

July 2, 2026

VIA EMAIL

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: Project 26-009-Response to Opposition Letters

Dear John,

We represent Sycamore Specialty Hospital, LLC in relation to their Certificate of Need application to establish a Long-Term Acute Care Hospital (“LTACH”) with an Inpatient Rehabilitation Unit in Sycamore, Illinois. The purpose of this letter is to respond to recently filed written comments in opposition to this application. As demonstrated below, the opposition arguments rest on fundamental mischaracterizations of the proposed project, the regulatory framework, the dynamics of LTACH referral systems, and the geographic realities of the service area.

The “Surplus Bed” and “Excess Capacity” Arguments Ignore Geographic Reality

Both opposition letters contend that excess LTAC bed capacity exists in the region and that no additional beds are warranted. Kindred asserts that HSA I has a 20-bed LTACH surplus (54 existing beds versus 34 calculated need). RML cites three recent LTACH closures, national post-pandemic utilization decline, and utilization data from facilities identifies as the closest LTACHs to the proposed site. These arguments share a fundamental geographic fallacy as they treat beds located 50–61 miles away in the Chicago suburbs as though they are accessible to residents of DeKalb County.

The geographic facts are as follows:

1. There are zero LTAC beds and zero IRF beds within the 17-mile geographic service area (“GSA”) of the proposed hospital.

2. HSA I spans nine counties (Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, and Winnebago) with a combined population of approximately 665,455 residents.
3. The “surplus” exists on paper because the calculated-need formula counts beds located 50–61 miles away in the Chicago suburbs. These are distances that are clinically and practically prohibitive for medically complex, ventilator-dependent, and neurologically impaired patients and their families.

The underutilization of facilities 50-61 miles from the proposed project reflects unique challenges in the Chicago metropolitan service area and should not be considered evidence that DeKalb County residents lack need for local LTACH services. If anything, the low utilization of these distant facilities demonstrates that patients in the Sycamore/DeKalb corridor are not reaching them. Both opponents’ own logic proves Applicants’ point: if geography matters enough that patients near other LTACHs would not travel 50 miles to Sycamore, then patients from the Sycamore area certainly are not traveling 50–60 miles to those facilities either. The access gap is real.

RML extends this geographic argument further by asserting that 70% of the referrals in Applicants’ physician letters originate from communities closer to other existing LTACHs, and that approval would therefore harm already-struggling providers. This argument conflates referral-letter geography with projected patient origin. Physician referral letters identify physicians willing to refer; they do not constitute the entirety of the projected patient population. The relevant criterion under Section 1110.265(b)(2) is that at least 75% of projected volume originate from residents of the GSA. Moreover, the suggestion that approval of a 40-bed facility in Sycamore would “harm” 91–133-bed facilities operating at 34–73% occupancy 50–61 miles away is speculative at best.

Moreover, the demographic trajectory favors increasing post-acute demand. Over the past decade (2013–2023), while the overall GSA population declined 8.6%, the population aged 65 and older which is the patient base that utilizes LTAC and IRF services at the highest rates grew 35%. Furthermore, population projections published on the HFSRB website projects the rapid growth of the 65 and older population will continue. The IDPH has projected an over 30% growth in the 65 and older population in DeKalb County from the April 1, 2020 census to 2035.

The Prior Kindred Closure Reflects Strategic Failure, Not Absence of Need

Both Kindred and RML argue that the Board’s approval of Kindred’s discontinuation in March 2025 demonstrates that LTACH services are not needed at this location. RML further cites the three recent Chicago-area LTACH closures (Kindred Chicago Central, Kindred Chicago Lakeshore, and Kindred Sycamore) as evidence of systemic overcapacity. Applicants respectfully disagree. Kindred Sycamore’s decline was driven by identifiable operational and strategic failures, not by an absence of patient demand.

Failure to adapt to CMS site-neutral LTCH PPS reforms. The Pathway for SGR Reform Act of 2013, fully effective as of FY2018, fundamentally changed LTACH reimbursement. Kindred did not restructure its case mix, service lines, or cost structure in response.

Sycamore Specialty Hospital is being designed from inception around CMS's dual-rate payment system, proactive case-mix management targeting high-acuity DRGs (MS-DRG 189, 592, 870), and admission screening that ensures patients meet the clinical severity thresholds required for full LTCH PPS reimbursement. The facility's hybrid LTAC/IRF model and technology-enabled care pathways are specifically engineered to succeed under site-neutral rules rather than despite them.

Failure to implement IRF integration. Kindred received Board approval for Project 22-002 in January 2022 to convert 10 LTAC beds to IRF. As of July 2023, no IRF beds were operational, citing construction delays and unresolved administrative issues. The proforma estimates this failure forfeited approximately \$4.5 million in annual revenue and pushed IRF-eligible patients to other Rehabilitation Hospitals in the state.

Unlike Kindred, Sycamore Specialty Hospital will activate all 12 IRF beds concurrently with the 40 LTAC beds. This will include a dedicated therapy gym space, physiatrist coverage, PT/OT/ST teams, and IRF-PAI compliance systems built into the modernization plan from day one. This type of co-located model allows patients to transition seamlessly from LTAC medical stabilization to IRF rehabilitation without external transfer, capturing opportunities and better patient outcomes that Kindred forfeited.

Failure to optimize case mix. Prior to closing, the Kindred Sycamore hospital did not target high-acuity DRGs or realign clinical programming to maximize reimbursement under the reformed PPS.

Sycamore Specialty Hospital will deploy a dedicated case-management team with active census management protocols, DRG validation, and acuity-adjusted admission screening to ensure every patient meets LTCH PPS high-acuity thresholds.

Weak referral-network alignment. Kindred lacked formal affiliations with major regional health systems, including Northwestern Medicine and Mercyhealth, and did not develop proactive case-management or transfer-center relationships.

Sycamore Specialty Hospital's operational plan includes a pre-opening clinical liaison team, early outreach to discharge planners, case managers, and referring physician groups at the 14 corridor hospitals (including Northwestern Medical Kishwaukee, Advocate Sherman, Javon Bea Hospital, UW Health SwedishAmerican, and AdventHealth Bolingbrook). Much of this outreach has already begun with letters of support from physicians in the area and at least one health system. Mercyhealth has already submitted a letter of support identifying 106 anticipated cases which is a level of institutional engagement that Kindred never achieved in its final years.

Corporate consolidation. ScionHealth is the private equity backed company that acquired Kindred Health from LifePoint Health. Following this merger, the operating framework prioritized growth markets with high occupancy and integrated care continuums. Kindred Sycamore was not prioritized because patients did not need care, but because the corporate parent chose not to invest in turnaround.

Sycamore Specialty Hospital is locally owned by physician-investors whose sole healthcare investment and operational focus is this facility. The ownership structure

ensures that capital, management attention, and referral development are concentrated entirely on making this single facility succeed rather than being diluted across a national portfolio.

The proposed project is not a reopening of the old Kindred model. It is a fundamentally redesigned, right-sized hybrid LTAC/IRF facility with dual-service integration, modernized equipment, interdisciplinary care teams, and active referral development. The former facility operated 69 beds; the proposed project right-sizes to 52 total beds within the existing 36-room physical plant, with phased, demand-based activation rather than reintroduction of the full prior capacity.

In January 2022, the Board approved Kindred's Project 22-002 to convert 10 LTAC beds to IRF beds at the former Kindred Sycamore Hospital. That project exceeded calculated IRF need (10 beds proposed versus 4 calculated) and fell below the 16-bed minimum unit size (10 beds proposed versus 16 required). Staff found Project 22-002 "not in conformance" on both Part 1110 and Part 1120, and the Board approved it anyway in substantial conformance, on the strength of a COMPdata-based GSA rehab-demand showing. That is a direct precedent: this Board has approved a sub-16-bed rehab unit at this address that exceeded calculated need. Kindred cannot credibly argue that services are unneeded at a location where it sought and received approval for the same category of services just four years ago.

The LTACH Referral System

The Applicants have great deference to the Board and its rules. However, the regulation itself is broader than a physician-letter-only reading. Section 1110.265(b)(2) requires documentation that the project's primary purpose is to serve area residents and that 75% of projected volume will come from the area — it does not, by its own text, limit that documentation exclusively to physician referral letters. Section 1110.265(b)(3) requires projected referrals and lists physician referral letters as a required form of documentation, but the same subsection also requires identification of the anticipated diagnoses and services, such as ventilator care. That requirement supports a clinically grounded demand analysis, not merely a tally of physician letters.

In practice, LTACH referrals are generated principally through institutional patient-flow systems within acute care hospitals. These systems include:

- Hospitalists, intensivists, pulmonologists, and infectious-disease physicians;
- Respiratory therapists and wound-care teams;
- Discharge planners and case managers;
- Utilization-review staff and payer representatives;
- Transfer-center personnel; and
- Patients' families.

A treating physician remains clinically important, but the administrative referral flows through discharge-planning and case-management infrastructure and is not exclusively through freestanding physician letters.

The absence of perfect physician-letter documentation is not the absence of patient need. The letters are one component of the demand record, not the complete record. The more probative

evidence is historical and claims-based utilization, acute care hospital discharge patterns, and the continued use of LTAC and IRF services at distant regional providers, which is precisely the evidence the Applicants' supplemental data analyses are designed to produce.

Patient-Level Discharge Data Validates the Demand Showing

RML used COMPdata discharge data to challenge Applicants' volume claims, comparing COMPdata discharges from key referring hospitals to numbers in the referral letters. This critique inadvertently validates COMPdata as a proper and probative source for measuring LTACH demand.

Applicants agree that COMPdata is useful and probative. The same COMPdata would show that RML selectively compared individual hospital discharge counts to referral-letter claims without accounting for the full corridor, the five-year trend, or the clinically qualifying patients who were never placed in an LTACH despite meeting admission criteria.

Staffing Instability

Kindred experienced difficulty maintaining adequate staffing levels in its final years, contributing to its inability to serve the patient volume the facility was designed to accommodate. Sycamore Specialty Hospital's staffing plan is designed to avoid this failure. The hospital will employ a hospitalist model with 24/7 on-site physician presence, competitive recruitment incentives, and partnerships with local nursing and therapy training programs. To address the staff concern regarding two independent labor pools for LTAC and IRF, certain nurses will be cross-trained for both units and respiratory therapists will support patients across both service lines, reducing duplication while maintaining clinical competency. The leadership team includes individuals with direct LTAC operational experience, including a former CEO of Kindred Chicago Central Hospital, a former CFO of both Kindred Hospital Chicago North and Holy Family Medical Center, and clinical executives with backgrounds in critical care nursing, rehabilitation program management, and hospital operations. This will ensure that staffing decisions are informed by practical LTACH experience rather than theoretical planning.

Conclusion

The opposition rests on three flawed premises: (1) that beds 50–61 miles away adequately serve DeKalb County residents; (2) that a prior operator's strategic failure proves absence of need; and (3) that physician referral letters are the sole permissible measure of LTACH demand. None of these premises withstands scrutiny.

The geographic service area has zero LTAC beds and zero IRF beds. Kindred's closure was driven by documented operational failures and corporate consolidation not market conditions. And the regulatory framework contemplates a demand analysis grounded in clinical data, institutional referral systems, and patient-level discharge evidence.

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If you have any questions or need any additional information regarding this transaction, please feel free to contact me at 312-212-4967.

Sincerely,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

A handwritten signature in blue ink, appearing to read "Juan Morado, Jr.", with a stylized flourish at the end.

Juan Morado, Jr.

JMJ