

September 24, 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-Submission of Additional Information in Response to an Intent to Deny

Dear John,

On behalf of Sycamore Specialty Hospital, LLC (the "Applicant"), we respectfully submit this supplemental analysis. It addresses two criteria: the calculated need determination under Section 1110.265(b)(1) and the maldistribution analysis under Section 1110.265(c)(2).

Our central point is straightforward. The Board's calculated need of 34 LTACH beds in Health Service Area I reflects how many patients actually made it into a long-term acute care bed not how many needed one. That figure depends on which patients a prior operator chose to admit, which referrals it pursued, which payers it contracted with, and how many beds it decided to staff. We do not ask the Board to disregard its formula. We ask the Board to recognize the 34-bed figure for what the underlying data can support: a floor based on observed placements, not a ceiling on demand.

Every figure cited below comes from the Board's own published files: the June 2, 2026 Staff Report for this project, the Illinois Hospital Profiles, and the Board's Inventory of Health Care Facilities and Services and Need Determinations.

I. Reported Patient Days Capture Only a Fraction of Qualifying Demand

The patient-day figures reported by Illinois LTACHs count only one thing: patients who made it all the way through the pipeline, identified inside a discharging hospital, referred out, authorized by a payer, accepted by a receiving facility, and admitted. That is a narrow count. It misses every patient who qualified clinically but was sent to a distant facility, placed in a skilled nursing facility, kept in the acute care hospital longer than necessary, denied payer authorization, turned away for

staffing or capacity reasons, or simply never identified as LTAC-eligible in the first place. Those patients are **absent** from the reported numbers.

What historical occupancy measures, then, is captured demand, not total demand. And it tells us nothing about where patients lived. A patient day recorded at a facility in Chicago or Hinsdale does not show whether that patient came from DeKalb County or whether a Health Service Area I resident was displaced to generate it.

The reverse is also true. Under the dual-rate payment system in effect since FY2016, some historically recorded LTACH volume would not meet today's criteria-qualifying standards. So reported days include some patients who would no longer qualify, while simultaneously excluding patients who would. The two populations overlap without containing each other. That is exactly why we ask the Board to considering treating the calculated need as an observation-bounded estimate rather than a determination of the qualifying population.

II. The 34-Bed Calculated Need Traces Back to the Closed Facility's Own Patient Days

Table Six of the July State Board Staff Report shows the utilization history of Kindred Hospital Sycamore, the only LTACH provider in this planning area for 2019 through 2023. When we normalize the three highest-volume years to the Board's 85% target occupancy, the result is striking:

Calendar Year	Reported Patient Days	Average Daily Census	Beds at 85% Occupancy
2020	11,442	31.35	36.88
2021	10,582	28.99	34.11
2022	9,591	26.28	30.91
Three-year average	10,538	28.87	33.97

A cross-check makes the point even sharper. Table One shows 106,918 LTAC patient days statewide against an Illinois population of 12,778,100, with a utilization rate of 0.00837 days per capita. Table Two puts the HSA I population at 665,455. Applying the statewide rate to this population yields just 5,568 patient days, an average daily census of 15.25, and only 17.9 beds at the 85% standard.

Those two numbers 34 and 17.9 cannot both be right. To reach 34 beds from a population of 665,455, you need a utilization rate of 0.01585 days per capita or 1.89 times the statewide rate in the same Staff Report. The calculated need cannot be derived from a statewide use rate applied to planning area population. But it can be derived, to within three one-hundredths of a bed, from the patient days of one closed facility.

The 34-bed figure is the sole basis for the non-conformance finding under 1110.265(b)(1), and it is the figure both objectors rely on. If the calculated need is in fact derived from the closed facility's reported days, then the planning area's "need" and its former "supply" are not two independent measurements. They are the same number expressed twice. On that basis, this application would be denied for exceeding a need figure generated by one prior operator's admission decisions in a planning area that now has zero LTACH beds. Both the objectors' argument that we exceed calculated need and our own prior citation of that figure as corroboration would rest on the same circularity.

III. Statewide Utilization Is Shrinking, But the Population Is Not

The statewide numbers tell a clear story:

Calendar Year	LTAC Admissions	LTAC Patient Days	Average Length of Stay
2019	4,102	137,070	33.4
2023	3,145	115,283	36.7
2025 (Staff Table One)	3,153	106,918	33.9

Between 2019 and 2025, LTACH patient days dropped roughly 22% and admissions fell roughly 23%, while the Illinois population barely changed. Between 2019 and 2023, admissions declined 23.3% but average length of stay increased 9.7%. That pattern of fewer admissions, longer stays, points to tighter admission screening, not to fewer sick patients. If the qualifying population were actually shrinking, admissions and length of stay would decline together.

The number of reporting facilities fell too. Table One of the State Board Staff Report lists seven remaining LTACHs in Illinois. Six are in Cook County; one is in Peoria County. The Board approved the closure of three LTACHs during this period, including the facility at this site.

National data confirms the pattern. MedPAC's July 2026 Post-Acute Care Data Book shows that nonqualifying LTACH stays nationally dropped from roughly 17,000 to 5,000 between FY2023 and FY2024, a 70% decline while qualifying stays held steady at approximately 42,000. Qualifying cases rose from 71% to 89% of traditional Medicare LTACH stays, and the total number of LTACHs nationally fell from 371 to 329. The site-neutral payment policy is driving the contraction in reported utilization, not a decline in the clinically eligible population. Illinois is following the same national trajectory.

IV. Six of Eleven Planning Areas Have Zero LTACH Utilization

This point deserves attention. In calendar year 2023, Health Service Areas 4, 5, 8, 9, 10, and 11 reported no LTACH admissions and no LTACH patient days. Zero. Those same six areas generated 142,665 intensive care patient days that year, with patients sick enough for the ICU, but producing no recorded LTACH utilization because no LTACH exists nearby.

The Staff Report confirms why. Table One shows that all seven licensed LTACHs in Illinois are in just two counties six in Cook County, one in Peoria County. The remaining 100 Illinois counties, including all nine counties in Health Service Area I, have no licensed LTACH bed.

The structural problem is clear: where no LTACH exists, no LTACH patient days get reported. Where no patient days are reported, no calculated need appears. Where no calculated need exists, no new LTACH can be approved. This is a closed loop. The formula, as constructed, cannot identify the very access gap that Section 1110.265(c)(2) is meant to address.

V. ICU Volume Provides an Independent Measure of Need

Every Illinois hospital reports intensive care patient days on the same Hospital Profile page as LTACH days. ICU volume is generated upstream of every LTACH admission decision and is not controlled by any LTACH operator. It is an acuity-based denominator that is independent of the numerator in question and should be an important consideration for the Board with regard to this project.

Calendar year 2023:

Health Service Area	ICU Patient Days	LTAC Patient Days	LTAC Days per ICU Day
HSA I	28,474	8,592	0.302
HSA 7 (highest supply)	235,182	68,716	0.292
Statewide	716,549	115,283	0.161
HSAs 4, 5, 8, 9, 10, 11	142,665	0	0.000

While HSA I still had a local LTACH, its residents used 0.302 LTAC days for every ICU day which was the highest rate in the state, marginally exceeding even HSA 7, the region with the most LTACH supply. Demand in this planning area was not weak. It ran at the top of the statewide range right up until the facility closed. The current gap is one of supply and geography, not clinical need.

Applying different regional benchmarks to HSA I's ICU volume produces the following bed estimates at the Board's 85% standard:

Reference Applied	Rate	Implied Days	Implied ADC	Beds at 85%
Statewide average (0.161)		4,581	12.6	14.8
HSA 7, highest supply (0.292)		8,320	22.8	26.8
HSA I own rate, 2023 (0.302)		8,592	23.5	27.7
HSA I realized days, 2019		10,462	28.7	33.7

The statewide-average figure of 14.8 beds is artificially low because it includes six planning areas with no LTACH utilization at all. Above that floor, the estimates converge between 27 and 34 beds which are consistent with the Board's own calculated need and with the prior operator's realized volume. Four independent reference points from the Board's own data all point to the same range.

VI. The "Excess Capacity" Argument Counts Beds That Do Not Exist

Table One reports statewide LTACH occupancy of 49.09% against 596 authorized beds. The objectors use numbers like these to argue there is surplus capacity. But that denominator includes beds that were never opened or staffed.

The Board's own data illustrates the distortion. In calendar year 2023, Health Service Area 6 had 199 authorized LTACH beds but only 93 that were actually set up and staffed. Occupancy measured against authorized beds: 25.4%. Occupancy measured against staffed beds: 54.3%. More than half the authorized capacity in that area never served a single patient.

The same problem works in reverse in this planning area. HSA I still carries authorized LTACH beds in the Inventory for a facility that has stopped operating. The objectors' claim that this area holds a surplus of 20 beds depends entirely on counting those phantom beds as real supply. They produce no patient days, serve no patients, and cannot take a single discharge placement.

The occupancy comparison from Table One puts the objectors' position in further perspective. At nothing more than the volume the prior operator was already handling, the proposed 40-bed facility would run at 72.2% occupancy:

Facility	Reported Occupancy	Source- State Board Staff Report
OSF Divine Mercy, Peoria	85.21%	Table One
Kindred Hospital Chicago	68.02%	Table One
RML Hinsdale	63.17%	Table One
Rush Specialty Hospital	61.13%	Table One
Kindred Hospital Northlake	41.01%	Table One
Prime Holy Family Medical Center	37.40%	Table One
RML Chicago	36.23%	Table One
Statewide aggregate	49.09%	Table One

That would exceed the reported occupancy of six of the seven LTACHs currently licensed in Illinois and beat the statewide aggregate by more than 23 percentage points. RML Specialty Hospital, which opposes this project on duplication grounds, reports 36.23% occupancy at its Chicago campus and 63.17% at Hinsdale. This comparison serves one purpose: to respond to the claim that this region has excess LTACH capacity.

VII. Federal Regulations Explain Why Reported Utilization Understates the Qualifying Population

How patients reach an LTACH matters to understand what the numbers miss. LTACH placement does not work like a traditional physician referral. It is a regulated, protocol-driven process that starts inside the discharging hospital.

Under 42 C.F.R. § 412.4, CMS classifies a transfer from a short-term acute care hospital to an LTACH as a post-acute care transfer, recognizing that some Medicare beneficiaries, those with prolonged ventilator dependence, multi-system organ failure, or refractory critical illness need care beyond the DRG-based acute care timeline.

Under 42 C.F.R. § 482.43, every acute care hospital must run a structured discharge-planning process: identify patients at risk without adequate post-discharge care, evaluate their needs, assess available post-acute providers including LTACHs, and incorporate the patient's preferences. The 2019 CMS discharge-planning final rule reinforced these requirements with interoperability mandates, electronic data transmission, and quality-metric disclosure.

The practical consequence is straightforward. LTACH admissions originate inside the referring hospital through case management, utilization review, and electronic systems not through community referral networks. When no LTACH is accessible, the hospital documents the unavailability and places the patient somewhere else, a skilled nursing facility, a prolonged acute stay, or home. The patient does not stop qualifying. The patient simply disappears from every utilization measure built on LTACH admissions and shows up instead as a nursing home admission, an extended hospital stay, or a discharge home. This is exactly why the ICU-based measure in Section V matters: it catches the population before the placement decision makes them invisible.

A second mechanism compounds the gap. Medicare Advantage prior-authorization practices block a significant share of clinically appropriate LTACH admissions before they happen. In June 2024, HHS-OIG reviewed prior-authorization requests to 19 large MA organizations and found that 65% of LTACH requests and 54% of IRF requests were denied at the initial stage. Of those denials that were appealed, 36% of LTACH denials and 43% of IRF denials were overturned meaning the initial denial was wrong about clinical need. The median appeal took 6 days for LTACH and 5 days for IRF requests, with roughly 16% of LTACH appeals taking 10 days or more.

MedPAC's September 2026 analysis reinforces the point. Using 2023 data for 25.6 million traditional Medicare and 27.8 million MA enrollees, LTACH utilization was approximately 2 stays per 1,000 traditional Medicare beneficiaries versus 1 per 1,000 MA enrollees. IRF utilization showed an even wider gap: 14 per 1,000 traditional Medicare versus 5 per 1,000 MA.

These national findings are preliminary, and we do not offer them as proof of local HSA I need. The point is narrower: realized utilization, the data feeding the Board's formula is shaped not just by clinical eligibility and geography but also by payer authorization practices that systematically keep qualifying patients out of LTACHs regardless of their medical condition.

IX. Conclusion

This submission presents seven points that we believe offer a different lens through which to evaluate this project:

1. Reported patient days measure only those patients who successfully navigated the full referral, authorization, and admission pipeline not the clinically qualifying population.
2. The Board's calculated need of 34 beds confirms substantial demand in this planning area. That figure closely tracks the closed facility's actual patient volume on every recent averaging window, meaning it reflects real patients who were actually being served and is a conservative baseline, not an overcount.
3. Although statewide reported LTACH utilization has declined since 2019, the decline is concentrated in nonqualifying stays that the site-neutral payment policy was designed to eliminate. Nationally, qualifying LTACH stays held steady at approximately 42,000

while nonqualifying stays fell 70%. The clinically eligible population has not shrunk — the screening has gotten tighter.

4. Six of the state's eleven planning areas report zero LTACH utilization, revealing a structural limitation in the formula: where no facility exists, no need can be calculated, and no new facility can be approved.
5. An independent, upstream measure to consider is ICU patient days. They show that HSA I generated LTACH demand at the highest rate in the state while a local facility remained open, and that four separate benchmarks from the Board's own data converge on a need range of 27 to 34 beds.
6. The objectors' excess-capacity argument relies on authorized bed counts that include beds never staffed, never opened, or belonging to a facility that has ceased operations not beds available to serve patients.
7. Federal discharge-planning regulations and Medicare Advantage prior-authorization practices each independently suppress the volume of qualifying patients who reach an LTACH, further confirming that realized utilization understates the population that needs this level of care.

We do not ask the Board to set aside its established criteria or to substitute our analysis for Staff's. We respectfully ask the Board to consider this information alongside its review criteria, because it offers a complementary perspective grounded entirely in the Board's own published data and that supports approval of this project. Health Service Area I currently has zero LTACH beds, the Board's own formula calculates a need for 34, and the analysis above demonstrates that this figure is more likely a floor than a ceiling. Approving this project would restore hospital-level post-acute access to a nine-county planning area that has none.

We appreciate the opportunity to provide this supplemental information and remain available to furnish any further information the Board may require.

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