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August 7, 2026

VIA EMAIL

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Sycamore Specialty Hospital, Project# 26-009, Additional Information

Dear Mr. Kniery:

On behalf of Sycamore Specialty Hospital, LLC, and Accelerated Medical Facilities, LLC (collectively, the "Applicant"), we respectfully submit this letter as additional information in support of Sycamore Specialty Hospital, Project# 26-009. This submission presents the analysis and expert opinion of Matthew Hamilton, Ed.D., MBA, and it addresses several matters including the significance of the prior operator's closure, the operational design and competency framework underlying the proposed project, the federally regulated Long Term Acute Care Hospital ("LTACH") referral and discharge-planning pathway, the hybrid LTAC/IRF operating model, and utilization and bed-count clarifications.

Background of Matthew Hamilton, Ed.D., MBA

Dr. Hamilton serves as Executive Director of the LTACH Leadership Institute, a national organization dedicated to establishing competency-based leadership standards for long-term acute care hospital professionals. He brings more than twenty-five years of executive leadership experience across both long-term acute care hospitals and short-term acute care hospitals, including service as Chief Executive Officer of three hospitals, as Chief Financial Officer, and as Chief Compliance Officer.

During his career, Dr. Hamilton developed and opened the largest freestanding LTACH in the State of New Jersey, as well as one of that state's first hospital-within-a-hospital LTACH models. He holds a Doctorate in Adult Education and Higher Learning (Ed.D.) and a Master of Business Administration, and is a United States Army veteran. His career has been devoted substantially to the development of long-term acute care hospitals from both the operational design and regulatory

pathways to financing and, where necessary, turnaround. Related to this Project, Dr. Hamilton serves as senior board advisor to the Sycamore Specialty Hospital executive leadership team.

State Board Staff Findings

Dr. Hamilton's analysis begins with the multiple findings of conformance with the Board's criteria for the establishment of a LTACH.

- The Staff Report determined that there are zero LTACH beds and zero inpatient rehabilitation beds within the 17-mile geographic service area.
- The Board's own formula calculates a current need for 34 LTACH beds in Health Service Area I.
- Staff finds the Service Accessibility criterion met.
- Staff finds there is no unnecessary duplication and no maldistribution of services here.
- Staff finds the project in full conformance with every financial and economic criterion under Part 1120.
- The project is capitalized with \$16.7 million in cash and carries no debt.

Closure of Kindred Sycamore Hospital

The opposition asks the Board to treat Kindred's business decision to exit the Sycamore facility as proof that the community no longer needs these services. Respectfully, that conclusion does not follow. Based on Dr. Hamilton's review of publicly available information and his experience with LTACH operations nationally, Kindred Sycamore does not appear to have closed because DeKalb County lacked medically complex patients. What the record shows is not a lack of patient need, but a prior operating model that was not redesigned for the post-2018 site-neutral payment system.

The Applicant contends the following issues were visible based on patient mix data:

- No case-mix restructuring. The facility does not appear to have restructured its case mix or admission screening around the high-acuity criteria required for full LTACH PPS reimbursement after FY2018. A growing share of census was accordingly reimbursed at site-neutral rates that cannot support hospital-level overhead.
- Insufficient Integration with Regional Referral Networks. The operation's alignment with the referral networks of surrounding health systems including Northwestern Medicine and Mercyhealth appeared weak in its final years, and our outreach efforts to connect with referral sources has provided anecdotal evidence confirming the same.
- Staffing instability. Publicly available data suggests staffing instability in the facility's final operating period.
- Failure to implement the HFSRB approved Inpatient Rehabilitation Unit. In January 2022, this Board approved Kindred Sycamore's Project 22-002 to convert ten beds to inpatient rehabilitation. In that application, Kindred itself documented hundreds of area residents needing comprehensive rehabilitation and a 168-patient unmet gap. Yet the approved rehabilitation unit was never opened. The revenue it would have generated, and the patients it would have served, were forfeited.

- Corporate consolidation. Under ScionHealth's post-merger operating framework, facilities not meeting corporate growth thresholds were divested rather than rebuilt.

The Board approved a closure in 2025. Hospital closures fracture a community's access to critical care, force families to trust distant facilities, and make daily visits logistically and financially prohibitive particularly for working-class families. A hospital also generates stable middle-class employment in nursing, respiratory therapy, pharmacy, laboratory, radiology, physical therapy, and ancillary services, supporting the local tax base and small-business economy.

How Sycamore Specialty Hospital Is Designed Differently

Through the LTACH Leadership Institute, Dr. Hamilton has codified the competencies that separate LTACHs that succeed under the modern payment system from those that fail. The result is an eight-domain competency framework:

- (1) LTACH Clinical Operations;
- (2) Regulatory and Compliance;
- (3) Financial and Business Acumen;
- (4) Leadership and People Management;
- (5) Patient and Family Experience;
- (6) Strategic and Operational Leadership;
- (7) Ethics and Professionalism; and
- (8) Healthcare Technology and Infrastructure.

Sycamore Specialty Hospital is being developed against this framework. Every leader in the facility, from the executive suite to the unit level, is being developed against defined competencies. This approach is intentional because the four risks that most frequently cause LTACH failure are precisely the failure modes visible in the building's recent history: compliance drift, staffing instability, documentation and billing error, and care-transition failure. To Dr. Hamilton's knowledge, this hospital may be among the first LTACHs in the country developed from inception as a working model of that competency standard.

The leadership team reflects this discipline: the proposed Chief Executive Officer is an experienced LTACH chief executive; the Chief Financial Officer is an experienced LTACH chief financial officer; and the Chief Nursing Officer is an experienced LTACH chief nursing officer. The operational vulnerabilities previously observed at this site are being engineered out through proactive design rather than managed reactively after they occur.

The proposed project pairs 40 LTACH beds with 12 IRF beds under one roof. This hybrid design is not an add-on, it is deliberate and part of the operating model. Dr. Hamilton identifies three structural advantages with this approach:

- (1) First, it serves patients. An LTACH patient who has been weaned from the ventilator or medically stabilized can move to the rehabilitation unit without leaving the building, preserving patient continuity, family proximity, and care-team familiarity. With a 25-day average LTACH stay, there is a natural cohort of patients who recover enough mid-stay to

qualify for rehabilitation but are not yet ready for home or a skilled nursing facility. Today, every one of those patients faces another ambulance transfer to another institution.

- (2) Second, it stabilizes the hospital. The two units operate under bifurcated Medicare payment systems with distinct rate-setting logic. The facility is hedged against volatility in either census and against policy change in either payment system—precisely the resilience the prior operator lacked when site-neutral reform arrived.
- (3) Third, it strengthens IRF compliance. The co-located model gives the hospital greater control over the IRF 60% rule¹ than any freestanding rehabilitation unit possesses. Clinical teams can pre-screen rehabilitation candidates while they are still LTACH patients within the same building, managing the qualifying-condition mix before admission rather than discovering it in a post-hoc audit.

The Applicant respectfully notes one implication for the demand record: a meaningful share of the IRF unit’s admissions will originate inside this hospital as internal step-down transfers from the LTACH census. That demand source exists from the day the facility opens, and no tally of external referral letters can capture it.

The LTACH Referral Pipeline and Discharge-Planning Framework

Dr. Hamilton also analyzed the question at the center of this record: how patients reach a long-term acute care hospital. The Applicant respectfully submits that the physician-letter analysis is but one method by which to determine what the pipeline to the hospital can look like.

The Federally Regulated Pathway. The discharge pathway from a short-term acute care hospital (“STACH”) to a LTACH is not typically a community-based referral pattern. It does not originate in a local physician’s discretionary judgment. It is a federally regulated, technology-driven process defined by the Centers for Medicare & Medicaid Services, triggered only when a patient’s clinical trajectory exceeds the limits of short-term acute care and when CMS-mandated discharge-planning requirements have been satisfied.

Under 42 CFR § 412.4, CMS classifies a discharge from a STACH to an LTACH as a post-acute care transfer, recognizing that certain Medicare beneficiaries, particularly those with prolonged ventilator dependence, multi-system organ failure, or refractory critical illness cannot recover within the DRG-based acute-care timeline. Under 42 CFR § 482.43, CMS further requires every STACH to conduct a structured, patient-centered discharge-planning process driven by clinical data, electronic medical record systems, and interoperability standards. Hospitals must: identify patients at risk for adverse outcomes without adequate discharge planning; formally evaluate each patient’s post-hospital needs; assess the availability and accessibility of LTACH services; and incorporate the patient’s goals of care and treatment preferences.

The 2019 CMS discharge-planning final rule reinforces this pathway by mandating interoperability, electronic transmission of clinical information, and transparent communication

¹ 42 CFR § 412.29(b)(2)

with patients and families regarding LTACH capabilities, quality metrics, and clinical appropriateness.

Implications for Demand Measurement. The primary source of patient transfer to an LTACH is initiated inside the referring hospital, through clinical criteria, electronic systems, and regulatory compliance, and not through community-based referral patterns. LTACHs are federally recognized, clinically essential components of the post-acute continuum. Without adequate LTACH access, STACHs cannot meet their discharge-planning obligations, families face unsafe long-distance transfers, and medically fragile patients lack the level of care that CMS explicitly identifies as necessary.

WellSky Technology Platform. In direct support of this framework, Sycamore Specialty Hospital will deploy WellSky as its post-acute care EMR/EHR platform and clinical and operational backbone. This technology ensures compliant discharge pathways, seamless interoperability, and the precise data exchange CMS regulations require. The integration provides real-time tracking of the 25-day average length of stay, validation of high-acuity criteria on every admission, documentation integrity for the IRF 60% rule, and connectivity into the care-transition and referral networks through which area hospitals' discharge planners place patients.

The Institutional Referral Record. For the seven hospitals within approximately twenty miles of the proposed site, there is currently no LTACH to which discharge planners can send patients. Those patients travel fifty or more miles or are placed in settings below their acuity. LTACH admissions are generated inside referring hospitals by case managers, discharge planners, utilization-review staff, and transfer centers operating under federal requirements. The demand record is institutional evidence: corridor hospital discharge data, Mercyhealth's letter identifying anticipated cases by ZIP code, and the WellSky-connected referral infrastructure described above.

Conclusion

Sycamore Specialty Hospital restores the sole hospital-level post-acute access point in a nine-county planning area where the Board's own formula calculates a 34-bed need and zero beds currently exist. The project achieves this through adaptive reuse of a previously certified hospital campus at approximately \$55 per square foot against the Board's standard of \$417, and is funded entirely in cash, led by executives who have operated these exact facilities, and developed as a competency-based LTACH leadership model.

If you have any additional questions or need any additional information following your review of this letter, please feel free to contact me via phone at 312-212-4967 or via email at JMorado@beneschlaw.com.

August 7, 2026
Page 6

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

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

Juan Morado Jr.