT 1
Type of Ownership of Applicant

Included with this attachment are Certificates of Good Standing for:

1. The Rehabilitation Institute of Southern Illinois, LLC;
2. Encompass Health Corporation; and
3. BJC Health System.

ATTACHMENT 1
Certificate of Good Standing
The Rehabilitation Institute of Southern Illinois, LLC

File Number 0735601-3

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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*

THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 01, 2019, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* MAY *A.D.* 2025 .

Authentication #: 2514302974 verifiable until 05/23/2026
Authenticate at https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Encompass Health Corporation

Delaware

The First State

I, CHARUNI PATIBANDA-SANCHEZ, 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 TWENTY-SECOND DAY OF MAY, A.D. 2025.

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

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "ENCOMPASS HEALTH CORPORATION" WAS INCORPORATED ON THE TWENTY-SECOND DAY OF FEBRUARY, A.D. 1984.

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

C. P. Sanchez

Charuni Patibanda-Sanchez, Secretary of State

Authentication: 203759043

Date: 05-22-25

2028917 8300

SR# 20252555492

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

ATTACHMENT 1
Certificate of Good Standing
Encompass Health Corporation

File Number 5731-571-7

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *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*

ENCOMPASS HEALTH CORPORATION, INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MAY 18, 1993, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* JULY *A.D.* 2025 .

Authentication #: 2520201828 verifiable until 07/21/2026
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
BJC Health System

STATE OF MISSOURI

John R. Ashcroft
Secretary of State

CORPORATION DIVISION
CERTIFICATE OF GOOD STANDING

I, JOHN R. ASHCROFT, Secretary of State of the State of Missouri, do hereby certify that the records in my office and in my care and custody reveal that

BJC HEALTH SYSTEM
N00045883

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

IN TESTIMONY WHEREOF, I hereunto set my hand and cause to be affixed the GREAT SEAL of the State of Missouri. Done at the City of Jefferson, this 15th day of July, 2024.

Secretary of State

Certification Number: CERT-07152024-0024

ATTACHMENT 2
Site Ownership

With the signatures provided on the Certification pages of this Certificate of Need ("CON") application, the Applicants attest that The Rehabilitation Institute of Southern Illinois site, that being 2351 Frank Scott Parkway East in Shiloh, Illinois, is owed by Progress East HealthCare Center (a wholly owned subsidiary of BJC HealthCare).

ATTACHMENT 3
Operating Entity/Licensee

Attached is the Certificate of Good Standing issued by the Illinois Secretary of State for The Rehabilitation Institute of Southern Illinois, LLC ("RISI"). RISI is the entity that will be licensed by the Illinois Department of Public Health.

ATTACHMENT 3
Operating Entity/Licensee

File Number 0735601-3

To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, 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

THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 01, 2019, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS 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* 23RD *day of* MAY ***A.D.*** 2025 .

Authentication #: 2514302974 verifiable until 05/23/2026
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 3
Operating Entity/Licensee

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

MAY 01, 2019 0735601-3

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

RE THE REHABILITATION INSTITUTE OF SOUTHERN ILLINOIS, LLC

DEAR SIR OR MADAM:

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

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

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

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

SINCERELY YOURS,

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

ATTACHMENT 3
Operating Entity/Licensee

07356013

FILE #

This space for use by Secretary of State.

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.cyberdrivelllinois.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

Type or print clearly.

Filing Fee: $150
Penalty: $
Approved:

FILED
MAY 01 2019
JESSE WHITE
SECRETARY OF STATE

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

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

3. Jurisdiction of organization: Delaware

4. Date of organization: April 15, 2019

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

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

9001 Liberty Parkway — Number / Street / Suite #

Birmingham, AL 35242 — City / State / ZIP

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

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

Chicago, — City
IL — State
60604 — ZIP

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

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

(continued on back)

ATTACHMENT 3
Operating Entity/Licensee

LLC-45.5

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

10. The Limited Liability Company: (check one)

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

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

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

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

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

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

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

Signature

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

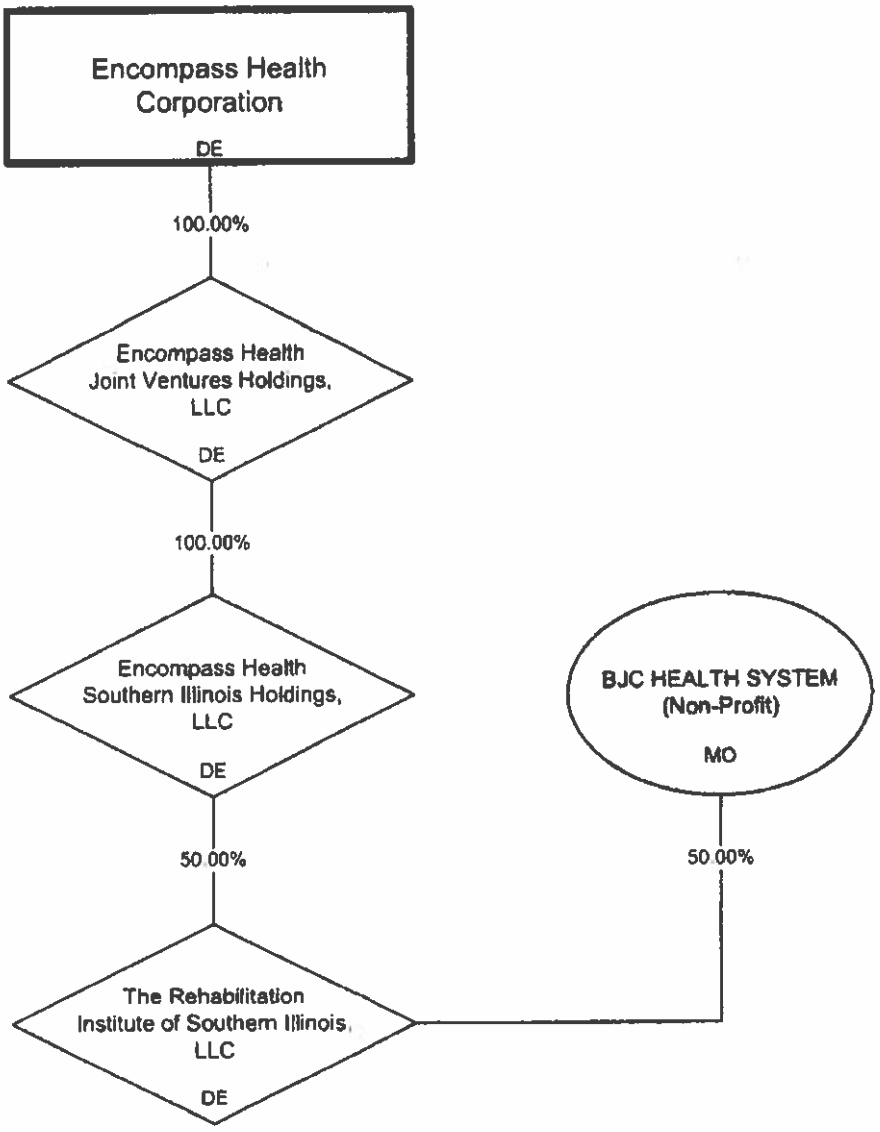
Encompass Health Southern Illinois Holdings, LLC
If applicant is signing for a company or other entity, state name of company or entity.

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

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

ATTACHMENT 4
Organizational Relationships

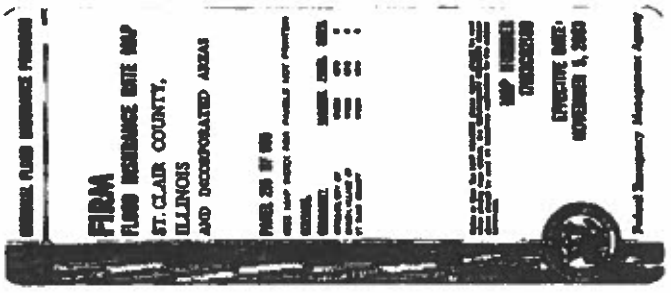
The Rehabilitation Institute of Southern Illinois, LLC

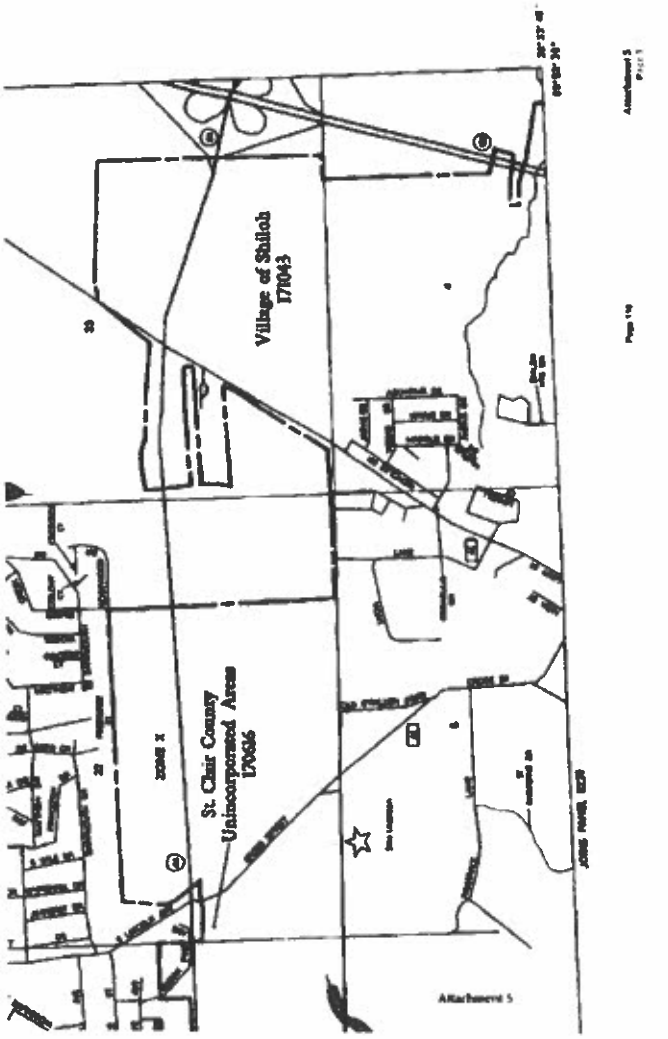


ATTACHMENT 5
Flood Plain Requirements

With the signatures provided on the Certification pages of this Certificate of Need application, the Applicants confirm that this project involving the construction of an addition to The Rehabilitation Institute of Southern Illinois, located at 2351 Frank Scott Parkway, East in Shiloh, Illinois, complies with the requirements of Executive Order #2006-5. A map confirming such, and provided by FEMA, is attached.

ATTACHMENT 5
Flood Plain Requirements





ATTACHMENT 6
Historic Preservation Act Requirements

The Applicants submitted a request for determination to the Illinois Department of Natural Resources – Preservation Services Division on June 12, 2025. A copy of that request is enclosed herein.

ATTACHMENT 6
Historic Preservation Act Requirements

Benesch
Attorneys at Law

Juan Morado, Jr.
71 South Wacker Drive, Suite 1600
Chicago, IL 60606
Direct Dial: 312.212.4967
Fax: 312.757.9192
jmorado@beneschlaw.com

June 12, 2025

VIA EMAIL

Jeffrey Kruchten
Chief Archaeologist
Preservation Services Division
Illinois Historic Preservation Office Illinois
Department of Natural Resources
1 Natural Resources Way
Springfield, IL 62702
SHPO Review@illinois.gov

Re: Certificate of Need Application for Rehabilitation Hospital Expansion

Dear Mr. Kruchten:

I am writing on behalf of my client, The Rehabilitation Institute of Southern Illinois, ("RISI") to request a review of the project area under Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). RISI is submitting an application for a Certificate of Need from the Illinois Health Facilities and Services Review Board. RISI seeks to expand its existing rehabilitation hospital with an additional twenty (20) patient rooms and expanded physical therapy space at its current location, 2351 Frank Scott Parkway E., Shiloh, IL 62269. The addition of patient beds at the rehabilitation hospital requires a CON application.

For your reference, we have enclosed pictures of the existing lot and topographic maps showing the general location of the project. We respectfully request a review of the project area and a determination letter at your earliest convenience. Thank you in advance for all of the time and effort that will be going into this review.

Should you have any questions or require additional information, please do not hesitate to contact me at 312-212-4967 or via email at JMorado@beneschlaw.com.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

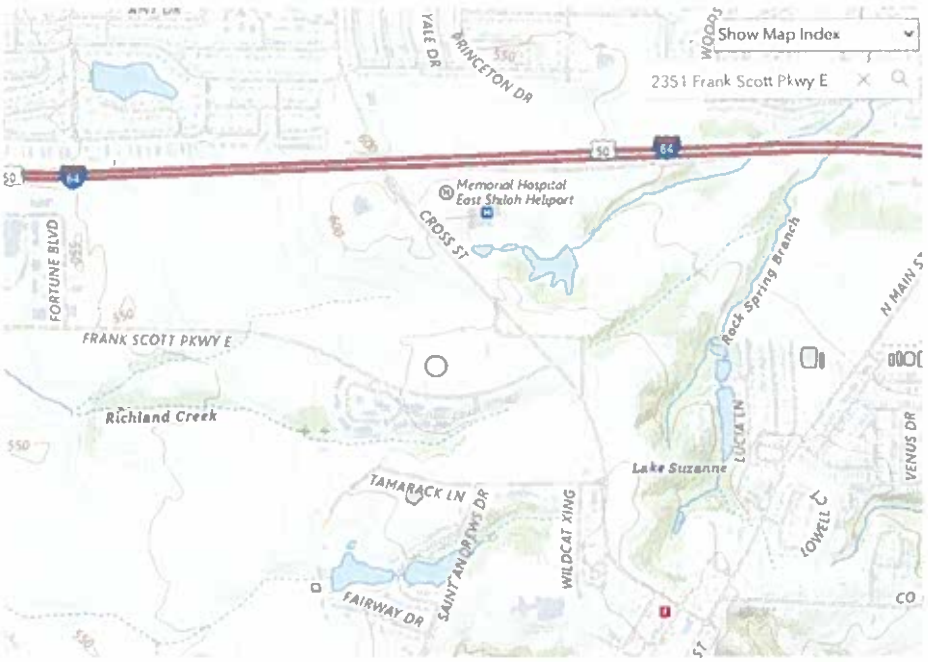
Juan Morado, Jr.

JMJ:
Enclosure

27132975 v1

ATTACHMENT 6
Historic Preservation Act Requirements

Historic Preservation Act Requirements
Topographic Map



27132975 v1

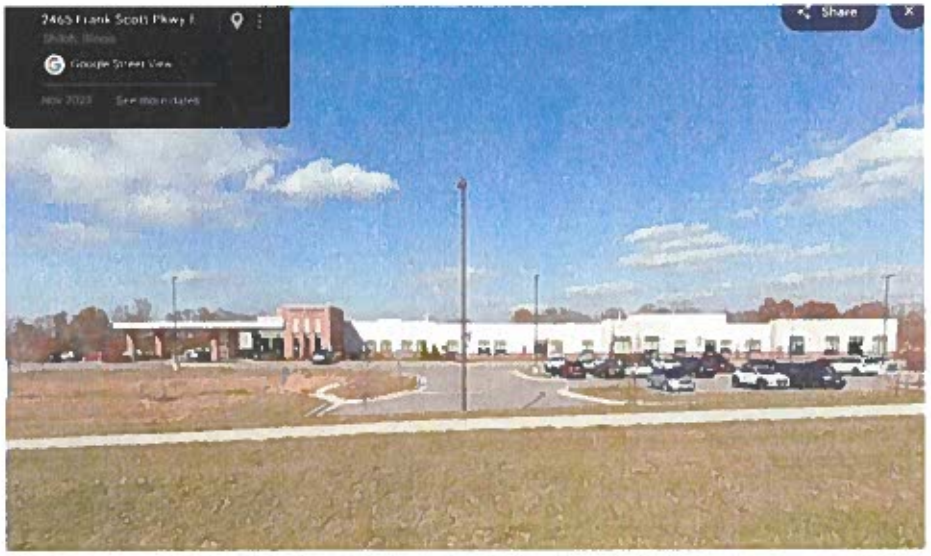
ATTACHMENT 6
Historic Preservation Act Requirements

Historic Preservation Act Requirements
Aerial View of Facility

27132975 v1

ATTACHMENT 6
Historic Preservation Act Requirements

Historic Preservation Act Requirements
Street View



27132975 v1

ATTACHMENT 6
Historic Preservation Act Requirements

Historic Preservation Act Requirements
Aerial View

27132975 v1

ATTACHMENT 7
Project Costs and Sources of Funds

PROJECT COSTS AND SOURCES OF FUNDS

PROJECT COSTS			
Pre-planning Costs			
Evaluation of Alternatives	$ 25,000		
Pre-Arch. Function Plan	$ 70,000		
Internal Approval Process	$ 25,000		
Misc./Other	$ 50,000		
		$	170,000
Site Preparation			
Parking and Walkways	$ 300,000		
Outdoor Lighting and Signage	$ 55,000		
Landscaping	$ 70,000		
Misc./Other	$ 50,000		
		$	475,000
New Construction Contracts			
please see ATTACHMENT 9		$	9,167,840
Contingency		$	548,000
Architectural and Engineering			
Design	$ 670,000		
Document Preparation	$ 35,000		
Interface with Agencies	$ 30,000		
Project Monitoring	$ 40,000		
Misc./Other	$ 50,000		
		$	825,000
Consulting & Other Fees			
Local approvals	$ 23,500		
CON-Related	$ 95,000		
Project Management	$ 275,000		
Interior Design	$ 20,000		
Equipment Planning	$ 20,000		
Misc./Other	$ 100,000		
		$	533,500
Movable Equipment			
Nursing Unit	$ 1,500,000		
Therapy Gymnasium	$ 325,000		
		$	1,825,000
Net Interest Expense		$	292,100
TOTAL COST		**$**	**13,836,440**
SOURCES OF FUNDS			
Other-please see ATT. 37		$	13,836,440
TOTAL SOURCE OF FUNDS		**$**	**13,836,440**

ATTACHMENT 8
Project Costs and Sources of Funds

The proposed project plans are at the preliminary stage. The proposed project completion date is November 1, 2029. Financial commitment for the project will occur following permit issuance and in accordance with HFSRB regulations.

ATTACHMENT 9
Cost Space Requirements

The proposed project involves the construction of a 20-bed rehab inpatient unit and therapy/exercise areas in a total of 13,204 GSF.

	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							
Inpatient Unit	$12,560,028	25,948	37,440	11,492		25,948	
Therapy/Exercise Area	$523,334	3,673	4,633	960		3,673	
	$13,083,362	29,621	42,073	12,452		29,621	
NON-REVIEWABLE							
Family Area	$753,078	1,909	2,661	752		1,909	
PROJECTED TOTAL	**$13,836,440**	**31,530**	**44,734**	**13,204**		**31,530**	

ATTACHMENT 11
Background of the Applicant

The following information is provided to illustrate the qualifications, background and character of the Applicants, and to assure the Health Facilities and Services Review Board that licensee will continue to provide a proper standard of health care services for the community.

Applicant BJC HealthCare maintains "ultimate control" of three hospitals and one long term care facility in Illinois:

- Memorial Hospital, located in Belleville-#0001461
- Memorial Hospital-East, located in Shiloh-#0005215
- Alton Memorial Hospital, located in Alton-#000026
- Memorial Care Center in Belleville

In addition, BJC Healthcare holds a 50% ownership interest in The Rehabilitation Institute of Southern Illinois.

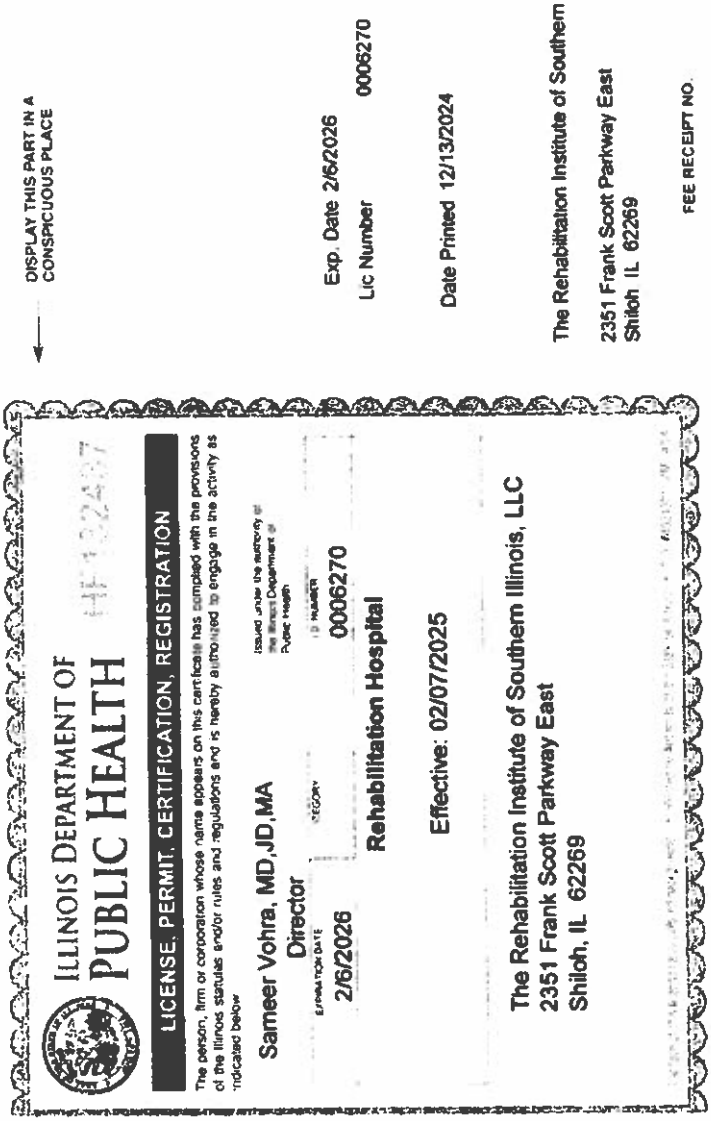
In addition to holding a 50% ownership in The Rehabilitation Institute of Southern Illinois, Applicant Encompass Health Corporation, through its subsidiaries, also holds a 50% ownership interest in Quad Cities Rehabilitation Institute in Moline (#0006312) and Van Matre Encompass Health Rehabilitation Institute in Rockford (#0005215). Encompass Health Rehabilitation Institute of Libertyville in Libertyville (#006288) is a wholly-owned subsidiary of Applicant Encompass Health Corporation.

In accordance with Review Criterion 1130.520(b)(3), Background of the Applicant, and with the signatures placed on the Certification pages of this application, the Applicants assure the Illinois Health Facilities and Services Review Board that:

None of the three Applicants nor any subsidiary entity has had any adverse actions against it during the three (3) year period prior to the filing of this application.

The Applicants each authorize the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1130.520(b)(3) or to obtain any documentation or information which the State Board or Agency finds pertinent to this Certificate of Need application.

ATTACHMENT 11
Background of the Applicant



DISPLAY THIS PART IN A CONSPICUOUS PLACE

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

Sameer Vohra, MD,JD,MA
Director

EXPIRATION DATE
2/6/2026

REGION

ID NUMBER
0006270

Issued under the authority of the Illinois Department of Public Health

Rehabilitation Hospital

Effective: 02/07/2025

The Rehabilitation Institute of Southern Illinois, LLC
2351 Frank Scott Parkway East
Shiloh, IL 62269

Exp. Date 2/6/2026
Lic Number 0006270

Date Printed 12/13/2024

The Rehabilitation Institute of Southern
2351 Frank Scott Parkway East
Shiloh IL 62269

FEE RECEIPT NO.

ATTACHMENT 11
Background of the Applicant

The Joint Commission

June 19, 2023

Cassidy Hoelscher, MHA
CEO
The Rehabilitation Institute of Southern Illinois, LLC
2351 Frank Scott Parkway East
Shiloh, IL 62269

Re: # 676788
CCN: # 143030
Deemed Program: Hospital
Accreditation Expiration Date: March 3, 2025

Dear Mrs. Hoelscher:

This letter confirms that your April 18, 2023 unannounced extension survey 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 June 15, 2023. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of April 19, 2023.

The Joint Commission is also recommending your organization for continued Medicare certification effective April 19, 2023. Please note that the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractor (MAC) 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(s):

The Rehabilitation Institute of Southern Illinois
d/b/a The Rehabilitation Institute of Southern Illinois
2351 Frank Scott Parkway East, Shiloh, IL, 62269

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,

Deborah A Ryan

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

ATTACHMENT 11
Background of the Applicant

The Joint Commission

Deborah A. Ryan, MS, RN
Executive Vice President
Division of Accreditation and Certification Operations

cc: CMS/Baltimore Office/Survey & Certification Group/Division of Acute Care Services
CMS/SOG Location 5 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

ATTACHMENT 12
Purpose of the Project

The purpose of the proposed project is to improve access to comprehensive physical rehabilitation services ("rehabilitation services") for the residents of the geographic service area ("GSA"), defined in Section 1100.510(d) as having a "normal travel radius" of 17 miles. This area is located in Health Service Area 11 ("HSA 11"). Since the hospital's opening in February 2022, the Rehabilitation Institute of Southern Illinois ("RISI") has experienced rapid and constant growth in terms of utilization, and exceeded the HFSRB's target utilization rate on a quarterly basis for the first time during the first quarter of 2024, and has operated in excess of that level for each quarter, since.

RISI is the only provider of rehabilitation services within the 17-mile radius, and one of only two providers in HSA 11, which is located across the Mississippi River from St. Louis, and includes Madison and St. Clair Counties, as well as portions of Clinton and Monroe Counties. The other provider of inpatient rehabilitation services in the general area is located 24 miles from RISI.

The 2026 population of HSA 11 is projected to be approximately 590,600 residents. Among the communities located in the GSA are Shiloh. O'Fallon, Belleville, East St. Louis, Collinsville, Edwardsville, and approximately twenty other communities/ZIP Code areas. As such, the proposed project will improve the health care and well-being of the market area population.

A complete list of all the ZIP Codes located in the GSA is provided below.

Since its opening, RISI has attracted patients from a broad area, primarily in Illinois, but with the patient population clearly being concentrated in the Illinois portion of the GSA. While, during 2024, patients residing in 126 separate ZIP Codes were admitted to the hospital, as depicted in the table below, in excess of 60% of the patients admitted resided in one of twelve Illinois ZIP Codes, all of which are in the designated GSA. This strong regional alignment confirms that RISI is effectively serving its intended population and demonstrates that the proposed expansion will directly benefit the residents of the GSA.

Zip Code	Community	# of Admissions	% of Admissions	Cumulative%
62269	Shiloh	128	11.9%	11.9%
62226	Belleville	81	7.5%	19.5%
62221	Belleville	73	6.8%	26.3%
62220	Belleville	69	6.4%	32.7%
62223	Belleville	67	6.2%	38.9%
62208	Fairview Heights	53	4.9%	43.9%
62234	Collinsville	44	4.1%	48.0%
62258	Mascoutah	33	3.1%	51.0%
62205	East Saint Louis	29	2.7%	53.7%
62206	East Saint Louis	24	2.2%	56.0%
62285	Smithton	24	2.2%	58.2%
62254	Lebanon	22	2.0%	60.2%
	Others, <2.0%	427	39.8%	100.0%

ATTACHMENT 12
Purpose of the Project

RISI is a 50/50 joint venture between BJC HealthCare, through its subsidiary Metro East Services, Inc., and Encompass Health Corporation. This partnership combines the national rehabilitation expertise, operational infrastructure, and proven clinical programs of Encompass Health with BJC HealthCare's deep regional presence, and integrated care network. Together, these organizations deliver the specialized, high-quality inpatient rehabilitation services necessary to meet the needs of residents within HSA 11.

Initially approved by the Illinois Health Facilities and Services Review Board ("HFSRB") as a 40-bed freestanding inpatient rehabilitation hospital, RISI was specifically designed to improve access to post-acute rehabilitation in HSA 11. Since opening, the facility has consistently operated at over 90% occupancy for the last year and a half, serving patients from throughout the 17-mile travel radius and beyond. The proposed 20-bed expansion directly responds to this sustained demand, ensuring that patients, regardless of payer source, can access timely and appropriate care without the delays or transfers that can occur when capacity is reached.

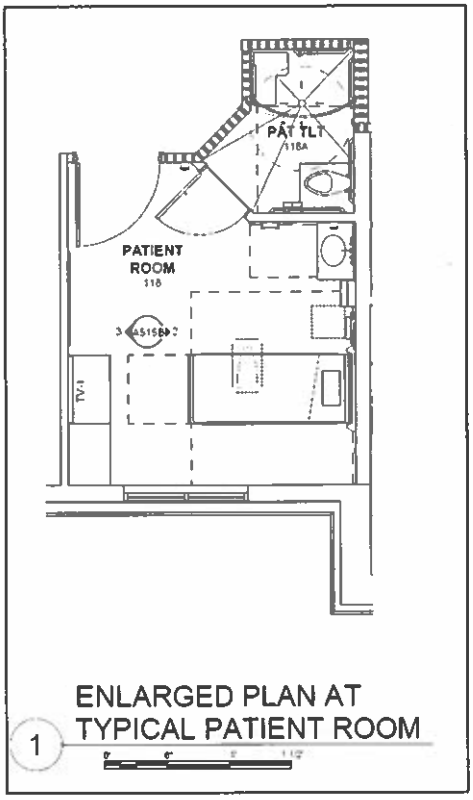
Patients at RISI are recovering from a broad spectrum of complex, serious conditions and stay for an extended time in our hospital. Their families and loved ones often drive for many miles, on multiple days for visits. This project ensures that patients with diverse and complex rehabilitation needs can access timely, high-quality inpatient rehabilitation close to home. By increasing capacity, RISI will reduce delays in care, prevent unnecessary transfers outside the region, and preserve continuity of treatment within the local healthcare network.

ATTACHMENT 12
Purpose of the Project

(Picture of RISI)

(Picture of RISI Therapy Gym)

ATTACHMENT 12
Purpose of the Project



The facility is built to address the needs of a medically complex rehabilitation population, ensuring both clinical capability and patient comfort. The new rooms will feature private, wheelchair-accessible patient rooms, each with a private, wheelchair-accessible bathroom and ample bedside space to allow caregivers and family members to participate actively in the patient's recovery process. All rooms are constructed to the full specifications of acute care inpatient rooms, including headwalls and integrated medical gas systems, enabling the safe and effective management of higher-acuity patients without transfer to another setting. Two (2) private bariatric/isolation rooms provide additional space in both the patient room and bathroom, specialized equipment such as overhead track lift systems, and negative air pressure capability to meet the unique needs of bariatric patients and those with communicable diseases. To further safeguard continuity of care and reduce patient stress, these patients will continue to have access to a dedicated dialysis treatment area which allows individuals requiring dialysis to receive treatment on-site during their inpatient rehabilitation stay, eliminating the need for disruptive and potentially risky off-site transport. These design features not only enhance patient safety and clinical quality but also directly support the timely, equitable access to specialized rehabilitation services that is central to this expansion request.

ATTACHMENT 12
Purpose of the Project

Nationally, Encompass Health hospitals serve a wide and balanced mix of patient diagnoses, reflecting the ability to care for varied clinical needs with specialized expertise. For reference, the overall mix of patients nationally (average for all Encompass Health hospitals) follows:

Admissions

IRF admission criteria	At the time of admission, a patient must meet medical necessity criteria including: • requirement of active and ongoing therapeutic intervention of multiple therapy disciplines • expectation of active participation in, and benefit from, an intensive rehabilitation therapy program • supervision by a physician through face-to-face visits at least 3 days a week
	At least 60% of patients must have at least one CMS-13 medical diagnosis or functional impairment
Average age of EHC patients	72 years old

Patient mix

Rehabilitation impairment category ("RIC")		2024
RIC 01	Stroke	18.4 %
RIC 02/03	Brain dysfunction	11.6 %
RIC 04/05	Spinal cord dysfunction	3.9 %
RIC 06	Neurological conditions	20.7 %
RIC 07	Fracture of lower extremity	8.1 %
RIC 08	Replacement of lower extremity joint	3.5 %
RIC 09	Other orthopedic	7.5 %
RIC 10/11	Amputation	2.4 %
RIC 14	Cardiac	3.9 %
RIC 17/18	Major multiple trauma	6.3 %
RIC 20	Other disabling impairments	11.4 %
–	All other RICs	2.3 %

Patients whose diagnoses fall within the Centers for Medicare & Medicaid Services' recognized rehabilitation impairment categories are typically medically complex cases, and these conditions frequently involve significant functional loss, multiple system involvement, and care needs that require coordinated, multidisciplinary therapy under 24-hour medical and nursing supervision. Patients in these categories benefit from the inpatient rehabilitation facility standard of care. This can typically include three hours of therapy per day, at least five days per week, delivered by specialized physical, occupational, and speech therapists in collaboration with rehabilitation physicians. National outcomes data support the efficacy of this model: for example, Medicare beneficiaries with stroke treated in IRFs achieve an average of 8–10 point greater improvement in mobility and 9–12 point greater improvement in self-care compared to those treated in skilled nursing facilities, often reaching functional levels that allow discharge home rather than to long-term care. For patients in these impairment categories, the IRF model is not only clinically appropriate but demonstrably superior in restoring independence, reducing caregiver burden, and lowering long-term healthcare costs—directly advancing the Board's goals of quality, effectiveness, and patient-centered care.[1]

Beyond anecdotal and institutional experience, robust national data confirm the superior outcomes of inpatient rehabilitation facilities ("IRFs") compared to skilled nursing facilities ("SNFs"). In a large cohort of nearly 100,000 Medicare beneficiaries with stroke, patients admitted to IRFs experienced far greater functional gains than those discharged to SNFs. Specifically, IRF patients achieved an average improvement of 11.6 points in mobility and 13.6 points in self-care scores, compared to only 3.5 and 3.2 points, respectively, for SNF patients. These functional gains were consistent across multiple statistical models and analytic approaches, underscoring the validity of the findings.[2]

[1] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2756256?resultClick=1
[2] *Id.*

ATTACHMENT 12
Purpose of the Project

These differences are not merely incremental; they represent clinically meaningful changes that directly affect a patient's discharge disposition and quality of life. For example, the Hong study notes that a 10-point improvement in self-care can mean the difference between a patient requiring maximal assistance from caregivers and one who can function with only supervision. Patients who require supervision are generally able to return home, while those needing maximal assistance often remain institutionalized or require ongoing in-home nursing support. Thus, the superior gains associated with IRF care translate directly into higher rates of community discharge, reduced long-term care utilization, and less strain on family caregivers.[3]

The study also highlights that these outcome advantages persist even after controlling for confounding factors such as patient demographics, comorbidities, and hospital characteristics. Across multivariate adjustment, propensity score analyses, and instrumental variable models, IRF care consistently yielded functional improvements that were two to three times greater than those achieved in SNFs. This consistency across analytic techniques strengthens the conclusion that the observed differences are attributable to the IRF model of intensive, multidisciplinary rehabilitation rather than selection bias.

In addition to functional outcomes, the study found notable differences in post-discharge mortality. In unadjusted analyses, patients treated in IRFs had a 30–365-day mortality rate of 17.5% compared to 30.5% for those treated in SNFs. While these differences narrowed after multivariate adjustment, the findings nevertheless suggest that the IRF model may confer survival advantages, possibly through better management of medical complexity, earlier mobilization, and improved functional recovery.[4]

Finally, these findings carry important implications for health policy and for the Board's consideration of this application. Stroke is the single largest impairment group treated in IRFs and represents a complex neurological condition requiring intensive, coordinated rehabilitation interventions. By supporting access to IRF-level care for appropriate patients, the Board will ensure that Illinois residents receive the most effective rehabilitation services available, thereby advancing both patient independence and system-wide cost efficiency through reduced reliance on long-term institutional care

BJC HealthCare

BJC HealthCare is one of the largest nonprofit healthcare organizations in the country, serving residents across the greater St. Louis, greater Kansas City, and southern Illinois. Its integrated system includes 24 hospitals including two of the most recognized hospitals in the US: Barnes-Jewish Hospital and St. Louis Children's Hospital.

BJC HealthCare has an unmatched track record in advancing community health through both clinical excellence and broad access. As the largest provider of charity care, unreimbursed care, and community benefit in Missouri, BJC delivers more than $900 million annually in free or reduced-cost medical care, health professional education, medical research, and community health programs. Many of these initiatives directly benefit residents of southern Illinois who rely on BJC's hospitals and specialists for advanced care not otherwise available locally.

BJC also brings strong operational integration across the continuum of care, including primary, specialty, acute, and post-acute services. This depth of coordination ensures that patients in HSA 11 have seamless transitions from acute care into the appropriate post-acute rehabilitation setting.

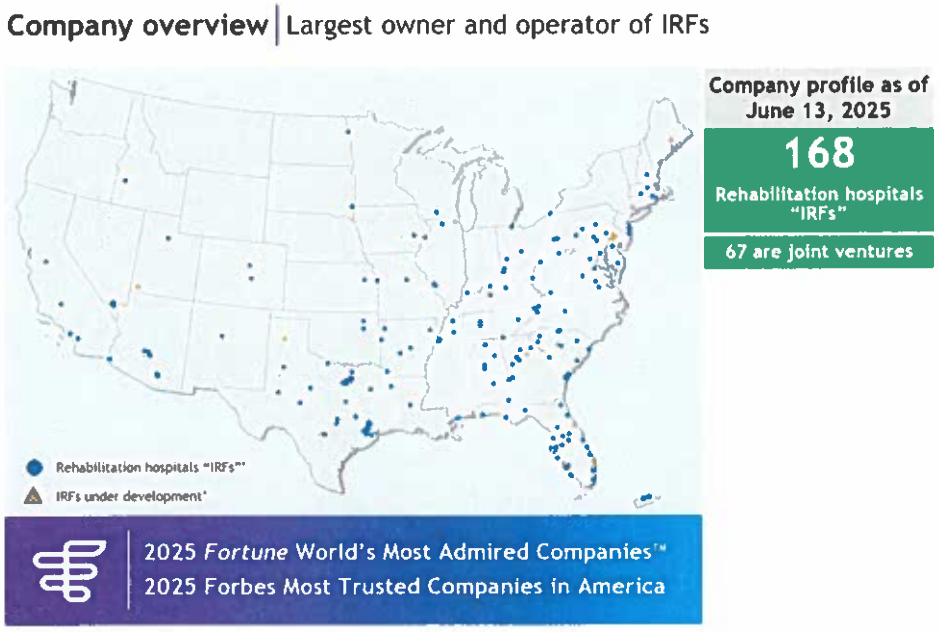
[3] *Id.*
[4] *Id.*

ATTACHMENT 12
Purpose of the Project

Encompass Health

Encompass Health (f/k/a HealthSouth Rehabilitation Corporation) is a national leader in inpatient rehabilitation services with 169 inpatient rehab hospitals in 38 states and Puerto Rico. Approximately **one in three** patients in the U.S. receiving inpatient rehabilitative care receive it through an Encompass Health rehabilitation hospital.

Many of Encompass'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 continues to bring 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.

There are many advantages of expanding an existing freestanding inpatient rehab-only hospital including for example:

- A facility design that makes clear some of the many advantages of a freestanding inpatient rehab hospital compared to typical in-hospital units, including significantly larger rehab therapy areas with more equipment and technology, an extensive outdoor therapy area, dedicated bariatric rehab rooms, dedicated isolation rooms, and a dedicated dialysis unit.
- The ability of a dedicated rehab hospital to recruit highly-specialized and specially-trained rehab-specific clinical staff members.
- Equal acceptance of rehab-appropriate patients from all general acute care providers so that HSA 11 residents receiving care at any HSA 11 general acute care hospital have the same chance of discharge to Rehab services as patients who are discharged from general acute care hospitals with their own in-hospital Rehab unit.

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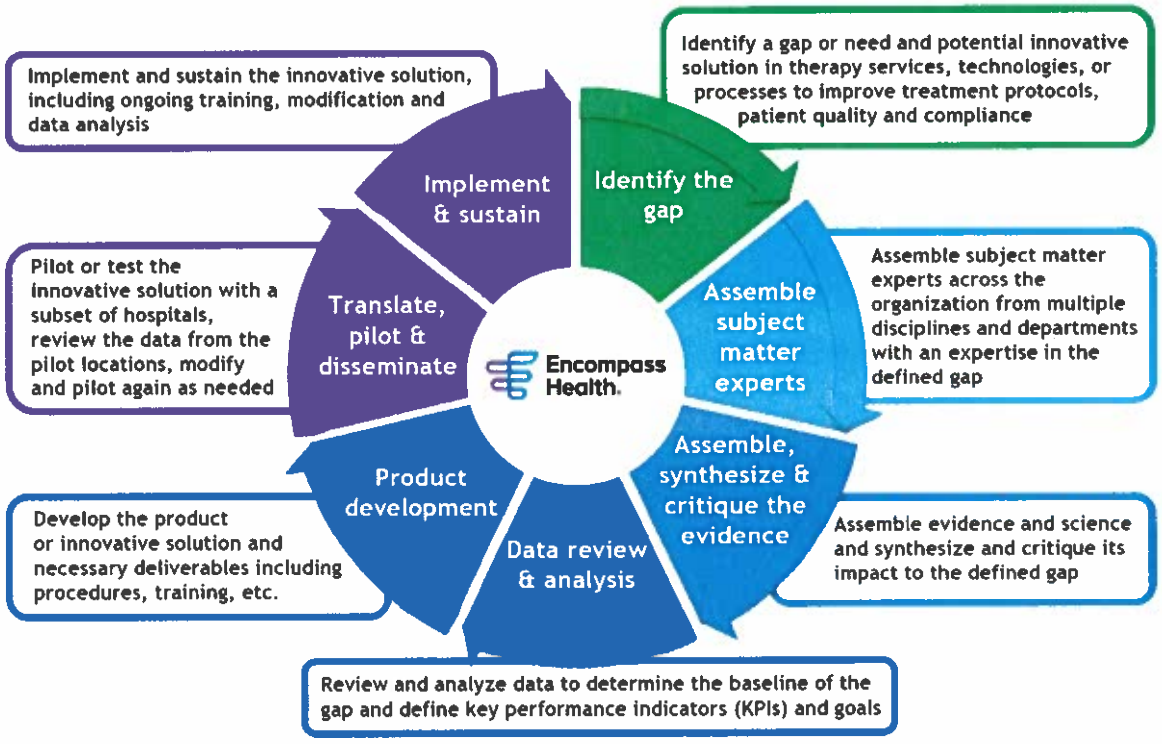
Encompass Health leverages operational best practices, economies of scale, and a robust clinical infrastructure to ensure consistent, high-quality care across all markets. Core operational initiatives include standardized clinical protocols, centralized data analytics for performance monitoring, and comprehensive staff training programs focused on rehabilitation-specific competencies. Encompass Health invests heavily in workforce development, including advanced clinical education for therapists, nurses, and rehabilitation physicians, ensuring staff are prepared to meet the needs of medically complex patients. This operational discipline produces measurable efficiencies, higher patient satisfaction, and improved outcomes, aligning with the Illinois Health Facilities and Services Review Board's objectives of quality, accessibility, and cost-effectiveness.

Encompass Health has developed an integrated post-acute innovation model that bridges the gap between acute care discharge and community reintegration. This model emphasizes seamless transitions of care, leveraging electronic health record interoperability, real-time communication with acute care partners, and coordinated care planning with patients, families, and referring providers. Through advanced outcome tracking and predictive analytics, Encompass Health identifies patients at risk for complications or readmissions and tailors rehabilitation plans accordingly. The company's commitment to innovation is evident in the deployment of leading-edge rehabilitation technologies, including robotic-assisted therapy devices, virtual reality platforms, and advanced neurorehabilitation tools. These resources enhance the intensity and precision of therapy, accelerate functional gains, and support personalized recovery pathways—critical for the medically complex and high-acuity populations served by inpatient rehabilitation hospitals like RISI.

Operational initiatives | Post-acute clinical innovation model



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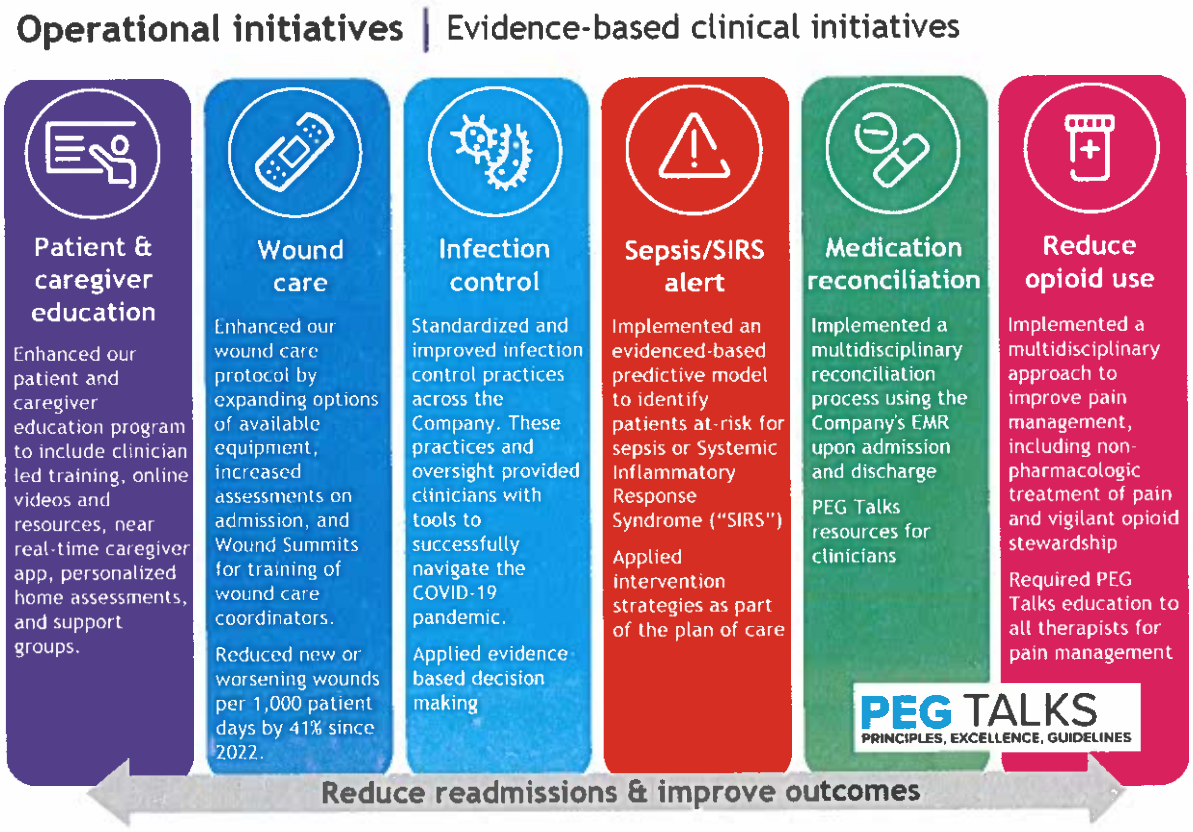
Encompass Health's clinical programs are built upon an evidence-based framework, incorporating best practices from the latest rehabilitation research and national guidelines. As a proud partner of the American Stroke Association's "Together to End Stroke" initiative, Encompass Health co-develops educational resources, clinical tools, and training modules for healthcare professionals and patients. Its hospitals maintain numerous Joint Commission disease-specific care certifications, including in stroke, brain injury, hip fracture, and amputee rehabilitation, reflecting adherence to rigorous, outcome-driven standards. Clinical initiatives include standardized assessment protocols to benchmark progress, early mobility programs to reduce deconditioning, and interdisciplinary team rounds to ensure coordinated, goal-oriented care. By embedding evidence-based practice into every phase of rehabilitation, Encompass Health achieves superior functional outcomes compared to national averages, reduces complications, and supports faster, safer discharges home—demonstrating the value of the IRF model for patients with complex rehabilitation needs.



Encompass Health has also developed nationally recognized expertise in stroke rehabilitation, supported by its longstanding partnership with the American Stroke Association through the Together to End Stroke initiative. In 2024, co-developed resources—including a lesson module on Exercising After Stroke and a "how-to" video simplifying everyday tasks for stroke survivors were presented at leading professional forums such as the International Stroke Conference, American Association of Neuroscience Nurses Annual Meeting, and World Stroke Congress. These educational and clinical tools, coupled with Encompass Health's interdisciplinary care model, directly translate into real-world functional gains for patients served at facilities like RISI.

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A recent large-scale national study compared functional outcomes for Medicare beneficiaries recovering from stroke in IRFs versus SNFs. The analysis included 99,185 patients discharged from acute care hospitals between 2013 and 2014, with 66.6% admitted to IRFs and 33.4% to SNFs. Patients in IRFs demonstrated significantly greater improvements in both mobility and self-care scores than those in SNFs, even after adjusting for patient demographics, comorbidities, and facility characteristics. On average, mobility scores improved by 11.6 points in IRFs compared to 3.5 points in SNFs, and self-care scores improved by 13.6 points versus 3.2 points, respectively. These are differences that remained robust across multiple statistical models.

These findings highlight that stroke, as a complex neurological condition, benefits substantially from the intensive, multidisciplinary rehabilitation model offered by IRFs. Such care often enables patients to progress from requiring maximal assistance to needing only supervision, making discharge to home more feasible and reducing the likelihood of long-term institutional care. In contrast, patients in SNFs experienced slower and less complete recovery of functional independence, despite typically having longer lengths of stay. The improved functional gains in IRFs have meaningful quality-of-life implications for patients and caregivers, as well as potential downstream cost savings from reduced reliance on long-term support services.

Importantly, the study addressed concerns about selection bias by using advanced statistical techniques, including instrumental variable analysis based on nonclinical factors such as geographic proximity to facilities. Across all models, the advantage of IRFs persisted, with differences in mobility improvements ranging from 5.6 to 10.4 points and self-care improvements from 8.7 to 11.9 points over SNFs. These results underscore that functional recovery benefits are not simply a reflection of healthier patients being directed to IRFs but reflect genuine differences in the rehabilitation model itself.

For RISI, which already operates at high utilization, the evidence supports the clear benefit of expanding IRF capacity. Adding 20 rehabilitation beds would allow more stroke patients in the Shiloh region to access the higher-intensity, specialized services associated with significantly better recovery outcomes. This expansion aligns with both patient need and public health priorities, ensuring that individuals with complex rehabilitation requirements—particularly those recovering from stroke—receive the most effective care setting to maximize independence and quality of life.[5]

[5] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2756256?resultClick=1

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Zip Codes Located In The Project's Geographic Service Area

ZIP CODE	City	State
62269	SHILOH	IL
62254	LEBANON	IL
62225	SCOTT AIR FORCE BASE	IL
62208	FAIRVIEW HEIGHTS	IL
62232	CASEYVILLE	IL
62221	BELLEVILLE	IL
62294	TROY	IL
62234	COLLINSVILLE	IL
62222	BELLEVILLE	IL
62226	BELLEVILLE	IL
62289	SUMMERFIELD	IL
62062	MARYVILLE	IL
62281	SAINT JACOB	IL
62203	EAST SAINT LOUIS	IL
62223	BELLEVILLE	IL
62220	BELLEVILLE	IL
62204	EAST SAINT LOUIS	IL
62034	GLEN CARBON	IL
62205	EAST SAINT LOUIS	IL
62243	FREEBURG	IL
62201	EAST SAINT LOUIS	IL
62207	EAST SAINT LOUIS	IL
62258	MASCOUTAH	IL
62293	TRENTON	IL
62202	EAST SAINT LOUIS	IL
62071	NATIONAL STOCK YARDS	IL
62061	MARINE	IL
62026	EDWARDSVILLE	IL
62040	GRANITE CITY	IL
62060	MADISON	IL
62206	EAST SAINT LOUIS	IL
62265	NEW BADEN	IL
62260	MILLSTADT	IL

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Zip Codes Located In The Project's Geographic Service Area

62266	NEW MEMPHIS	IL
62059	LOVEJOY	IL
62090	VENICE	IL
63102	SAINT LOUIS	MO
63101	SAINT LOUIS	MO
62285	SMITHTON	IL
62216	AVISTON	IL
63150	SAINT LOUIS	MO
63156	SAINT LOUIS	MO
63157	SAINT LOUIS	MO
63158	SAINT LOUIS	MO
63160	SAINT LOUIS	MO
63163	SAINT LOUIS	MO
63164	SAINT LOUIS	MO
63166	SAINT LOUIS	MO
63169	SAINT LOUIS	MO
63171	SAINT LOUIS	MO
63177	SAINT LOUIS	MO
63178	SAINT LOUIS	MO
63179	SAINT LOUIS	MO
63180	SAINT LOUIS	MO
63182	SAINT LOUIS	MO
63188	SAINT LOUIS	MO
63195	SAINT LOUIS	MO
63197	SAINT LOUIS	MO
63199	SAINT LOUIS	MO
62239	DUPO	IL
63155	SAINT LOUIS	MO
63167	SAINT LOUIS	MO
63106	SAINT LOUIS	MO
63104	SAINT LOUIS	MO

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JAMA Network Open

Original Investigation | Geriatrics

Comparison of Functional Status Improvements Among Patients With Stroke Receiving Postacute Care in Inpatient Rehabilitation vs Skilled Nursing Facilities

Ickpyo Hong, PhD, OTR; James S. Goodwin, MD; Timothy A. Reistetter, PhD, OTR; Yong-Fang Kuo, PhD; Trudy Mallinson, PhD, OTR; Amol Karmarkar, PhD; Yu-Li Lin, MS; Kenneth J. Ottenbacher, PhD, OTR

Abstract

IMPORTANCE Health care reform legislation and Medicare plans for unified payment for postacute care highlight the need for research examining service delivery and outcomes.

OBJECTIVE To compare functional outcomes in patients with stroke after postacute care in inpatient rehabilitation facilities (IRF) vs skilled nursing facilities (SNF).

DESIGN, SETTING, AND PARTICIPANTS This cohort study included patients with stroke who were discharged from acute care hospitals to IRF or SNF from January 1, 2013, to November 30, 2014. Medicare claims were used to link to IRF and SNF assessments. Data analyses were conducted from January 17, 2017, through April 25, 2019.

EXPOSURES Inpatient rehabilitation received in IRFs vs SNFs.

MAIN OUTCOMES AND MEASURES Changes in mobility and self-care measures during an IRF or SNF stay were compared using multivariate analyses, inverse probability weighting with propensity score, and instrumental variable analyses. Mortality between 30 and 365 days after discharge was included as a control outcome as an indicator for unmeasured confounders.

RESULTS Among 99 185 patients who experienced a stroke between January 1, 2013, and November 30, 2014, 66 082 patients (66.6%) were admitted to IRFs and 33 103 patients (33.4%) were admitted to SNFs. A higher proportion of women were admitted to SNFs (21 466 [64.8%] women) than IRFs (36 462 [55.2%] women) ($P < .001$). Compared with patients admitted to IRFs, patients admitted to SNFs were older (mean [SD] age, 79.4 [7.6] years vs 83.3 [7.8] years; $P < .001$) and had longer hospital length of stay (mean [SD], 4.6 [3.0] days vs 5.9 [4.2] days; $P < .001$) than those admitted to IRFs. In unadjusted analyses, patients with stroke admitted to IRF compared with those admitted to SNF had higher mean scores for mobility on admission (44.2 [95% CI, 44.1-44.3] points vs 40.8 [95% CI, 40.7-40.9] points) and at discharge (55.8 [95% CI, 55.7-55.9] points vs 44.4 [95% CI, 44.3-44.5] points), and for self-care on admission (45.0 [95% CI, 44.9-45.1] points vs 41.8 [95% CI, 41.7-41.9] points) and at discharge (58.6 [95% CI, 58.5-58.7] points vs 45.1 [95% CI, 45.0-45.2] points). Additionally, patients in IRF compared with those in SNF had larger improvements for mobility score (11.6 [95% CI, 11.5-11.7] points vs 3.5 [95% CI, 3.4-3.6] points) and for self-care score (13.6 [95% CI, 13.5-13.7] points vs 3.2 [95% CI, 3.1-3.3] points). Multivariable, propensity score, and instrumental variable analyses showed a similar magnitude of better improvements in patients admitted to IRF vs those admitted to SNF. The differences between SNF and IRF in odds of 30- to 365-day mortality (unadjusted odds ratio, 0.48 [95% CI, 0.46-0.49]) were reduced but not eliminated in multivariable analysis (adjusted odds ratio, 0.72 [95% CI, 0.69-0.74]) and propensity score analysis (adjusted odds ratio, 0.75 [95% CI, 0.72-0.77]). These differences were no longer statistically significant in the instrumental variable analyses.

(continued)

Key Points

Question Is change in physical function associated with receiving postacute care after a stroke in inpatient rehabilitation vs skilled nursing facilities?

Findings This cohort study included 99 185 patients who received postacute care in inpatient rehabilitation or skilled nursing facilities after a stroke. Care in an inpatient rehabilitation facility was associated with greater improvement in mobility and self-care compared with care in a skilled nursing facility, and a significant difference in functional improvement remained after accounting for patient, clinical, and facility characteristics at admission.

Meaning These findings suggest that there is room for payment reform in postacute care and highlight the need to target decision-making regarding discharge to postacute facilities based on patient needs and potential for recovery.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

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Purpose of the Project

Abstract (continued)

CONCLUSIONS AND RELEVANCE In this cohort study of a large national sample, inpatient rehabilitation in IRFs for patients with stroke was associated with substantially improved physical mobility and self-care function compared with rehabilitation in SNFs. This finding raises questions about the value of any policy that would reimburse IRFs or SNFs at the same standard rate for stroke.

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Introduction

More than 40% of Medicare beneficiaries are discharged from acute care hospitals to postacute care each year. Reports by the National Academy of Sciences[1] and the Institute of Medicine[2] have found that postacute care was the largest contributor to geographic variation in Medicare costs. The 2014 Improving Medicare Post-Acute Care Transformation (IMPACT) Act[3] requires the Secretary of the Department of Health and Human Services to establish a unified payment system for postacute care. As a step in this process, the Medicare Payment Advisory Commission recommended that inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs) explore similar episode-based reimbursement for a given condition. The proposal is based, in part, on the substantial overlap in patient populations served by IRFs and SNFs.[4,5]

The purpose of our study was to examine changes in functional status in a national sample of Medicare beneficiaries with stroke who received inpatient rehabilitation at an IRF or SNF following acute hospital discharge. We selected stroke because it is a major cause of disability in the United States and an important public health issue; patients with stroke have complex neurological disorders that require a range of treatments and expertise, and stroke represents the largest impairment group treated in IRFs.[6]

In this study, we compared functional outcomes of patients with stroke who were discharged from a hospital to an IRF or SNF. There are challenges in comparing outcomes in observational studies, the most important of which is bias by indication, or selection bias. Inpatient rehabilitation facilities have more stringent criteria for admission than do SNFs, including the requirement that patients be able to complete 3 hours of rehabilitation therapy daily. Several studies[7-9] have shown that traditional methods of controlling for patient characteristics, such as logistic regression and propensity analyses, tend not to be effective in the face of strong selection biases. There are several approaches to mitigating this problem. One approach is to assess how large a bias would have to be to eliminate the association observed, which allows the reader to judge whether the existence of such a bias is plausible, such as by use of the E-value.[10] Another approach is to indirectly assess the strength of the bias and whether it is eliminated by a specific analytic approach, such as by using a control outcome, a measure that should not be affected by differences between the 2 treatments but would be affected by selection biases. In this study, we used all-cause mortality between 30 and 365 days after hospital discharge as a control outcome. The control outcome should be strongly related to the underlying health of the patients but only minimally influenced by residence in an IRF vs SNF. If the statistical analyses show significant IRF vs SNF differences in 30- to 365-day mortality, that result would suggest that underlying selection biases remain. A third approach is to use analytic approaches shown to minimize selection biases, such as instrumental variable analysis.[7,9] We used these 3 approaches to compare outcomes of patients with stroke who were discharged from acute care to IRFs vs SNFs.

We hypothesized that patients discharged to IRFs would have larger improvements in mobility and self-care function than those discharged to SNFs.

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Methods

This study was approved by the institutional review board of the University of Texas Medical Branch and complies with the Centers for Medicare & Medicaid Services (CMS) Data Use Agreement requirements, which waived the need for informed consent for use of the study data because data were deidentified. We reported the study findings according to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

Study Data

Our data included Medicare files from 2012 to 2014. These files included Master Beneficiary Summary for patient demographics, Medicare Provider Analysis and Review for claims from hospital and postacute care stays with clinical variables, Inpatient Rehabilitation Facility-Patient Assessment Instrument from IRF,[4,11] Minimum Data Set 3.0 from SNF,[12] and the Provider of Services Current Files for hospital characteristics.

Sample Selection

The study sample included Medicare beneficiaries 66 years or older discharged from January 1, 2013, to November 30, 2014, to an IRF or SNF after an index acute stay for stroke denoted by Medicare Severity Diagnosis Related Group codes 061 to 066 (eFigure in the Supplement).[13] Additional inclusion criteria included Medicare Part A coverage without enrollment in a health maintenance organization in the year before and 1 month after the index stroke discharge, residing in the community prior to the index stroke hospitalization, and full mobility and self-care functional measures at the IRF admission and discharge or SNF admission and last follow-up (eTable 1 and eTable 2 in the Supplement).

Functional Measures: Mobility and Self-Care

Our methods are described in more detail in the eAppendix in the Supplement. We used mobility and self-care items from the Inpatient Rehabilitation Facility-Patient Assessment Instrument and the Minimum Data Set 3.0 (eTable 3 in the Supplement). The Inpatient Rehabilitation Facility-Patient Assessment Instrument includes 5 mobility items and 6 self-care items, with a 7-point rating scale. The Minimum Data Set 3.0 consists of 6 mobility items with a 4-point rating scale and 5 self-care items with a 5-point rating scale.

We used the crosswalk developed by Mallinson et al[14] to construct comparable admission and discharge functional scores for the postacute care settings.[15] The scores at admission and discharge for mobility and self-care are reported on a scale of 0 to 100 points, with higher scores indicating greater functional status. This method has demonstrated efficacy in several settings.[16,17]

Covariates

Patient characteristics included age at admission to IRF or SNF (ie, 66-69, 70-74, 75-79, 80-84, or ≥85 years), sex, race/ethnicity (ie, non-Hispanic white, non-Hispanic black, Hispanic, or other), length of stay (LOS) in acute care (ie, 1-3, 4-7, 8-11, 12-25, or ≥26 days), Medicaid eligibility, type of stroke (ischemic or hemorrhagic) and any stay in intensive care. The race/ethnicity variable was defined by the CMS and was included because some outcomes differ among racial/ethnic groups.[18] The 30 most frequent CMS Hierarchical Condition Categories for comorbidities were identified through diagnoses on the inpatient claims from the previous year and the secondary diagnoses during the index stroke hospitalization (eTable 4 and eTable 5 in the Supplement).[19] In addition, we added 6 diagnoses related to cognitive function (eTable 6 in the Supplement). Hospital characteristics included location (urban or rural), hospital type (ie, for-profit, nonprofit, or other), presence of swing beds (yes or no), rehabilitation unit within hospital (yes or no), teaching hospital (yes or no), number of stroke discharges from the index hospital in the same year of the index stroke discharge, and number of beds in index stroke hospital.

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Outcomes

The outcomes were changes in mobility and self-care scores during the IRF or SNF stay. As a control outcome, we assessed mortality between 30 and 365 days after hospital discharge. We selected this outcome to assess how well the analytic techniques controlled for any differences in underlying health status between patients admitted to IRF or SNF. The assumption was that mortality in this time frame would be closely linked to health status and minimally associated with the type of facility.

Statistical Analysis

Data were analyzed from January 17, 2017, through April 25, 2019. We began with unadjusted bivariate analyses of all variables compared across IRF and SNF settings. We used several analytic approaches to control for potential confounders across IRF and SNF settings, including multivariable analysis, inverse probability weighting with propensity scores and instrumental variable analyses. The multivariable approach used ordinary least squares, adjusting for covariates. Next, we used inverse probability treatment weighting with propensity scores with and without multilevel adjustment.

The propensity score was generated with a logistic regression model using an average treatment effect estimation[20] that incorporated all covariates listed in eTable 4 and eTable 5 in the Supplement. If any covariates in the propensity score model were not balanced, we additionally controlled for those covariates in the outcome models. Next, we used hierarchical general linear mixed-effects models to account for patients nested within hospitals. Additionally, we used ordinary least squares models with inverse probability treatment weighting, with propensity scores also adjusted for unbalanced covariates, to compare functional status outcome (ie, mobility and self-care) at discharge from IRF or SNF.

We used instrumental variable analysis to adjust for unmeasured confounders across patients and facilities.[21] The instrumental variables included difference in the distance from the acute care hospital to the nearest IRF vs the nearest SNF, difference in the distance from the beneficiary's residence to the nearest IRF vs nearest SNF, number of stroke patients discharged to an IRF in the hospital referral region (HRR) in 2013 through 2014, and the previous discharge location assignment (IRF or SNF) for patients with the same type of stroke from the same acute care hospital (eTable 7 and eTable 8 in the Supplement). We estimated the parameters using 2-stage least square regression.[22-24] For the control outcome of 30- to 365-day mortality, the parameters were estimated from 2-stage residual inclusion models because the outcome was dichotomous. Lastly, we calculated E-values for mobility scores, self-care scores, and mortality between patients admitted to IRF or SNF, to assess the potential magnitude of unmeasured confounding that might have produced the results.[10] Data were analyzed using SAS statistical software version 9.4 (SAS Institute). *P* values were 2-tailed, and statistical significance was set at less than .05.

Results

A total of 99 185 patients with stroke from 3405 hospitals were included in the study, including 66 082 patients (66.6%) who received stroke rehabilitation in an IRF and 33 103 patients (33.4%) who received stroke rehabilitation in an SNF. Table 1 presents the baseline differences in the patient characteristics between those admitted to IRFs or SNFs. A higher proportion of women were admitted to SNFs (21 466 [64.8%] women) than IRFs (36 462 [55.2%] women) ($P < .001$). Compared with patients admitted to IRFs, patients admitted to SNFs were older (mean [SD] age, 79.4 [7.6] years vs 83.3 [7.8] years; $P < .001$), had longer hospital LOS (mean [SD], 4.6 [3.0] days vs 5.9 [4.2] days; $P < .001$), and had more comorbidities (mean [SD], 2.8 [2.0] comorbidities vs 3.3 [2.1] comorbidities; $P < .001$) (Table 1, eTable 4 in the Supplement). The LOS in SNFs was more than 2-fold that in IRFs (mean [SD], 38.1 [24.1] days vs 15.2 [7.3] days).

Table 2 presents the unadjusted mobility and self-care scores at admission and discharge for patients in IRFs and SNFs, along with the change in scores between admission and discharge.

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Table 1. Characteristics of Patients Admission to IRF and SNF

Variable	Patients, No. (%) IRF (n = 66 082)	SNF (n = 33 103)	P Value[a]
Age, mean (SD), y[b]	79.4 (7.6)	83.3 (7.8)	<.001
66-69	7959 (12.0)	1869 (5.6)	
70-74	11 994 (18.2)	3244 (9.8)	
75-79	13 421 (20.3)	4931 (14.9)	
80-84	13 931 (21.1)	6978 (21.1)	
≥85	18 777 (28.4)	16 081 (48.6)	
Sex			
Men	29 620 (44.8)	11 637 (35.2)	<.001
Women	36 462 (55.2)	21 466 (64.8)	
Race/ethnicity			
Non-Hispanic white	52 826 (79.9)	26 775 (80.9)	<.001
Non-Hispanic black	7753 (11.7)	3915 (11.9)	
Hispanic	3202 (4.9)	1371 (4.1)	
Other	2301 (3.5)	1042 (3.1)	
Stroke type			
Ischemic	58 872 (89.1)	29 272 (88.4)	.002
Hemorrhagic	7210 (10.9)	3831 (11.6)	
Length of stay in acute care, mean (SD), d[b]	4.6 (3.0)	5.9 (4.2)	<.001
1-3	28 099 (42.5)	9723 (29.4)	
4-7	29 996 (45.4)	16 403 (49.6)	
8-11	5839 (8.8)	4390 (13.3)	
12-25	2066 (3.1)	2403 (7.3)	
≥26	82 (0.1)	184 (0.6)	
Admission function score, mean (SD)[c]			
Mobility[d]	44.2 (7.4)	40.8 (9.4)	<.001
Self-care[e]	45.0 (11.1)	41.9 (11.7)	<.001
No. of comorbidities, mean (SD)[b]	2.8 (2.0)	3.3 (2.1)	<.001
Medicaid eligible	10 454 (15.8)	7222 (21.8)	<.001
Stayed in ICU or CCU	39 195 (59.3)	17 178 (51.9)	<.001
Urban hospital	60 114 (91.0)	28 207 (85.2)	<.001
Hospital type			
For-profit	9480 (14.3)	4074 (12.3)	
Nonprofit	48 815 (73.9)	24 848 (75.1)	<.001
Other	7787 (11.8)	4181 (12.6)	
Swing bed	1710 (2.6)	2023 (6.1)	<.001
Rehabilitation unit in IRF[f]	40 742 (61.7)	14 657 (44.3)	<.001
Teaching hospital	34 919 (52.8)	15 858 (47.9)	<.001
Stroke discharges, No., mean (SD)[b]	248.0 (175.9)	218.7 (174.8)	<.001
Hospital beds, No., mean (SD)[b]	463.0 (329.2)	414.2 (332.0)	<.001

Abbreviations: CCU, cardiac care unit; ICU, intensive care unit; IRF, inpatient rehabilitation facilities; SNF, skilled nursing facilities.

[a] Based on χ^2 test.

[b] Based on Wilcoxon rank sum test.

[c] Scores were scaled on 0- to 100-point scales, with higher scores indicating greater functional status.

[d] Mobility score for IRF measured the level of help needed for transfer to bed, chair, or wheelchair, transfer to toilet, transfer tub or shower, locomotion via walking or a wheelchair, and locomotion on stairs. Mobility score for SNF measured the level of help needed for bed mobility, transfer, walking in a room, walking in a corridor, locomotion on the unit, and locomotion off the unit.

[e] Self-care scores in IRF measured the level of help needed for eating, grooming, bathing, dressing upper body, dressing lower body, and toileting. For SNF, self-care score measured the level of help needed for dressing, eating, toilet use, personal hygiene, and bathing.

[f] Indicates a rehabilitation unit that is part of an acute care hospital rather than a free-standing rehabilitation facility.

Table 2. Unadjusted Admission and Discharge Results

Score	Mean (95% CI) IRF Mobility	IRF Self-care	SNF Mobility	SNF Self-care
At admission	44.2 (44.1-44.3)	45.0 (44.9-45.1)	40.8 (40.7-40.9)	41.8 (41.7-41.9)
At discharge	55.8 (55.7-55.9)	58.6 (58.5-58.7)	44.4 (44.3-44.5)	45.1 (45.0-45.2)
Change	11.6 (11.5-11.7)	13.6 (13.5-13.7)	3.5 (3.4-3.6)	3.2 (3.1-3.3)

Abbreviations: IRF, inpatient rehabilitation facilities; SNF, skilled nursing facilities.

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Compared with patients in IRFs, patients in SNFs had lower mean scores for mobility (44.2 [95% CI, 44.1-44.3] points vs 40.8 [95% CI, 40.7-40.9] points) and self-care (45.0 [95% CI, 44.9-45.1] points vs 41.8 [95% CI, 41.7-41.9] points) at admission and for mobility (55.8 [95% CI, 55.7-55.9] points vs 44.4 [95% CI, 44.3-44.5] points) and self-care (58.6 [95% CI, 58.5-58.7] points vs 45.1 [95% CI, 45.0-45.2] points) at discharge. The changes in mobility and self-care scores were substantially greater among IRF patients. For mobility, the change was 11.6 (95% CI, 11.5-11.7) points for patients in IRFs vs 3.5 (95% CI, 3.4-3.6) points for those in SNFs. For self-care, the change was 13.6 (95% CI, 13.5-13.7) points vs 3.2 (95% CI, 3.1-3.3) points.

After applying propensity score weights, most demographics and comorbidities were balanced between IRF and SNF (49 of 52 variables [94.2%]) (eTable 4 and eTable 5 in the Supplement). Table 3 presents stroke outcomes by mobility and self-care discharge scores for patients in IRF or SNF. Regardless of covariate adjustment method, the patients with stroke who were discharged from IRF had higher mobility and self-care scores than those discharged from SNF. In multivariate adjustment analysis, the mean (SE) difference in scores between patients from IRF vs SNF was 7.8 (0.05) points for mobility and 9.7 (0.06) points for self-care. In the multilevel multivariate propensity score inverse probability of treatment weighting model, the mean (SE) difference in scores between patients from IRF vs SNF was 8.0 (0.04) points for mobility and 9.9 (0.05) points for self-care. Results of instrumental variable analyses are summarized in Table 3 and show similar results, including by differential distance from acute care hospital to nearest IRF or SNF (mean [SE] difference: mobility score, 8.2 [0.34] points; self-care score, 9.8 [0.39] points), by differential distance from patient's residence to nearest IRF or SNF (mean [SE] difference: mobility score, 5.6 [0.63] points; self-care score, 8.7 [0.72] points), by percentage of IRFs within the acute hospital HRR (mean [SE] difference: mobility score, 10.4 [0.21] points; self-care score, 11.9 [0.25] points), and by previous IRF or SNF assignment by stroke type within each hospital (mean [SE] difference: mobility score, 9.2 [0.30] points; self-care score, 10.7 [0.34] points). In all models, the changes in mobility and self-care scores for those discharged from IRFs were at least 2-fold those for patients discharged from SNFs.

In order to assess the ability of the various analytic techniques to adjust for unmeasured confounders, we assessed mortality between 30 and 365 days as a control outcome (Table 4). In unadjusted analyses, patients with stroke who were discharged from IRF had lower mortality than those discharged from SNF (17.5% vs 30.5%, OR, 0.48 [95% CI, 0.46-0.49]). Adjustment for patient and hospital characteristics in a multivariate adjustment model increased the OR to 0.72 (95% CI, 0.69-0.74), which was similar to results of the inverse probability weighted propensity models

Table 3. Change in Score From Admission to Discharge in IRF and SNF

	Score, Mean (SE)					
	IRF		SNF		Difference	
Analysis	Mobility	Self-care	Mobility	Self-care	Mobility	Self-care
Estimation method						
Unadjusted	11.6 (0.03)	13.6 (0.04)	3.5 (0.03)	3.2 (0.04)	8.0 (0.05)	10.4 (0.06)
Multivariate adjustment	11.5 (0.03)	13.4 (0.03)	3.7 (0.04)	3.7 (0.05)	7.8 (0.05)	9.7 (0.06)
Propensity score models						
Multivariate IPTW adjustment[a]	11.5 (0.03)	13.4 (0.03)	3.5 (0.03)	3.4 (0.03)	8.0 (0.04)	9.9 (0.05)
Multilevel multivariate IPTW adjustment	11.4 (0.03)	13.2 (0.04)	3.4 (0.03)	3.4 (0.04)	8.0 (0.04)	9.9 (0.05)
Instrumental variable analysis						
Differential distance from acute to nearest IRF or SNF	11.7 (0.12)	13.4 (0.13)	3.4 (0.23)	3.6 (0.26)	8.2 (0.34)	9.8 (0.39)
Differential distance from beneficiary to nearest IRF or SNF	10.8 (0.21)	13.1 (0.24)	5.2 (0.42)	4.4 (0.48)	5.6 (0.63)	8.7 (0.72)
Percentage of IRFs within acute hospital referral region	12.4 (0.07)	14.2 (0.09)	2.0 (0.14)	2.2 (0.16)	10.4 (0.21)	11.9 (0.25)
Previous IRF or SNF assignment by stroke type within each hospital	12.0 (0.10)	13.7 (0.12)	2.8 (0.20)	3.0 (0.23)	9.2 (0.30)	10.7 (0.34)

Abbreviations: IPTW, inverse probability of treatment weighting; IRF, inpatient rehabilitation facility; SNF, skilled nursing facility

[a] After applying propensity score weights, most demographics and stroke comorbidities were balanced between IRF and SNF (49 out of 52 variables), except for admission mobility score (IRF mean [SD], 43.3 [6.6]; SNF, 43.7 [12.0]; $P < .001$), admission self-care score (IRF, 44.0 [9.8]; SNF, 44.3 [14.3]; $P = .001$), and hemiplegia or hemiparesis (IRF, 43.7%; SNF, 42.7%; $P = .02$).

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(adjusted odds ratio, 0.75 [95% CI, 0.72-0.77]). In contrast, the 4 instrumental variable models resulted in odds of mortality closer to 1.0, with ORs ranging from 0.92 (95% CI, 0.76-1.11) when adjusted for previous IRF or SNF assignment by stroke type within each hospital to 1.25 (95% CI, 0.88-1.76) when adjusted by differential distance from patient's residence to the nearest IRF or SNF (Table 4).

Lastly, for each outcome, we calculated the E-value to assess the minimum strength of association that an unmeasured confounder would need to have with the outcome and postacute care setting to eliminate the association between postacute care setting and each outcome (eTable 9 in the Supplement). The lower confidence limit of the E-value was 4.0 for the change in mobility and 4.2 for self-care scores. E-values this large indicate that the association between function score change and postacute care setting we observed was strong.[10]

Discussion

Currently, the decision-making process in selecting postacute care services is heavily influenced by nonclinical factors.[25-30] This is shown by the substantial geographic variation in the proportions of patients with stroke discharged to IRFs or SNFs.[28] The choice is associated with measures of availability, such as distance to the nearest facility.[29] The association of IRF vs SNF use with these nonclinical factors allows investigators to use them as instruments in an instrumental variable analysis, which should better control for unmeasured confounders that might be influencing the choice of IRF vs SNF.

Comparative research related to functional outcomes for persons with stroke receiving rehabilitation in IRFs vs SNFs is limited, to our knowledge. A recent systematic review reported better functional outcomes and higher costs for patients in IRFs compared with those in SNFs and emphasized the need for additional research.[4] Limited research has reported generally better functional outcomes associated with patients in IRFs vs SNFs after a stroke.[4,29,31,32] The findings of our study support this trend. In the 4 instrumental variable models, the differences in improvement in mobility scores between IRF and SNF patients between 5 and 10 points and for self-care scores, the difference was between 8 and 12 points. A 10-point difference in self-care in an IRF is the difference between a patient rating of needing maximal assistance vs needing supervision. Maximal assistance requires another person to physically assist the patient. Needing supervision simply involves another person being present to monitor the activity but not provide physical assistance unless required. Patients at the level of needing supervision are usually ready for discharge to home, while patients needing maximal assistance will require continued institutional care or in-home nursing support after discharge from postacute care.[32,33]

We also found differences in functional outcomes between IRF and SNF using logistic regression and propensity scores. However, the inability of more analytical techniques to eliminate the

Table 4. 30- to 365-d Mortality From Hospital Discharge Between IRFs and SNFs

Analysis	Odds Ratio (95% CI)
Estimation method	
Unadjusted	0.48 (0.46-0.49)
Multivariate adjustment	0.72 (0.69-0.74)
Propensity score model	
Multivariate IPTW adjustment	0.75 (0.72-0.77)
Multilevel multivariate IPTW adjustment	0.72 (0.69-0.74)
Instrumental variable	
Differential distance from acute to nearest IRF or SNF	1.01 (0.82-1.23)
Differential distance from beneficiary to nearest IRF or SNF	1.25 (0.88-1.76)
Percentage of IRFs with the acute hospital referral region	1.02 (0.89-1.17)
Previous IRF or SNF assignment by stroke type within each hospital	0.92 (0.76-1.11)

Abbreviations: IPTW, inverse probability of treatment weighting; IRF, inpatient rehabilitation facilities; SNF, skilled nursing facilities.

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differences in the control outcome of all-cause mortality between 30 and 365 days suggests that those approaches did not eliminate selection biases. This pattern is consistent with prior comparative effectiveness studies using observational data[7-9] and reinforces the view that such techniques should be avoided in the face of strong selection bias.

Our study adds to the accumulating scientific literature that better functional outcomes, such as mobility and self-care, are associated with discharge from IRFs vs SNFs among stroke survivors.[4,29,31,32] This has not been true for other conditions, such as hip fracture or joint replacement.[3,5] A study by Mallinson et al[3,4] comparing mobility and self-care outcomes, which were measured in the same way as in our study, among patients with hip fracture receiving rehabilitation from IRFs, SNFs, or home health agencies found no statistically significant differences in fully adjusted models. The difference in findings between the Mallinson et al study[3,4] and our study could be related to many factors. We believe the difference in conditions (ie, hip fracture and joint replacement vs stroke) is the most plausible explanation.

Stroke is a complex neurological condition affecting multiple body systems and requiring intensive rehabilitation from several disciplines with different areas of expertise. An IRF is designed to provide intensive rehabilitation to complex patients who need specialized care. To effectively and safely implement unified payment in postacute care,[3] it will be necessary to recognize differences in the rehabilitation needs of patients with stroke and other complex conditions. The CMS 60% rule identifies 13 diagnostic conditions that classify a facility as an IRF for Medicare reimbursement.[35] Stroke is the largest category of these conditions, with 20.5% of all patients in IRFs in 2017.[6]

The instrumental variable analyses in this study describe the outcomes of the marginal patient, that is, those patients who reasonably could have been discharged either to an IRF or SNF. The assumption is that there are patients at the ends of the spectrum who are highly likely to be discharged to an IRF or SNF, but that there are also patients in the middle who could go to either one and for whom the choice is influenced by nonclinical factors. It is not possible to directly measure the size of the population of marginal patients. In a study of Medicare spending and outcomes after postacute care for stroke and hip fracture, Buntin et al[36] estimated the percentage or marginal patients as between 20% to 30% of patients with hip fracture or stroke. One way to estimate the size of the marginal patient population is to examine the distribution in variation in percentage of patients with stroke discharged to an IRF or SNF among HRRs. The assumption is that the underlying health of patients with stroke would vary somewhat among HRRs, but not markedly, and that the variation reflects local availability of the 2 types of facilities along with other medical cultural issues. Our findings are similar to what Buntin et al[36] estimated as the percentage of patients with marginal stroke and hip fracture. Our findings and the research of Buntin et al[36] indicate that it may be possible to improve our ability to identify appropriate candidates for the high-intensity, specialized services provided in IRFs.

Additional research is necessary to confirm our findings and to identify whether any of the other 13 conditions identified by CMS as priority diagnoses for receiving services in IRFs (the 60% rule) may also show differences in functional outcomes based on treatment in IRFs vs SNFs. Our findings also have implications regarding the IMPACT Act.[3] Studies that compare functional outcomes for all patients discharged to postacute care may be missing treatment effects that appear only in some impairment groups requiring the intense or specialized rehabilitation available in IRFs.[30] For many hospital discharges, the postacute care setting may not matter, but our results suggest that, for at least one-third of patients with a stroke, discharge to an IRF vs SNF was associated with a significant difference in self-care and mobility at discharge.

As the IMPACT Act[3] and unified payment are implemented, it will be important to accurately identify subgroups and target patients who would do better in one setting vs another. The current CMS rules for identifying priority patients for IRFs are a good start, but challenges remain, such as the large disparity in the availability of IRFs vs SNFs. Another concern is the current cost differential between postacute care settings. The Medicare Payment Advisory Commission reports[6,37] consistently demonstrate that IRF costs are higher than those of SNF and home health. In a unified

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payment system, there would be financial incentives to shift high-cost patients, such as patients with stroke and other complex medical conditions, to lower-cost postacute care options. Effective administrative oversight will be required to ensure patients receive the appropriate care in the right setting.

Limitations

This study has limitations. Our findings are based on Medicare files for IRF and SNF settings only and are not applicable to stroke rehabilitation in other postacute venues (eg, home health care, long-term care hospitals, or outpatient care). We were not able to examine cognitive function before and after the stroke, stroke severity, or location of the stroke. The number of items to measure cognitive function in the IRF and SNF assessment protocols are small, and our preliminary analyses to develop a cocalibrated crosswalk revealed low precision.[16,38] Instead, we included diagnoses associated with cognitive dysfunction in the comorbidities that were controlled for (eTable 6 in the Supplement). The development of a standardized measure of cognitive function is an important area for future research and is included as part of the IMPACT Act.[3] Previous investigations have consistently reported that the costs for rehabilitation services provided in SNFs are significantly lower than in IRFs, even when the longer LOSs associated with SNFs are considered.[4,36] We did not conduct cost comparisons or cost benefit analyses associated with outcomes across the 2 postacute settings. This is an important topic for future research.

Conclusions

This cohort study found that Medicare beneficiaries who received services at an IRF after a stroke demonstrated greater improvement in mobility and self-care compared with patients who received inpatient rehabilitation at a SNF. A significant difference in functional improvement remained after accounting for patient, clinical, and facility characteristics at admission. Our findings indicate the need to carefully manage discharge to postacute care based on the patient's needs and potential for recovery. Postacute care reform based on the IMPACT Act[3] must avoid a payment system that shifts patients with stroke who could benefit from intensive inpatient rehabilitation to lower cost settings.

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Corresponding Author: Kenneth J. Ottenbacher, PhD, OTR, University of Texas Medical Branch, School of Health Professions, Division of Rehabilitation Sciences, 301 University Blvd, Galveston, TX 77555-1137 (kottenba@utmb.edu).

Author Affiliations: University of Texas Medical Branch, School of Health Professions, Division of Rehabilitation Sciences, Galveston (Hong); University of Texas Medical Branch, School of Medicine, Sealy Center on Aging, Department of Internal Medicine, Galveston (Goodwin); University of Texas Health Science Center at San Antonio, School of Health Professions, Department of Occupational Therapy, San Antonio (Reistetter); University of Texas Medical Branch, School of Medicine, Sealy Center on Aging, Department of Preventive Medicine and Population Health, Galveston (Kuo); George Washington University, School of Medicine and Health Sciences, Clinical Research and Leadership, Washington, DC (Mallinson); University of Texas Medical Branch, School of Health Professions, Division of Rehabilitation Sciences, Galveston; now with Department of Physical Medicine and Rehabilitation, School of Medicine, Virginia Commonwealth University, Richmond (Karmarkar); University of Texas Medical Branch, School of Medicine, Department of Preventive Medicine and Population Health, Galveston (Lin); University of Texas Medical Branch, School of Health Professions, Sealy Center on Aging, Division of Rehabilitation Sciences, Galveston (Ottenbacher).

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Author Contributions: Dr Ottenbacher had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Goodwin, Reistetter, Kuo, Karmarkar, Ottenbacher.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Hong, Goodwin, Ottenbacher.

Critical revision of the manuscript for important intellectual content: All authors.

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ATTACHMENT 13
Alternatives

With the purpose of the proposed project being to address the current and projected need for inpatient comprehensive physical rehabilitation beds in the identified service area, three primary alternatives were considered: (1) to do nothing, continuing to operate RISI as it is operated today; (2) to pursue a project similar in scope but with more or fewer than the twenty additional beds being proposed; and (3) to rely on non-facility alternatives such as outpatient rehabilitation, partnerships with skilled nursing facilities, or tele-rehabilitation.

Alternative 1 – Do Nothing

The "do nothing" alternative was dismissed because it fails to address the documented and projected demand for additional inpatient rehabilitation capacity. RISI is already experiencing sustained high occupancy and wait times for admission, and these conditions are expected to persist and grow given the service area's aging population and increasing incidence of stroke, neurological disease, and other qualifying impairment categories. Without additional beds, patients would face prolonged delays or be forced to seek care outside the service area, compromising accessibility. While this option would have the advantage of no capital or operating cost impact, it would not advance the Board's objectives of assuring access to high-quality, cost-effective care.

Alternative 2 – A Project with More or Fewer Beds

The option of developing a project with more or fewer than twenty beds was also considered and dismissed. A smaller bed complement would inadequately address the demonstrated need, leaving persistent access challenges and under-serving the patient population. While capital and operating costs would be reduced under this scenario, the benefits to patients and the community would be insufficient. Conversely, adding significantly more than twenty beds would generate higher capital and operating costs without a commensurate increase in need at this time, creating potential inefficiencies and underutilization risk. Either variation would fail to align resources appropriately with the scope of demand identified in the planning analysis.

Alternative 3 – Non-Facility Alternatives

Consideration was also given to non-facility alternatives such as expanding outpatient rehabilitation programs. While these modalities can complement inpatient rehabilitation, none are clinically appropriate substitutes for patients who meet the criteria for comprehensive inpatient rehabilitation. Patients in this category typically require intensive, multidisciplinary therapy, 24-hour medical and nursing oversight, and the coordinated care model of an inpatient rehabilitation facility.

Conclusion on Alternatives

After careful consideration, the applicants determined that the proposed project of adding twenty beds represents the most appropriate and balanced solution. It addresses the identified need, ensures improved accessibility for patients in the service area, maintains high-quality care standards, and does so in a manner that is both operationally feasible and financially responsible. The proposed scope is sized to meet—not exceed—the community's needs, positioning the project as a prudent and sustainable response to the Board's statutory planning criteria.

ATTACHMENT 14
Size of the Project

The proposed project is very limited in scope, having only two functional areas: the 20-bed patient unit, consisting of twenty private rooms and an expanded therapy gymnasium. The patient unit, which includes all clinical and non-clinical design components required by IDPH licensure, is 11,492 square feet; and the therapy gymnasium is being expanded by 960 square feet, to a total of 4,633 square feet. The HFSRB does not have a space standard for therapy gymnasiums.

Eighteen standard patient rooms, each consisting of 220 net square feet, are being provided. In addition, two bariatric patient rooms, each measuring 376 net square feet, will be included; one of these will also be equipped for isolation care. All patient rooms will feature a private bathroom with a shower.

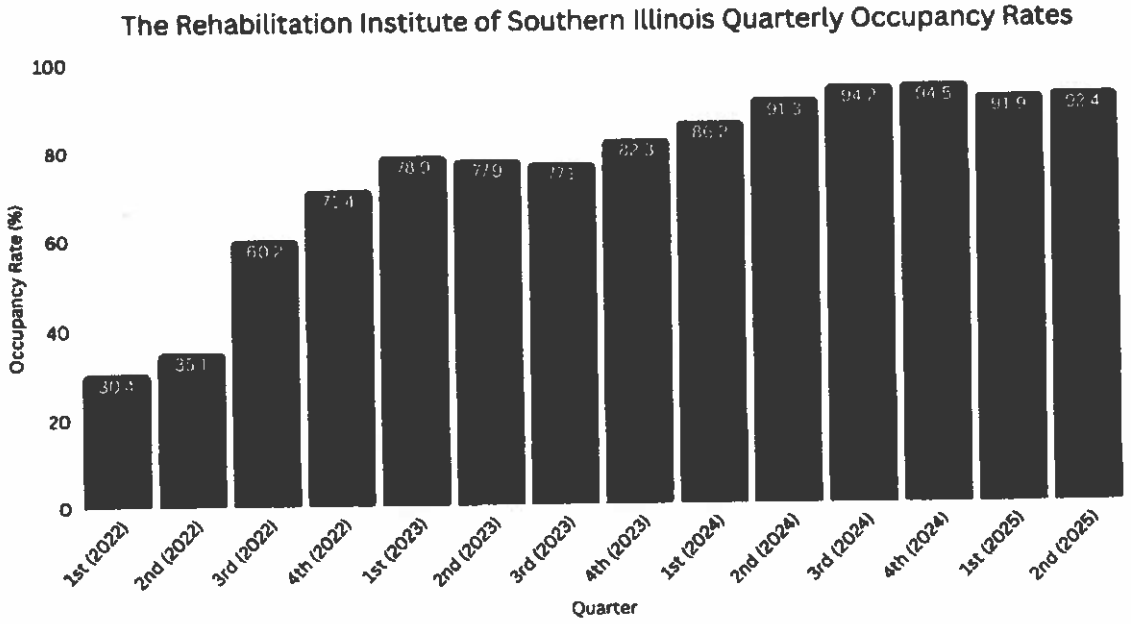
The table below compares the planned square footage of the proposed patient care unit to the HFSRB standard.

SIZE OF PROJECT				
DEPARTMENT / SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
20 Bed Inpatient Unit	11,492	13,200	1,708	YES

ATTACHMENT 15
Project Service Utilization

The Rehabilitation Institute of Southern Illinois ("RISI") was approved as a 40-bed hospital in September 2020, admitted its first patient in February 2022, and since that time has experienced steady growth in terms of utilization. The hospital reached the state's occupancy standard before the end of its first year of operation, and for the past year and a half has operated above 90% occupancy on a consistent basis. As a result of the extraordinarily high average daily census and knowing that the hospital's average length of stay will remain constant, **only 13 additional patients per day are needed to reach the HFSRB target occupancy rate, once the hospital's bed complement increases from forty to sixty beds, as proposed**.

The graph below depicts the utilization increases experienced by since RISI's opening.



It should be noted that the hospital operates with a waiting list. During 2024, sixty-five patients were placed on the hospital's waiting list for various periods of time, awaiting an available bed. Further, the 65-patient figure underrepresents the number of patients whose admissions are delayed while awaiting a bed. When RISI informs a referral source (typically an acute-care hospital) that no beds are available, the source assumes continued capacity constraints and waits several days before contacting RISI with additional referrals.

Recognizing the absolute significance of acute care hospitals as a referral source, and consistent with discussions with HFSRB staff, letters from selected area hospitals, identifying projected referrals to RISI were requested from the five hospitals responsible for the highest volumes of referrals to RISI in 2024. Three of the hospitals accounting for the greatest number of referrals (Barnes Jewish Hospital, Memorial Hospital and Memorial Hospital-East) are BJC HealthCare hospitals, with the other two being HSHS St. Elizabeth's Hospital (O'Fallon) and St. Louis University Hospital. Those five hospitals cumulatively referred 81.4% of the patients admitted to RISI in 2024. Letters received in response to the request are attached.

ATTACHMENT 15
Project Service Utilization

Also of note are the following:

- BJC HealthCare hospitals referred a total of 561 patients to RISI in 2024, accounting for 52.2% of RISI's admissions.
- During 2023, a total of 1,114 Illinois residents were referred from all BJC HealthCare hospitals to inpatient rehabilitation hospitals/programs.

Projected Referrals

No substantial changes in the sources or distribution of referrals are anticipated through the second year following the proposed project's completion, 2029; with BJC HealthCare continuing to refer approximately 52% of RISI's admissions, 42% being referred by other hospitals and 7% being referred by non-hospital sources. In addition, and for planning purposes, the average length of stay ("ALOS") of patients admitted to RISI is projected to remain at its current level of 12.44 days.

The table below identifies anticipated referrals, based on the current distribution of referrals and the letters received. In projecting the 2029 referrals and subsequently patient days, the average length of stay was projected to remain constant at the 2024 level through 2029, admissions and patient days were to remain at the 2024 levels through 2027, increasing by 25% during the first year following the expanded capacity, and 10% in 2029.

	2024 Referrals (actual)	2029 Referrals (projected)
BJC Heath hospitals	561	775
Non-BJC Health hospitals	440	620
Non-hospital sources	73	80
Total	**1,074**	**1,475**

As a result of the above, year two projected utilization was calculated as follows:

	Patient Days 2024	Patient Days 2029	State Standard	Met Standard?
Inpatient Rehab	13,366	18,363	18,304+	Yes

In summary, it is projected that the hospital's average daily census in 2029 will be 50.3 patients.

ATTACHMENT 15
Project Service Utilization

BJC HealthCare

June 19, 2025

Mike Constantino
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

Since the opening of The Rehabilitation Institute of Southern Illinois ("RISI"), BJC HealthCare's hospitals have preferentially sent patients needing inpatient rehabilitation services to RISI, particularly residents of the Metro East region of Illinois. Three BJC hospitals bear special mention: Barnes-Jewish Hospital, Memorial Hospital in Belleville, and Memorial Hospital Shiloh. Barnes-Jewish is a tertiary academic medical center with numerous specialty programs, including transplant, the Siteman Cancer Center, and a Level I trauma center. It is a perennial top-ten hospital in the US. Memorial Hospital and Memorial Hospital Shiloh are community hospitals near RISI.

In 2023, BJC hospitals discharged 1,114 Illinois residents to inpatient rehabilitation providers. Of those, 493 patients were admitted to RISI and 621 were discharged to other rehabilitation facilities, most in Missouri. Patients referred by BJC to RISI in 2024 increased to 561, and we estimate that 90% resided in the Illinois portion of the Metro East region.

While the number of patients discharged to RISI from the BJC hospitals is substantial, more Illinois patients could have stayed in Illinois. The 621 rehab patients referred elsewhere in 2023, mainly in Missouri, were due to the high census at RISI and their waiting list. These patients, alone, would and could fill the proposed bed addition. And with recent RISI occupancy consistently approaching 100%, this issue has only amplified in recent months.

When the planned additional beds become available, we estimate that annual discharges to RISI from the BJC hospitals will increase by approximately 225 patients annually, with, at minimum, 90% of the "incremental" patients being residents of the Illinois portion of the Metro East region.

Increased accessibility to beds at RISI will be a significant benefit for Illinois residents. The most common diagnoses of patients referred to RISI are multiple trauma, stroke, and spinal cord injury. Before discharge to a rehabilitation facility, these patients and their families endured a lengthy hospital stay, about two weeks, which can limit families' ability to interact with the patients due to travel issues. With the subsequent stay in a rehabilitation facility also exceeding two weeks, a patient's total hospitalization can often exceed a month, resulting in a significant hardship on families and limiting their ability to participate in the rehabilitation process. The addition of beds at RISI will improve access and family participation, which in turn improves care.

ATTACHMENT 15
Project Service Utilization

BJC HealthCare

Sincerely,

Greg Bratcher
Director, Government Relations

Signature of Notary

Subscribed and sworn to me before

this 19 day of June, 2025.

Official Seal
ERICA L BRODERICK
Notary Public, State of Illinois
Commission No. 9[illegible]1
My Commission Expires December 18, 2027

Seal

ATTACHMENT 15
Project Service Utilization

HSHS
St. Elizabeth's
Hospital

May 23, 2025

Honorable Debra Savage, Chairperson
Illinois Health Facilities & Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62762

Dear Chairperson Savage,

This letter is being provided in response to Review Criterion 1110.205.b.4.B in support of The Rehabilitation Institute of Southern Illinois' plans to add twenty comprehensive physical rehabilitation beds.

Supporting our efforts to optimize safe and efficient discharge disposition of our hospitalized patients, The Rehabilitation Institute has become a highly reputable and trusted partner in caring for patients across southwestern Illinois. I can assure you that without this subacute clinical partnership, our ability to provide effective inpatient care at St. Elizabeth's Hospital would be negatively impacted. More importantly patients in the metro-east would be forced to leave home for this type of specialized care.

During calendar year 2024, HSHS St. Elizabeth's Hospital, St. Joseph's Hospital – Breese, St. Joseph's Hospital – Highland, and St. Francis Hospital – Litchfield referred 547 patients to The Rehabilitation Institute of Southern Illinois for inpatient rehabilitation care following hospitalization within our facilities. In calendar year 2025 we are on pace to refer 744 patients to the Rehabilitation Institute of Southern Illinois. This is a 36% increase over 2024 and due to a sustained demand for inpatient hospital beds, I do not anticipate a decline in this demand. It is important to clarify that the identified patients originated within the Center for Medicare and Medicaid's defined service area for the HSHS hospitals identified above.

This expansion project is a sound example of how southwestern Illinois health care entities located collaborate in a manner that not only supports high-quality patient care but focusses on the reduction of redundant specialty services in effort to dampen rapidly rising costs.

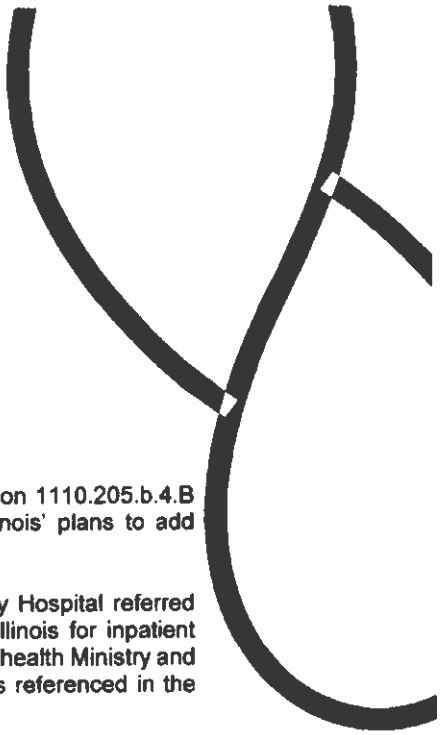
Thank you for the opportunity to share my support of the CON application for The Rehabilitation Institute of Southern Illinois.

Sincerely,

Chris Klay
President and CEO
HSHS St. Elizabeth's Hospital

1 St Elizabeth's Blvd
O Fallon, Illinois 62269
618-234-2120
steliz.org

ATTACHMENT 15
Project Service Utilization



SSMHealth.

Saint Louis University Hospital
1201 S. Grand Blvd.
St. Louis, MO 63104
phone: 314-257-8000

May 30, 2025

Dear Illinois Health Facilities and Services Review Board,

This letter is being provided in response to Review Criterion 1110.205.b.4.B in support of The Rehabilitation Institute of Southern Illinois' plans to add twenty comprehensive physical rehabilitation beds.

During calendar 2024, SSM Health Saint Louis University Hospital referred 235 patients to The Rehabilitation Institute of Southern Illinois for inpatient rehabilitation care. This institution is very supportive of our health Ministry and helps house many of our Illinois rehabilitation patients, as referenced in the data point above.

Throughout the years our teams locally have shared their liaisons are very professional and our staff love to work with them. I support the request for expansion efforts.

Sincerely,

Mitch Miller

Mitch Miller, MHA
Director – Strategy and Business Development

ATTACHMENT 16
Unfinished or Shell Space

NOT APPLICABLE - The proposed project does not include plans for shell space.

ATTACHMENT 17
Assurances

NOT APPLICABLE - The proposed project does not include plans for shell space.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205(b)(2) - Service to Planning Area Residents

The primary patient population currently being admitted to RISI resides in the HFSRB-designated planning area, and that trend is anticipated to continue.

While, during 2024, patients residing in 126 separate ZIP Codes were admitted to the hospital, as depicted in the table below, in excess of 60% of the patients admitted resided in one of twelve ZIP Codes, all of which are in the designated service area, and in Illinois. As such, the proposed project will primarily benefit the residents of the designated service area.

Zip Code	Community	# of Admissions	% of Admissions	Cumulative%
62269	Shiloh	128	11.9%	11.9%
62226	Belleville	81	7.5%	19.5%
62221	Belleville	73	6.8%	26.3%
62220	Belleville	69	6.4%	32.7%
62223	Belleville	67	6.2%	38.9%
62208	Fairview Heights	53	4.9%	43.9%
62234	Collinsville	44	4.1%	48.0%
62258	Mascoutah	33	3.1%	51.0%
62205	East Saint Louis	29	2.7%	53.7%
62206	East Saint Louis	24	2.2%	56.0%
62285	Smithton	24	2.2%	58.2%
62254	Lebanon	22	2.0%	60.2%
	others, <2.0%	427	39.8%	100.0%

This patient origin data confirms that well over 50% of admissions are from within the planning area, satisfying the applicable regulatory requirement. The proposed project is therefore designed to ensure continued and expanded access to care for residents of the designated service area.

A 2024 ZIP Code-specific patient origin analysis is provided in ATTACHMENT 12.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205(b)(2) - Service Demand

As discussed in ATTACHMENT 15, the source of referrals to rehabilitation hospitals is, in the vast majority of instances, as a transfer from an acute care hospital, and for RISI, during 2024 five hospitals accounted for 82.6% of the hospital's referrals/admissions. That high concentration of referrals coming from only five acute care hospitals as well as the current distribution of referrals are anticipated to continue.

Historical utilization data, as required by Section 1110.205.b)4, is provided in ATTACHMENT 15. It is also important to note that RISI currently operates with a waiting list as a result of its high utilization.

As discussed in ATTACHMENT 15, because the vast majority of referrals to rehabilitation hospitals are made by acute care hospitals rather than by physicians, the five hospitals accounting for the largest numbers of referrals to RISI were asked to provide letters, estimating projected referrals. The response letters are provided in ATTACHMENT 15.

As discussed in Attachment 15, the primary source of referrals to rehabilitation hospitals is transfers from acute care hospitals. For RISI, during 2024, five acute care hospitals accounted for 82.6% of the hospital's referrals and admissions. This high concentration of referral sources, along with the current distribution of referrals, is anticipated to continue moving forward.

Historical Service Demand

Historical utilization data required under Section 1110.205(b)(4)(A) is provided in Attachment 15. These data demonstrate that RISI's average annual occupancy rates have equaled or exceeded the occupancy standards for the rehabilitation category of service during each of the last two years. In addition, RISI has consistently maintained a waiting list of patients due to high utilization, underscoring the need for additional bed capacity.

Projected Utilization

Because the vast majority of referrals to rehabilitation hospitals are initiated by acute care hospitals rather than by individual physicians, the five hospitals that account for the largest number of referrals to RISI were asked to provide letters estimating projected referral volumes. Copies of these letters are provided in Attachment 15. These referral estimates confirm that demand for RISI's services is expected to remain strong and exceed current available capacity.

Conclusion

As a result of the combination of sustained high occupancy levels that meet or exceed Board standards, the existence of patient waitlists, and documented referral projections from the facility's key referring hospitals provides clear evidence that the proposed expansion is necessary to reduce high occupancy and meet projected demand for comprehensive physical rehabilitation services within the planning area.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205(e)(1) - Staffing

The Applicants have carefully considered the clinical and professional staffing needs associated with the proposed project, including the additional beds and the anticipated increase in patient volume. The applicants affirm that all applicable licensure requirements and Joint Commission staffing standards can and will be met.

It is projected that 14.9 additional FTEs will be required to appropriately staff the expanded unit. These positions are expected to include:

- 8.1 FTE Nursing
- 2.0 FTE Physical Therapy
- 1.0 FTE Occupational Therapy
- 0.6 FTE Speech Therapy
- 0.6 FTE Pharmacy
- 0.6 FTE Case Management
- 1.0 FTE Dietary
- 1.0 FTE Environmental Services
  Total: 14.9 FTEs

Recruitment for these positions will begin approximately 90 days prior to the unit's opening. Based on current labor market conditions and the applicant's prior experience, no unusual difficulties in attracting qualified personnel are anticipated. Recruitment efforts will include the use of Encompass Health system resources, as well as newspaper advertisements, word-of-mouth referrals, professional journals, and other targeted outreach strategies as necessary.

Accordingly, the Applicants are confident that the necessary staffing will be available to support the successful implementation and operation of the proposed project.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205(f) - Performance Requirements

The HFSRB's standard for the minimum size of a comprehensive physical rehabilitation hospital is 100 beds. Upon completion, RISI will increase from the forty beds approved by the State Board in 2020 to sixty beds. To the applicant's best knowledge, there are only two rehabilitation hospitals in Illinois having as many as 100 beds, those being Shirley Ryan Ability Lab and Marianjoy Rehabilitation Hospital.

While projected utilization does not justify 100 beds at the Shiloh site, the applicants acknowledge that while 100 beds could be provided simply to meet this review criterion; doing so, however, would not be viewed as reasonable from a planning perspective.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205(g) – Assurances

With the signatures on the Certification pages of this Certificate of Need application, the applicants attest that they fully anticipate that during the second year following the completion of the proposed project, the hospital will reach an occupancy rate of, at minimum, 85%, consistent with the occupancy rate target specified in 77 Ill. Adm. Code 1100.

ATTACHMENT 20
Clinical Service Areas other than Categories of Service
Criterion 1110.270(c)(1) - Deteriorated or Functionally Obsolete Facilities

These sub-criteria are not applicable to this project because the hospital was built in 2021-2023, and the proposed project does not involve the renovation of any existing space.

The proposed project involves three clinical services, not classified by the HFSRB as "categories of service:" physical therapy, occupational therapy, and speech therapy. The HFSRB does not maintain utilization nor size standards for any of these three services.

With the hospital being only three years old, the areas occupied by these services have not deteriorated appreciably. However, with the anticipated increase in overall hospital utilization, additional capacity is required.

The table below identifies the historical and projected utilization of the three services, holding treatments per patient day constant at the 2024 level.

Clinical Service	2023	2024	Per Patient Day	Year 2
Physical Therapy	15,150	15,994	1.2	22,338
Occupational Therapy	14,978	16,309	1.22	22,710
Speech Therapy	4,116	5,385	0.4	7,446

ATTACHMENT 20
Clinical Service Areas other than Categories of Service
Criterion 1110.270(c)(3)(B) - Occupancy

The Rehabilitation Institute of Southern Illinois admitted its first patient in February of 2022, experienced rapid and constant growth through 2022 and 2023, with the HFSRB's 85% occupancy target being exceeded within the hospital's first year of operation and in each subsequent quarter, exceeded 90% occupancy.

ATTACHMENT 34
Availability of Funds

The total estimate project cost is $13,836,440. The Applicants have sufficient resources and will complete the project with existing cash and securities.

ATTACHMENT 35
Financial Viability

Pursuant to the requirements of 77 Ill. Admin. Code Section 1120.13, the Applicants have demonstrated financial viability by committing to finance the entirety of the project with existing cash and/or securities. In addition, the Applicants maintain a bond rating of "A" or higher. Enclosed are copies of the respective rating reports as supporting evidence of compliance.

9/3/25, 8:20 PM BJC Health System | Summary | Moody's

BJC Health System

SUMMARY
REPORTS
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FINANCIALS
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TOOLS:
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CREDIT OPINION
BJC Health System
27 FEB 2025 | MOODY'S INVESTORS SERVICE
BJC Health System (BJC, Aa2 stable) benefits from its prominent reputation as a leading academic

SYNOPSIS
INDUSTRY OUTLOOK
Not-for-Profit and Public Healthcare - US
13 NOV 2024 | MOODY'S INVESTORS SERVICE
The median operating cash flow

RATINGS & ASSESSMENTS NEWS VIEW ALL

RATING ACTION
Moody's Ratings assigns P-1 to BJC Health System's (MO) new tax-exempt CP program
20 MAR 2025 | MOODY'S INVESTORS SERVICE

RATING ACTION
Moody's Ratings assigns Aa2 to BJC Health System's (MO) Ser. 2025; outlook stable
26 FEB 2025 | MOODY'S INVESTORS SERVICE

RATING ACTION
Moody's Ratings assigns underlying VMIG 1 to BJC Health System's (MO) variable rate, Series 2008A
17 OCT 2024 | MOODY'S INVESTORS SERVICE

ISSUER REPORTS VIEW ALL

CREDIT OPINION
BJC Health System: Update to credit analysis
10 JUL 2024 | MOODY'S INVESTORS SERVICE

CREDIT OPINION
BJC Health System: Update to credit analysis
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CREDIT OPINION
BJC Health System: Update to credit analysis
11 MAR 2021 | MOODY'S INVESTORS SERVICE

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SECTOR COMMENT
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02 SEP 2025 | MOODY'S INVESTORS SERVICE

DATA REPORT
Public Finance - US: 2025-26 updates to macro-level scorecard inputs for US K-12 public schools, and cities and counties methodologies
28 AUG 2025 | MOODY'S INVESTORS SERVICE

MEDIAN REPORTS
Local Government - New Jersey: Medians - New Jersey local governments show economic growth and stable reserves
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RATINGS VIEW ALL

SENIORMOST TAX BACKED RATING
Aa2
LT SR GO UNDERLYING
26 FEB 2025

SENIORMOST REVENUE BACKED RATING
Aa2
LT SR REV UNDERLYING
26 FEB 2025

OUTLOOK
Stable
26 FEB 2025

Source: Moody's Investors Service

ESG Scores

from Moody's Investors Service

ESG CREDIT IMPACT SCORE (CIS)
CIS-2
11 MAR 2025

ESG ISSUER PROFILE SCORES (IPS)
11 MAR 2025

ENVIRONMENTAL	SOCIAL	GOVERNANCE
E-2	S-3	G-2

Methodology ESG Peer Comparison

Source: Moody's Investors Service

Latest Ratings & Assessments VIEW ALL

Withdrawn Affirmation

Description	Action	Current	Type	Dat
Tax-Exempt Commercial Paper Notes (BJC Health System Tax-Exempt CP Program), Series D	New	P-1	Underlying	20
Tax-Exempt Commercial Paper Notes (BJC Health System Tax-Exempt CP Program), Series D	New	P-1	Underlying	20
Variable Rate Demand Health Facilities Revenue Bonds, Series 2008E	Affirmation	VMIG 1	Underlying	26
Variable Rate Demand Health Facilities Revenue Bonds, Series 2008C	Affirmation	VMIG 1	Underlying	26
Variable Rate Demand Health Facilities Revenue Bonds, Series 2008E	Affirmation	VMIG 1	Underlying	26

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Moody's Org Id
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Market Segment
U.S. Public Finance

Sector
Hospitals & Health Service Providers

State
Missouri

ATTACHMENT 35
Financial Viability

BJC HealthCare

May 20, 2025

Mike Constantino
Illinois Health Facilities and Services Review Board
c/o Jack Axel
525 W. Jefferson St., Second Floor
Springfield, IL 62761

Dear Mr. Constantino:
The Rehabilitation Institute of Southern Illinois is applying for a Certificate of Need to add twenty beds to its facility. As part of a CON application, submission of the financial section is waived if the applicant has a bond rating of "A" or better.

The two underlying partners of this facility are BJC Health System and Encompass Health. BJC Health System has a bond rating of Aa2 from Moody's and AA from S&P Global (formerly Standard & Poor's). The rating documentation was originally filed as part of CON application 24-026 last fall; however, attached are updated letters reaffirming the financial strength of BJC.

It is our understanding, through discussions with staff, that in lieu of both underlying partners having an A rating, BJC Health System can guarantee completion of the project. With this letter, we assure the Illinois Health Facilities and Services Review Board that the project described in the CON application will be completed.

Thank you for helping us understand the nuances of the Illinois CON process. Please call 314-323-1231 with any questions.

Respectfully,

Greg Bratcher
Director, Government Relations

Enc.: S&P Global and Moody's bond rating documents

BJC The world's best medicine. Made better.

ATTACHMENT 35
Financial Viability

Moody's Ratings assigns Aa2 to BJC Health System's (MO) Ser. 2025; outlook stable

New York, February 26, 2025 -- Moody's Ratings (Moody's) has assigned a Aa2 to BJC Health System's (MO) (BJC) proposed Health Facilities Revenue Bonds (BJC Health System) Series 2025A and its [Long-Term Rate] Health Facilities Revenue Bonds (BJC Health System) Series 2025B and Series 2025C. At the same time, we affirmed BJC's existing Aa2 revenue bond ratings and its VMIG 1 and P-1 on its self-liquidity backed VRDBs and commercial paper, respectively. The outlook is stable.

Although BJC will increase debt (by between 18%-23%), the Aa2 assignment and affirmation is supported by strong cash levels and operating cash flow margins that will be sustained in the high-single digit range, which will allow for still favorable leverage

ATTACHMENT 35
Financial Viability

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Health System (SLHS), another academic-oriented system in Kansas City. Days cash will remain strong with restricted cash providing additional cushion. Leverage rises with new debt, but cash to debt and debt to cash flow will still be favorable. Operating cash flow (OCF) margins, constrained by labor costs and reimbursement pressure, will benefit from ongoing integration of SLHS and likely approach 9% over the next two years. Favorable cash levels will counterbalance risk from less liquid investments. Beyond sector wide challenges, limited growth prospects in St. Louis remain.

BJC's underlying VMIG 1 and P-1 ratings are based on BJC's long-term rating and are further supported by BJC's own liquidity. This liquidity is based on the adequacy of liquid investments to support un-remarketed variable rates bonds and maturing commercial paper as well as management processes to ensure timely payment.

RATING OUTLOOK

The stable outlook reflects OCF margins sustained in the 8%-9% range. The outlook further reflects maintenance of strong days

ATTACHMENT 35
Financial Viability

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- Short-term rating: not applicable

FACTORS THAT COULD LEAD TO A DOWNGRADE OF THE RATINGS

- Inability to sustain OCF margins that can fully fund capital needs

- Rise in leverage, such that debt to cash flow or cash to debt are sustained above 2.75x or below 250%, respectively

- Sustained decline in days cash to below 275 days

- Short-term rating based on self-liquidity: material decline in daily liquidity, decline in BJC's overall credit quality, or decline in BJC's debt and treasury management

LEGAL SECURITY

Bonds are secured by a joint and several obligation of the Obligated Group, which consists of hospitals owned and operated by BJC Health System. SLHS joined BJC's obligated group in February 2024.

USE OF PROCEEDS

Funding of capital projects and refinancing of Series 2014.

ATTACHMENT 35
Financial Viability

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METHODOLOGY

The principal methodology used in the long-term ratings was Not-for-profit Healthcare published in October 2024 and available at https://ratings.moodys.com/rmc-documents/430698. The principal methodology used in the short-term ratings was US Municipal Short-term Debt published in October 2024 and available at https://ratings.moodys.com/rmc-documents/430699. Alternatively, please see the Rating Methodologies page on https://ratings.moodys.com for a copy of these methodologies.

REGULATORY DISCLOSURES

For further specification of Moody's key rating assumptions and sensitivity analysis, see the sections Methodology Assumptions and Sensitivity to Assumptions in the disclosure form. Moody's Rating Symbols and Definitions can be found on https://ratings.moodys.com/rating-definitions.

For any affected securities or rated entities receiving direct credit support/credit substitution from another entity or entities subject

ATTACHMENT 35
Financial Viability

Related Entities

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a subsequently issued bond or note of the same series, category/class of debt, or security, or pursuant to a program for which the ratings are derived exclusively from existing ratings, in accordance with Moody's rating practices, can be found in the most recent Credit Rating Announcement related to the same class of Credit Rating.

For provisional ratings, the Credit Rating Announcement provides certain regulatory disclosures in relation to the provisional rating assigned, and in relation to a definitive rating that may be assigned subsequent to the final issuance of the debt, in each case where the transaction structure and terms have not changed prior to the assignment of the definitive rating in a manner that would have affected the rating.

Moody's does not always publish a separate Credit Rating Announcement for each Credit Rating assigned in the Anticipated Ratings Process or Subsequent Ratings Process.

Regulatory disclosures contained in this press release apply to the credit rating and, if applicable, the related rating outlook or rating

ATTACHMENT 35
Financial Viability

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Diana Lee
Lead Analyst

Daniel Steingart
Additional Contact

Releasing Office:
Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
U.S.A
JOURNALISTS: 1 212 553 0376
Client Service: 1 212 553 1653

Related Entities

BJC Health System
Missouri State Health & Educ. Facs. Auth.

2 Issuers

ATTACHMENT 35
Financial Viability

YEAR 2 OPERATING COST per Patient Day*

Projected Patient Days: 18,615

Salaries and Benefits	$16,521,293
Medical Supplies	$1,039,966
	$17,561,259
Per Patient Day:	$ 943.39

YEAR 2 CAPITAL COST per CASE

Projected Patient Days: 18,615

Depreciation	$ 2,543,967
Amortization	$1,039,966
Interest	$ 2,846
	$ 2,546,813
Per Patient Day:	$ 136.82

*Note: RISI does not provide outpatient services

ATTACHMENT 38
Safety Net Impact Statement

The Rehabilitation Institute of Southern Illinois ("RISI") is committed to providing high- quality, accessible inpatient rehabilitation services to all patients in need, regardless of payer source. While RISI is not formally designated as a "safety-net hospital" under the criteria set forth in 305 ILCS 5/5-Se.1, the facility plays an important role in the regional healthcare landscape by accepting and treating Medicaid patients within its designated service area. The proposed expansion project will not adversely impact essential healthcare services in the community, nor will it inhibit the ability of any other provider or health system to continue offering such services.

RISI's expansion is not expected to displace or duplicate any other providers of rehabilitation services. Rather, it is designed to improve access to inpatient rehabilitation for residents of Madison, St. Clair, Clinton, and Monroe counties-areas with significant aging populations and chronic health disparities. The increased bed capacity will support timely access to medically necessary rehabilitation services, helping reduce delays in care, particularly for Medicaid patients who often face extended wait times for post-acute services. RISI will continue its policy of accepting Medicaid patients and maintaining access for patients with limited financial means.

RISI serves an area encompassing diverse, often disadvantaged communities in southern Illinois-particularly in Madison and St. Clair Counties, regions with measurable health disparities:

- Madison County's poverty rate (11.3%) exceeds national norms.
- The county's racial composition includes approximately 8-9% Black or African American residents, who experience disproportionate burdens of chronic illness.
- Rates of substance use, obesity, and chronic disease in Madison County exceed Illinois averages.

By expanding its bed capacity, RISI enhances access to high-quality rehabilitation care-supporting improved recovery outcomes and addressing racial and socioeconomic inequities in post-acute services.

The proposed project will have no material impact on the ability of any other provider or healthcare system to sustain their services. RISI is a freestanding, single-purpose rehabilitation hospital and does not rely on elective or outpatient services to support its financial viability. The facility's expansion is self-contained and does not involve service lines that might draw patient volume away from general acute care hospitals.

The proportion of Medicaid patient days at RISI has steadily increased over the past three years, and RISI remains committed to serving Medicaid beneficiaries who are clinically appropriate for admission to an inpatient rehabilitation hospital.

RISI is a joint venture between Encompass Health Corporation-one of the nation's leading providers of post-acute rehabilitation services-and BJC HealthCare, a 24-hospital system in southern Illinois, eastern Kansas, and across Missouri; including an academic medical center. community hospitals. and outpatient facilities. The project will enhance RISI's capacity to serve patients recovering from complex conditions such as stroke, neurological injury, joint replacement, and debilitating chronic disease. Expansion of access to inpatient rehabilitation is a documented need in Illinois and is associated with better functional outcomes, reduced hospital readmissions, and lower long-term care utilization particularly for underserved populations.

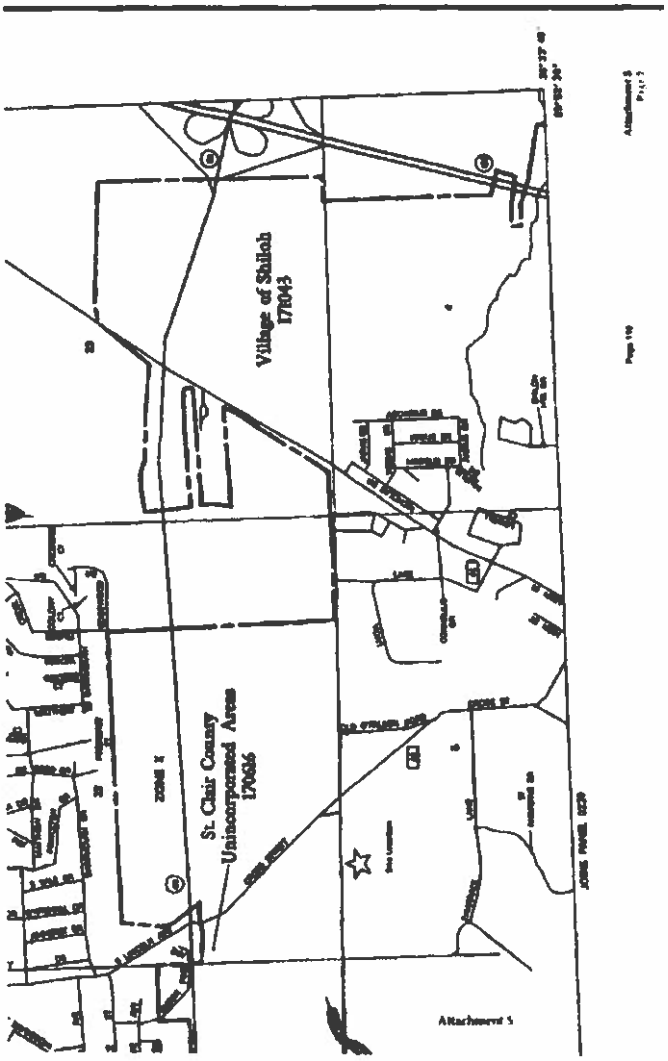
ATTACHMENT 39
Charity Care

CHARITY CARE			
	2022	2023	2024
Net Patient Revenue	**$10,219,692**	**$17,698,316**	**$22,282,534**
Amount of Charity Care (charges)	$0	$24,720	$34,414
Cost of Charity Care	$0	$20,262	$28,208

ATTACHMENT 40
Flood Plain Information

With the signatures provided on the Certification pages of this Certificate of Need application, the Applicants confirm that this project involving the construction of an addition to The Rehabilitation Institute of Southern Illinois, located at 2351 Frank Scott Parkway, East in Shiloh, Illinois, complies with the requirements of Executive Order #2006-5. A map confirming such, and provided by FEMA, is attached.

ATTACHMENT 40
Flood Plain Information



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

INDEX OF ATTACHMENTS