

26-642

RECEIVED

SEP 3 2026

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: Rehabilitation Institute of Springfield, LLC		
Street Address: 4685 Wabash Avenue, <i>Identified as PINs 21-11.0-300-030 & 21-11.0-300-034</i>		
City and Zip Code: Springfield, 62711		
County: Sangamon	Health Service Area: 3	Health Planning Area:

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

Exact Legal Name:	Rehabilitation Institute of Springfield, LLC
Street Address:	9001 Liberty Parkway
City and Zip Code:	Birmingham, 35242
Name of Registered Agent:	Illinois Corporation Service Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, 62703
Name of Chief Executive Officer:	Douglas E. Coltharp
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
- Corporations and limited liability companies must provide an Illinois certificate of good standing. - Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.	
APPEND DOCUMENTATION AS ATTACHMENT 1 , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Primary Contact (Person to receive ALL correspondence or inquiries)

Name(s):	Juan Morado, Jr. and Mark J. Silberman
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 and 312.212.4952
E-mail Address:	JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number:	312.767.9192

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

Name(s):	Dana Mollohan, CPA, MBA
Title:	System Director, Business Development & Planning
Company Name:	Memorial Health
Address:	340 W. Miller Street, Springfield, IL 62702
Telephone Number:	217.725.8865
E-mail Address:	Mollohan.Dana@mhsil.com
Fax Number:	217.527.3267
Name:	Susan S. Lyerly, Esq.
Title:	National Director, Certificate of Need Program
Company Name:	Encompass Health
Address:	9001 Liberty Parkway, Birmingham, AL 35242
Telephone Number:	205.969.4528
E-mail Address:	Susan.Lyerly@Encompasshealth.com
Fax Number:	

Facility/Project Identification

Facility Name: Rehabilitation Institute of Springfield, LLC		
Street Address: 4685 Wabash Avenue, Identified as PINs 21-11.0-300-030 & 21-11.0-300-034		
City and Zip Code: Springfield, 62711		
County: Sangamon	Health Service Area: 03	Health Planning Area:

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

Exact Legal Name:	Memorial Health Ventures
Street Address:	340 W. Miller Street
City and Zip Code:	Springfield, 62702
Name of Registered Agent:	Zach Dinardo
Registered Agent Street Address:	340 W. Miller Street
Registered Agent City and Zip Code:	Springfield, 62702
Name of Chief Executive Officer:	Evan Davis
CEO Street Address:	340 W. Miller Street
CEO City and Zip Code:	Springfield, 62702
CEO Telephone Number:	217.899.4011

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(s):	Juan Morado, Jr. and Mark J. Silberman
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 and 312.212.4952
E-mail Address:	JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number:	312.767.9192

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

Name(s):	Dana Mollohan, CPA, MBA
Title:	System Director, Business Development & Planning
Company Name:	Memorial Health
Address:	340 W. Miller Street, Springfield, IL 62702
Telephone Number:	217.725.8865
E-mail Address:	Mollohan.Dana@mhsil.com
Fax Number:	217.527.3267

Facility/Project Identification

Facility Name: Rehabilitation Institute of Springfield		
Street Address: 4685 Wabash Avenue, <i>Identified as PINs 21-11.0-300-030 & 21-11.0-300-034</i>		
City and Zip Code: Springfield, 62711		
County: Sangamon	Health Service Area: 3	Health Planning Area:

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

Exact Legal Name:	Encompass Health Springfield Holdings, LLC
Street Address:	9001 Liberty Parkway
City and Zip Code:	Birmingham, 35242
Name of Registered Agent:	Illinois Corporation Service Company
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, 62703
Name of Chief Executive Officer:	Douglas E. Coltharp
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	
- Corporations and limited liability companies must provide an Illinois certificate of good standing. - Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.	
APPEND DOCUMENTATION AS ATTACHMENT 1 , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Primary Contact [Person to receive ALL correspondence or inquiries]

Name(s):	Juan Morado Jr. and Mark J. Silberman
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 and 312.212.4952
E-mail Address:	JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number:	312.767.9192

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

Name:	Susan S. Lyerly, Esq.
Title:	National Director, Certificate of Need Program
Company Name:	Encompass Health
Address:	9001 Liberty Parkway, Birmingham, AL 35242
Telephone Number:	205.969.4528
E-mail Address:	Susan.Lyerly@Encompasshealth.com
Name:	Susan S. Lyerly, Esq.

Facility/Project Identification

Facility Name: Rehabilitation Institute of Springfield		
Street Address: 4685 Wabash Avenue, Identified as PINs 21-11.0-300-030 & 21-11.0-300-034		
City and Zip Code: Springfield, 62711		
County: Sangamon	Health Service Area: 3	Health Planning Area:

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

Exact Legal Name:	Memorial Health System
Street Address:	340 W. Miller Street
City and Zip Code:	Springfield, 62702
Name of Registered Agent:	Zach Dinardo
Registered Agent Street Address:	340 W. Miller Street
Registered Agent City and Zip Code:	Springfield, 62702
Name of Chief Executive Officer:	Mandy Eaton
CEO Street Address:	340 W. Miller Street
CEO City and Zip Code:	Springfield, 62702
CEO Telephone Number:	217.788.4440

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(s):	Juan Morado, Jr. and Mark J. Silberman
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 and 312.212.4952
E-mail Address:	JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number:	312.767.9192

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

Name(s):	Dana Mollohan, CPA, MBA
Title:	System Director, Business Development & Planning
Company Name:	Memorial Health
Address:	340 W. Miller Street, Springfield, IL 62702
Telephone Number:	217.725.8865
E-mail Address:	Mollohan.Dana@mhsil.com
Fax Number:	217.527.3267

Facility/Project Identification

Facility Name: Rehabilitation Institute of Springfield		
Street Address: 4685 Wabash Avenue, <i>Identified as PINs 21-11.0-300-030 & 21-11.0-300-034</i>		
City and Zip Code: Springfield, 62711		
County: Sangamon	Health Service Area: 3	Health Planning Area:

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

Exact Legal Name:	Encompass Health Corporation
Street Address:	9001 Liberty Parkway
City and Zip Code:	Birmingham, AL 35242
Name of Registered Agent:	Corporation Service Company
Registered Agent Street Address:	251 Little Falls Drive
Registered Agent City and Zip Code:	Wilmington, DE 19808
Name of Chief Executive Officer:	Mark Tarr
CEO Street Address:	9001 Liberty Parkway
CEO City and Zip Code:	Birmingham, AL 35242
CEO Telephone Number:	205.967.7116

Type of Ownership of Applicants

☐ 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(s):	Juan Morado Jr. and Mark J. Silberman
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 and 312.212.4952
E-mail Address:	JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number:	312.767.9192

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

Name:	Susan S. Lyerly, Esq.
Title:	National Director, Certificate of Need Program
Company Name:	Encompass Health
Address:	9001 Liberty Parkway, Birmingham, AL 35242
Telephone Number:	205.969.4528
E-mail Address:	Susan.Lyerly@Encompasshealth.com
Name:	Susan S. Lyerly, Esq.

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

Name:	Susan S. Lyerly, Esq.
Title:	National Director, Certificate of Need Program
Company Name:	Encompass Health
Address:	9001 Liberty Parkway, Birmingham, AL 35242
Telephone Number:	205.970.7926
E-mail Address:	Susan.Lyerly@Encompasshealth.com
Fax Number:	(205) 969-4528

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Memorial Health System
Address of Site Owner:	340 W. Miller Street, Springfield, IL 62702
Street Address or Legal Description of the Site:	5.8 acres of unimproved property at 4685 Wabash Avenue, Springfield, IL 62711
**Attachment 2 includes the Letter of Intent and related documentation for the 5.8-acre unimproved parcel at 4685 Wabash Avenue, Springfield, Illinois, a portion of the approximately 41-acre parcel identified as PIN 21-11.0-300-030. Rehabilitation Institute of Springfield will be located on this unimproved property.	
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:	Rehabilitation Institute of Springfield, LLC
Address:	4685 Wabash Avenue, Springfield, IL 62711, Identified as PINs 21-11.0-300-030 & 21-11.0-300-034
☐ 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. **

*****The Applicant submitted a request for a Letter of Clearance to the Illinois Department of Natural Resources, Preservation Services Division on August 10, 2026. A final determination has not been received as of the filing of this application. The Applicant commits to not financially obligate the Project until a clearance letter is received from the Department. A copy of the submission is included with this attachment.***

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.

Rehabilitation Institute of Springfield, LLC ("Rehabilitation Institute of Springfield", "Springfield Rehab Institute", or "Rehab Institute") proposes to establish a new 60-bed freestanding comprehensive physical rehabilitation ("rehab") hospital to be located in Springfield, Sangamon County, Health Service Area ("HSA") 3. The proposed project addresses an identified gap in the need for additional beds in the region. This is a 'substantive' project because it proposes the establishment of a healthcare facility.

The proposed project will be a 50/50 joint venture between Memorial Health System ("Memorial" or "Memorial Health") and Encompass Health Corporation ("Encompass" or "Encompass Health"), a Delaware Corporation. Memorial Health Ventures, an affiliate of Memorial Health, will have a fifty percent (50%) ownership interest in the Licensee, Rehabilitation Institute of Springfield, LLC. Memorial Health is an Illinois nonprofit corporation. Encompass Health also will have a fifty percent (50%) ownership interest in the Licensee, Rehabilitation Institute of Springfield, LLC.

Currently, HSA 3 includes two comprehensive physical rehabilitation providers: Springfield Memorial Hospital ("Springfield Memorial" or "SMH"), which is licensed for 30 comprehensive physical rehabilitation beds; and Blessing Hospital in Quincy (Adams County), which is licensed for 18 beds. Springfield Memorial Hospital will file a Certificate of Exemption to discontinue offering inpatient rehab services through the permanent discontinuation of its existing rehab beds upon the opening of the proposed 60-bed hospital.

The Rehabilitation Institute of Springfield will be located on approximately 5.8 acres of unimproved real property located at 4685 Wabash Avenue in Springfield. The site is easily accessible for all HSA 3 residents and the greater Springfield area because of its close proximity and easy access to Interstates 72 and 55 as well as State Roads 97 and 29.

The total project cost estimate for the new 60-bed freestanding hospital is \$66,263,120. The project will be funded by Encompass Health with cash and equivalents. The land for the proposed hospital is owned by Memorial Health. Rehabilitation Institute of Springfield expects to accept its first patient on January 1, 2029.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation	\$ 158,400	\$ 201,600	\$ 360,000
Site Preparation	\$ 1,320,362	\$ 1,680,460	\$ 3,000,822
Off Site Work			
New Construction Contracts	\$ 27,470,754	\$ 15,119,562	\$ 42,590,316
Modernization Contracts			
Contingencies	\$ 2,572,625	\$ 927,375	\$ 3,500,000
Architectural/Engineering Fees	\$ 1,627,500	\$ 542,500	\$ 2,170,000
Consulting and Other Fees	\$ 2,131,603	\$ 768,397	\$ 2,900,000
Movable or Other Equipment (not in construction contracts)	\$ 5,708,389	\$ 2,057,751	\$ 7,766,140
Bond Issuance Expense (project related)			
Net Interest Exp. During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	\$ 2,922,385	\$ 1,053,457	\$ 3,975,842
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$ 43,912,018	\$ 22,351,102	\$ 66,263,120
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$ 43,912,018	\$ 22,351,102	\$ 66,263,120
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$ 43,912,018	\$ 22,351,102	\$ 66,263,120
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 \$ <u>2,329,000</u>

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 ☒ Schematics ☐ Preliminary ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): <u>January 1, 2029</u>
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 department's 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]

Department/Area	Cost	Gross Square Feet*		Amount of Proposed Total Gross Square Feet* That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Nursing Unit	\$32,793,029	-	34,719	34,719	-	-	-
Pharmacy	\$525,150	-	556	556	-	-	-
Employee Suite	\$1,407,325	-	1,490	1,490	-	-	-
Therapy	\$7,703,648	-	8,156	8,156	-	-	-
Renal Dialysis	\$1,482,866	-	1,570	1,570	-	-	-
Total Clinical	\$43,912,018	-	46,491	46,491	-	-	-
NON REVIEWABLE							
Administrative	\$6,328,058	-	4,745	4,745	-	-	-
Dietary	\$4,343,663	-	3,257	3,257	-	-	-
Engineering	\$3,927,392	-	2,945	2,945	-	-	-
General Stores	\$1,176,242	-	882	882	-	-	-
Circulation	\$6,575,747	-	4,930	4,930	-	-	-
Total Non-clinical	\$22,351,102	-	16,759	16,759	-	-	-
TOTAL	\$66,263,120	-	63,250	63,250	-	-	-
APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

***Note: All square feet shown are Building Gross Square Feet (BGSF).**

Facility Bed Capacity and Utilization - NOT APPLICABLE

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available**. **Include observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

NOT APPLICABLE (PROJECT IS FOR A NEW 60-BED INPATIENT REHAB HOSPITAL)

FACILITY NAME:		CITY:			
REPORTING PERIOD DATES:		From:		to:	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:					

CERTIFICATION

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

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

This Application is filed on the behalf of Rehabilitation Institute of Springfield, 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 Springfield Holdings, LLC

PRINTED TITLE

SIGNATURE

Evan Davis

PRINTED NAME

President

Memorial Health Ventures

PRINTED TITLE

Notarization:

Subscribed and sworn to before me

this 24 day of August

Notarization:

Subscribed and sworn to before me

this ____ day of _____

Signature of Notary

Signature of Notary

Seal

Notary Public, Alabama State at Large

Kristy H. Horsley

Expires 2/28/2029

Seal

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

This Application is filed on the behalf of Rehabilitation Institute of Springfield, 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 Springfield Holdings, LLC

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this ____ day of ____

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

SIGNATURE

Evan Davis

PRINTED NAME

President

Memorial Health Ventures

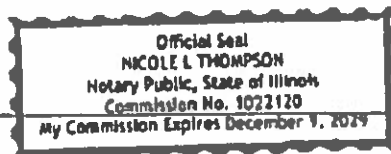
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 21st day of August, 2024

Signature of Notary

Seal

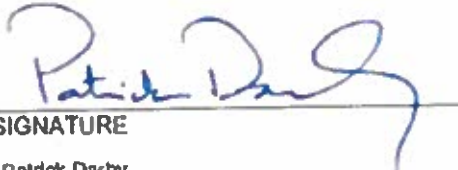


CERTIFICATION

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

- o In the case of a corporation, any two of its officers or members of its Board of Directors;
- o 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);
- o 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);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o In the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Encompass Health Springfield Holdings, 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

Patrick Darby

PRINTED NAME

Manager

PRINTED TITLE


SIGNATURE

Julie Duck

PRINTED NAME

Manager

PRINTED TITLE

Notarization:

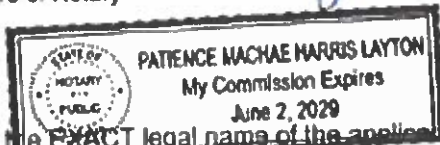
Subscribed and sworn to before me
this 28 day of August

Notarization:

Subscribed and sworn to before me
this 24 day of August


Signature of Notary

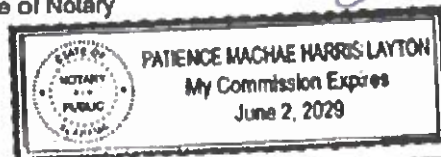
Seal



*Insert the EXACT legal name of the applicant


Signature of Notary

Seal



CERTIFICATION

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

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o 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);
- o 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);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o 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 and CFO

PRINTED TITLE

SIGNATURE

Patrick Darby

PRINTED NAME

Executive Vice President, General Counsel, and Secretary

PRINTED TITLE

Notarization:

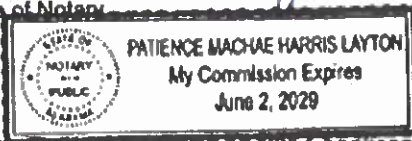
Subscribed and sworn to before me
this 28 day of August

Notarization:

Subscribed and sworn to before me
this 28 day of August

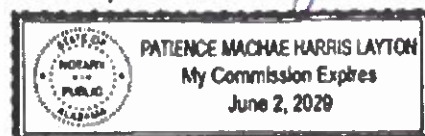
Signature of Notary

Seal



Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

CERTIFICATION

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

- o In the case of a corporation, any two of its officers or members of its Board of Directors;
- o 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);
- o 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);
- o In the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o In the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Memorial Health Ventures 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

Evan L Davis

PRINTED NAME

Chair and President
PRINTED TITLE

SIGNATURE

Robert J. Ellison
PRINTED NAMEVice-Chair
PRINTED TITLE

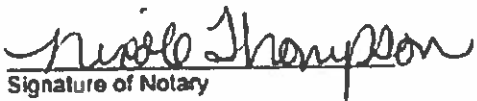
Notarization:

Subscribed and sworn to before me

this 21 day of August, 2026

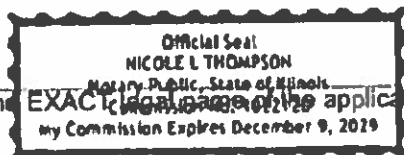
Notarization:

Subscribed and sworn to before me

this 21 day of August, 2026

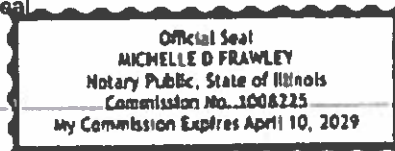
Signature of Notary

Seal



Signature of Notary

Seal



*Insert the EXACT legal name of the applicant
my Commission Expires December 9, 2029

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 Memorial Health System d/b/a Memorial Health.

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.

Mandy C Eaton
SIGNATURE

Mandy C. Eaton
PRINTED NAME

President and CEO
PRINTED TITLE

Cheryl S. Martin
SIGNATURE

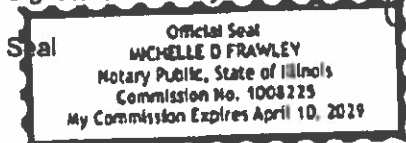
Cheryl S. Martin
PRINTED NAME

Chairperson of the Board of Directors
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 27 day of August, 2020

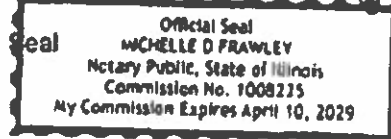
Michelle D Frawley
Signature of Notary



Notarization:

Subscribed and sworn to before me
this 27 day of August 2020

Michelle D Frawley
Signature of Notary



*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 is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)**PURPOSE OF PROJECT**

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED GROSS SQ FT	STATE STANDARD	DIFFERENCE	MET STANDARD?
Comprehensive Physical Rehab Beds	34,719	39,600 GSF (525-660 per bed)	-4,881 GSF	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)	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	Rehab Hospital	N/A	11,610 Pt Days 53.0% Occ.	85%	No
YEAR 2	Rehab Hospital	N/A	16,718 Pt Days 76.3% Occ.	85%	Yes*

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

****The Project will achieve 85% occupancy in November 2030, which is Month 11 of Project Year 2. Thus, the project achieves the target occupancy by the end of Project Year 2, which complies with the service-specific standard.***

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	0	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.			

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 that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable **[Indicate the dollar amount to be provided from the following sources]:**

<u>\$66,263,120</u>	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion; b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience. c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts; d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
<u>\$66,263,120</u>	TOTAL FUNDS AVAILABLE
APPEND DOCUMENTATION AS ATTACHMENT 34 , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

NOTE: THE PROJECT WILL BE FUNDED THROUGH INTERNAL SOURCES.

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

1. "A" Bond rating or better
2. **All of the projects capital expenditures are completely funded through internal sources**
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 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*			Projected
Enter Historical and/or Projected Years:	2016	2017	2018	CON Year 2
Current Ratio	N/A	N/A	N/A	6.5
Net Margin Percentage	N/A	N/A	N/A	4.4%
Percent Debt to Total Capitalization**	N/A	N/A	N/A	N/A
Projected Debt Service Coverage**	N/A	N/A	N/A	N/A
Days Cash on Hand	N/A	N/A	N/A	75.0
Cushion Ratio**	N/A	N/A	N/A	N/A

*Rehabilitation Institute of Springfield, LLC is a new entity; historical data is not applicable.

**Applicant has no long-term debt.

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

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

- 1) Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Sq. Ft. New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
New Construction	\$ 673.37	-	63,250	-	-	-	\$ 42,590,316	-	\$42,590,316
Contingency	\$ 55.34	-	63,250	-	-	-	\$ 3,500,000	-	\$3,500,000
TOTALS	\$ 728.71	-	63,250	-	-	-	\$ 46,090,316	-	\$46,090,316

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

Factor	CON Year 2
Salaries and Wages	\$ 15,548,400
Benefits	3,700,600
Supplies	1,398,300
Total Operating Costs	\$ 20,647,300
Patient Days	16,718
Cost per Day	\$ 1,235.03

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

Factor	CON Year 2
Depreciation	\$ 2,897,400
Total Capital Costs	\$ 2,897,400
Patient Days	16,718
Cost per Day	\$ 173.31

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, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

Please note: The applicant is a new entity; thus has no history of services. However, the Safety Net Impact of Applicants' related entities are provided in Attachment 38.

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.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

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

Please note: The applicant is a new entity; thus has no history of services. However, the Charity Care Information of Applicants' related entities is provided in **Attachment 39**.

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1.	Applicant Identification including Certificate of Good Standing	33-43
2.	Site Ownership	44-49
3.	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership	50-52
4.	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	53-55
5.	Flood Plain Requirements	56-58
6.	Historic Preservation Act Requirements	59-63
7.	Project and Sources of Funds Itemization	64-65
8.	Financial Commitment Document if required	66
9.	Cost Space Requirements	67-70
10.	Discontinuation	N/A
11.	Background of the Applicant	71-77
12.	Purpose of the Project	78-151
13.	Alternatives to the Project	152-153
14.	Size of the Project	154-160
15.	Project Service Utilization	161
16.	Unfinished or Shell Space	162
17.	Assurances for Unfinished/Shell Space	163
18.	Master Design and Related Projects	N/A
Service Specific:		N/A
19.	Medical Surgical Pediatrics, Obstetrics, ICU	164-218
20.	Comprehensive Physical Rehabilitation	N/A
21.	Acute Mental Illness	N/A
22.	Open Heart Surgery	N/A
23.	Cardiac Catheterization	N/A
24.	In-Center Hemodialysis	N/A
25.	Non-Hospital Based Ambulatory Surgery	N/A
26.	Selected Organ Transplantation	N/A
27.	Kidney Transplantation	N/A
28.	Subacute Care Hospital Model	N/A
29.	Community-Based Residential Rehabilitation Center	N/A
30.	Long Term Acute Care Hospital	N/A
31.	Clinical Service Areas Other than Categories of Service	N/A
32.	Freestanding Emergency Center Medical Services	N/A
33.	Birth Center	N/A
Financial and Economic Feasibility:		219-222
34.	Availability of Funds	N/A
35.	Financial Waiver	223-332
36.	Financial Viability	333-336
37.	Economic Feasibility	337-345
38.	Safety Net Impact Statement	346-347
39.	Charity Care Information	

Applicant/Licensee Corporate Information
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 1
Type of Ownership Applicants

Included with this Attachment are the Certificates of Good Standing for each Applicant:

1. Rehabilitation Institute of Springfield, LLC
2. Encompass Health Corporation
3. Encompass Health Springfield Holdings, LLC
4. Memorial Health Ventures
5. Memorial Health System

ATTACHMENT 1
Certificate of Formation
Rehabilitation Institute of Springfield, LLC

Delaware
The First State

Page 1

I, CHARUNI PATIBANDA-SANCHEZ, SECRETARY OF STATE OF THE
STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND
CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "REHABILITATION
INSTITUTE OF SPRINGFIELD, LLC", FILED IN THIS OFFICE ON THE
FIFTH DAY OF AUGUST, A.D. 2026, AT 12:34 O'CLOCK P.M.



10724160 8100
SR# 20263962494

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

C. P. Sanchez

Charuni Patibanda-Sanchez, Secretary of State

Authentication: 204739186
Date: 08-05-26

ATTACHMENT 1
Certificate of Formation
Rehabilitation Institute of Springfield, LLC

STATE OF DELAWARE
CERTIFICATE OF FORMATION
OF LIMITED LIABILITY COMPANY

The undersigned authorized person, desiring to form a limited liability company pursuant to the Limited Liability Company Act of the State of Delaware, hereby certifies as follows:

1. The name of the limited liability company is Rehabilitation Institute of Springfield, LLC.

2. The Registered Office of the limited liability company in the State of Delaware is located at 251 Little Falls Drive, in the City of Wilmington, Delaware 19808. The name of its registered agent at such address is Corporation Service Company.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation of Rehabilitation Institute of Springfield, LLC this 5th day of August, 2026.



Julie Duck
Authorized Person

Applicant/Licensee Corporate Information
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 1
Certificate of Formation
Rehabilitation Institute of Springfield, LLC



OFFICE OF THE SECRETARY OF STATE

ALEXI GIANNOULIAS-Secretary of State

18280469
AUGUST 06, 2026

ILLINOIS CORPORATION SERVICE COMPANY
801 ADLAI STEVENSON DRIVE
SPRINGFIELD, IL 62703-4261

RE REHABILITATION INSTITUTE OF SPRINGFIELD, LLC

Congratulations! We're pleased to inform you that your request to transact business in the State of Illinois has been approved, and your Limited Liability Company (LLC) has been recorded with the Illinois Secretary of State's office. We wish you success with your new business!

Under state law, LLCs must file an annual report before the first day of the anniversary month each year. (It is important to file your report on time to avoid penalties or dissolution.) Printed annual reports will be mailed to the registered agent 45 days before the due date.

Online Assistance for Your Business:
Visit www.ilsos.gov to:

- o File your annual report online
- o Check the "status" of your company
- o Access Publications, forms and other services
- o Purchase a Certificate of Good Standing

Again, congratulations on this exciting accomplishment!

Please do not hesitate to contact my Business Services Department if you have any questions or need further assistance.

Sincerely,

Alexi Giannoulis
Illinois Secretary of State
Department of Business Services
Limited Liability Division
800-252-8980

ATTACHMENT 1
Certificate of Formation
Rehabilitation Institute of Springfield, LLC

Form **LLC-45.5**
May 2018

**Illinois
Limited Liability Company Act
Application for Admission to
Transact Business**

Approved: _____

This space for use by Secretary of State.

ALEXI GIANNOULIAS
SECRETARY OF STATE

- (continued on back)

Applicant/Licensee Corporate Information
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 1
Certificate of Formation
Rehabilitation Institute of Springfield, LLC

LLC-45.5

9. Purpose(s) for which the company is organized and proposes to conduct business in Illinois (see Note 2):
inpatient 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 Springfield 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: August 6, 2026

Month, Day, Year


Signature

Douglas E. Coltharp, President

Name and Title (type or print)

Encompass Health Springfield 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 "LP." However, a limited liability company that will provide services licensed by the Illinois Department of Financial and Professional Regulation must instead contain the term Professional Limited Liability Company, PLLC or P.L.L.C. in the name.

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

ATTACHMENT 1
Certificate of Formation
Rehabilitation Institute of Springfield, LLC

Delaware
The First State

Page 1

I, CHARUNI PATIBANDA-SANCHEZ, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "REHABILITATION INSTITUTE OF SPRINGFIELD, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE FIFTH DAY OF AUGUST, A.D. 2026.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "REHABILITATION INSTITUTE OF SPRINGFIELD, LLC" WAS FORMED ON THE FIFTH DAY OF AUGUST, A.D. 2026.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.



10724160 8300

SR# 20263966735

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

C. B. Sanchez

Charuni Patibanda-Sanchez, Secretary of State

Authentication: 204741713

Date: 08-05-26

Attachment 1
Certificate of Good Standing
Encompass Health Corporation

File Number 5731-571-7



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, 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.



Authentication #: 2624303176 verifiable until 08/31/2027
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 31ST day of AUGUST A.D. 2026 .

Alexi Giannoulas
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Encompass Health Springfield Holdings, LLC

Delaware
The First State

Page 1

I, CHARUNI PATIBANDA-SANCHEZ, SECRETARY OF STATE OF THE STATE
OF DELAWARE, DO HEREBY CERTIFY "ENCOMPASS HEALTH SPRINGFIELD
HOLDINGS, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF
DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR
AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRTY-FIRST DAY OF
AUGUST, A.D. 2026.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN
ASSESSED TO DATE.



10714408 8300

SR# 20264251935

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

C. P. Sanchez

Charuni Patibanda-Sanchez, Secretary of State
Authentication: 204989162

Date: 08-31-26

ATTACHMENT 1
Certificate of Good Standing
Memorial Health Ventures

File Number 5411-259-9



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, 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

MEMORIAL HEALTH VENTURES, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 17, 1986, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



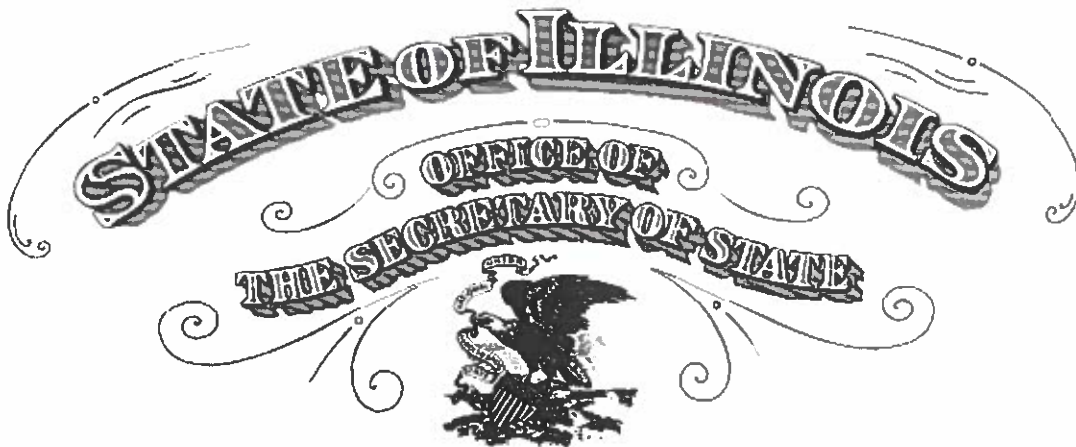
Authentication #: 2623903178 verifiable until 08/27/2027
Authenticate at: <https://www.sos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 27TH day of AUGUST A.D. 2026 .

Alexi Giannoulis
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Memorial Health System

File Number 5248-617-3



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, 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

MEMORIAL HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON AUGUST 21, 1981, ADOPTED THE ASSUMED NAME MEMORIAL HEALTH ON SEPTEMBER 27, 2016, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 2621600782 verifiable until 08/04/2027
Authenticate at: <https://www.sos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 4TH day of AUGUST A.D. 2026 .

Alexi Giannoulas
SECRETARY OF STATE

Site Ownership

Rehabilitation Institute of Springfield, LLC

**ATTACHMENT 2
Site Ownership**

The site for the proposed facility is owned by Memorial Health System. The current address for the proposed facility is 4685 Wabash Avenue Springfield, Illinois 62711. The site is also identified with Property Index Numbers 21-11.0-300-030 & 21-11.0-300-034. The land will be transferred to the joint venture, Rehabilitation Institute of Springfield, LLC. A Letter of Intent regarding the property is provided in Attachment 2.

ATTACHMENT 2 Site Ownership

DocuSign Envelope ID: A7E98B6A-2B18-828D-83F2-8C4E6337E4C8



August 25, 2026

Re: Non-Binding Letter of Intent regarding approximately 5.8 acres of unimproved real property located at 4685 Wabash Avenue, Springfield, Sangamon County, Illinois 62711 (PIN 21-11.0-300-030)

To Whom it May Concern:

Encompass Health Springfield Holdings, LLC, a Delaware limited liability company ("Encompass") and Memorial Health Ventures, an Illinois non-profit corporation ("Memorial") wish to memorialize the parties' understanding and agreement to the following terms and conditions pursuant to which Encompass and Memorial intend to form a joint venture, known as Rehabilitation Institute of Springfield, LLC, a Delaware limited liability company (the "JV"), which JV will own and operate an inpatient rehabilitation hospital on the above-described property. This Letter of Intent is non-binding except as expressly provided otherwise in the final paragraph hereof.

Terms and Conditions:

- **Property Description:** Approximately 5.8 acres of unimproved real property located at 4685 Wabash Avenue, Springfield, Sangamon County, Illinois 62711 (the "Property"), as generally depicted on Exhibit A attached hereto and consists of properties in two PIN numbers. The southerly three acres and cross hatched as shown on Exhibit A is a portion of PIN #21-11.0-300-034 and the additional property is approximately 2.8 acres as a portion of PIN #21-11.0-300-030, which is made up of approximately 41 unimproved acres.
- **Memorial's Interest in the Property:** The southerly three acres is owned by Memorial Medical Center. The northern 2.8 acres is under Contract for Sale of Real Estate effective as of May 10, 2026 (the "Underlying Contract"), by Memorial's affiliate, Memorial Health System, an Illinois Not-For-Profit Corporation from a third-party property owner. The legal descriptions and exact size of the approximately 2.8 acre tract will be determined after the civil engineering is completed for both the Encompass

ATTACHMENT 2

Site Ownership

DocuSign Envelope ID: A7E98B6A-2B16-828D-83F2-8C4E8337E4C6

Hospital Development as well as designing and study of the drainage for the 41 acres.

- **Contribution:** After the Closing under the Underlying Contract, Memorial will contribute the Property to the JV.
- **Intended Use:** The parties intend for the JV to develop and improve the Property as an inpatient rehabilitation hospital (the "Intended Use").
- **Confidentiality:** Except for communications with attorneys, brokers, accountants, consultants, architects, engineers, contractors, and other third-party advisors or service providers that Encompass, Memorial, and/or the JV engages or considers engaging in relation to the Property, Encompass, Memorial, and the JV agree that the terms and conditions of this Letter of Intent are confidential and that neither party shall disclose any information regarding the terms or the parties hereto. Notwithstanding the foregoing, Encompass and the JV are expressly permitted to communicate about the Property with governing authorities and/or utility companies in connection with the Intended Use of the Property. Further, Encompass and the JV are expressly permitted to provide a copy of this agreement to governing authorities or utility companies in the event required in connection with any applications for entitlements and approvals in connection with the Intended Use of the Property, including in connection with the JV's application for a Certificate of Need.

[signatures follow]

Site Ownership

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 2 Site Ownership

DocuSign Envelope ID: A7E98B6A-2B18-828D-83F2-8C4E6337E4C8

This Letter of Intent is non-binding (except for the "Confidentiality" provision above, which is binding) and is not intended to constitute a contract for the purchase of the Property nor to otherwise create any legal obligations to purchase or contribute the Property, but is intended only to summarize the general terms and conditions under which Encompass and Memorial agree to pursue their joint venture and the Intended Use of the Property as contemplated herein.

Encompass Health Springfield Holdings, LLC

By: Edmund Ball

Name: Edmund Ball

Title: Vice President

Memorial Health Ventures, LLC

By: Evan Dine

Name: Evan Dine

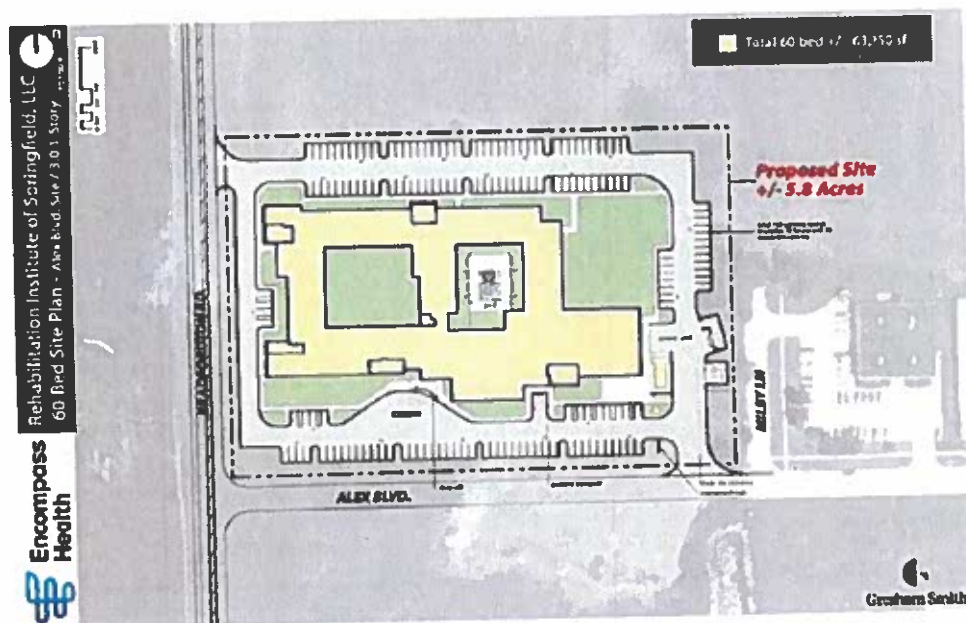
Title: VP Clinical Operations

3
4913-5484-3076, v. 3

ATTACHMENT 2 Site Ownership

Docusign Envelope ID: A7E98B6A-2B18-828D-83F2-BC4E6337E4C8

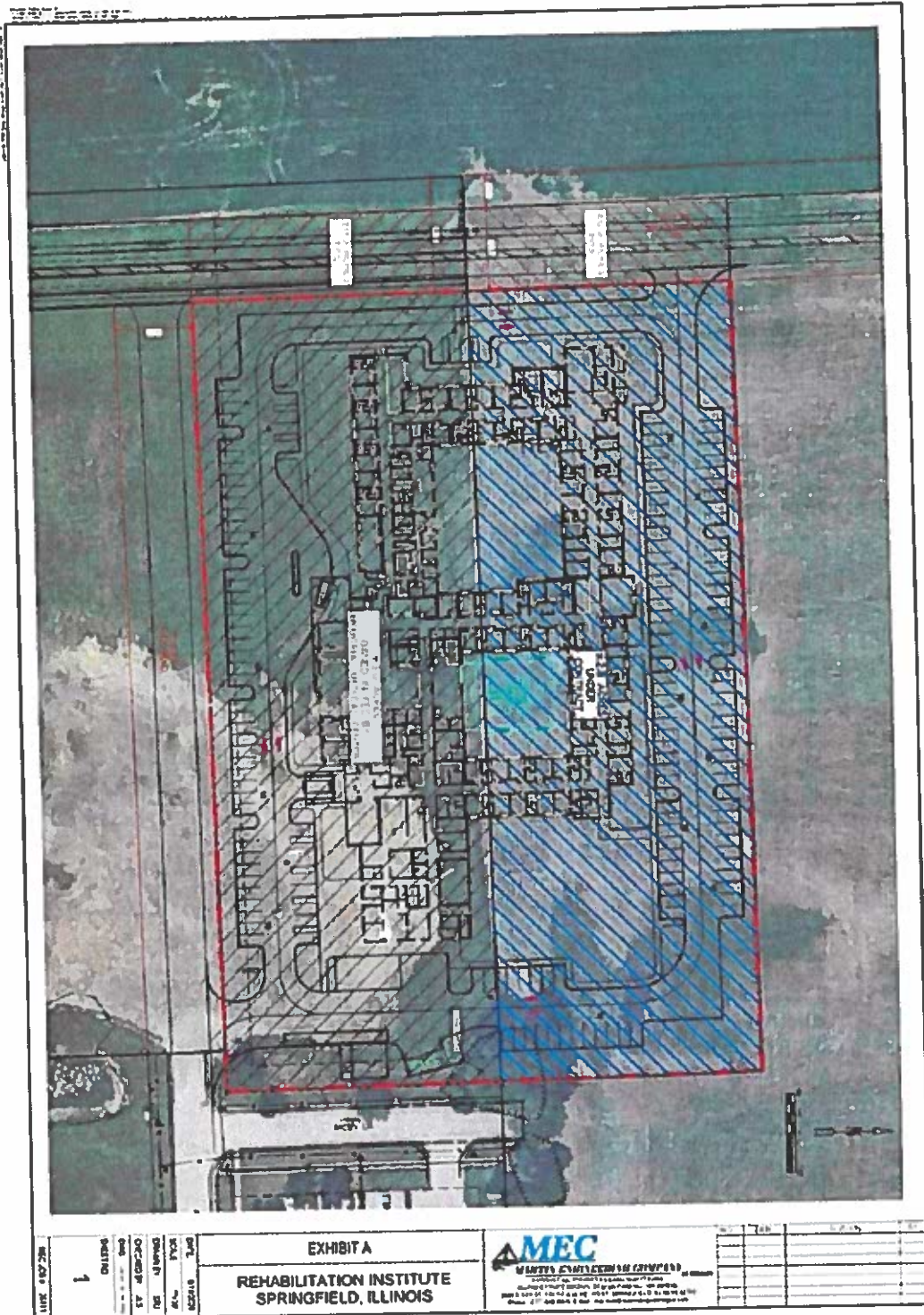
Exhibit A



Site Ownership
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 2 Site Ownership

Design Envelope ID: A7E9886A-2818-428D-83F2-8C4E6337E403



Persons with 5% or Greater Interest in the Licensee
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 3
Operating Entity/Licensee

Enclosed is the Certificate of Formation issued by the Illinois Secretary of State for the proposed licensee, Rehabilitation Institute of Springfield, LLC.

Rehabilitation Institute of Springfield, the Licensee, will be a 50-50 joint venture between Memorial Health Ventures, an affiliate of Memorial Health, and Encompass Health Springfield Holdings, LLC, an affiliate of Encompass Health Corporation.

Persons with 5% or Greater Interest in the Licensee
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 3
Operating Entity/Licensee

18280469

Form LLC-45.5 May 2018 Secretary of State Department of Business Services Limited Liability Division 501 S. Second St., Rm. 351 Springfield, IL 62756 217-524-8008 www.cyberdriveillinois.com Payment must be made by certified check, cashier's check, Illinois attorney's check, C.P.A.'s check or money order payable to Secretary of State. If check is returned for any reason this filing will be void.	Illinois Limited Liability Company Act Application for Admission to Transact Business SUBMIT IN DUPLICATE Type or print clearly. Filing Fee: \$150 Penalty: \$ Approved: <i>MP</i>	FILE # This space for use by Secretary of State. FILED AUG 08 2026 ALEXI GIANNOULIAS SECRETARY OF STATE
--	---	---

- Limited Liability Company name (see Note 1): Rehabilitation Institute of Springfield, LLC
 - 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.)
 - Jurisdiction of organization: Delaware
 - Date of organization: August 5, 2026
 - Period of duration: perpetual
(Enter perpetual unless there is a date of dissolution provided in the agreement, in which case enter that date.)
 - Address of the principal place of business: (P.O. Box alone or c/o is unacceptable.)
9001 Liberty Parkway

Number	Street	Suite #
<u>Birmingham</u>	<u>AL</u>	<u>35242</u>
City	State	ZIP
 - Registered agent: Illinois Corporation Service Company

First Name	Middle Name	Last Name
<u>Registered office: 801 Adlai Stevenson Drive</u>		
Number	Street	Suite #
<u>Springfield</u>	<u>IL</u>	<u>62703</u>
City		ZIP
- Note: The registered agent must reside in Illinois. If the agent is a business entity, it must be authorized to act as agent in this state.
8. If applicable, date on which company first conducted business in Illinois: _____

(continued on back)

Persons with 5% or Greater Interest in the Licensee
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 3
Operating Entity/Licensee

LLC-48.5

9. Purpose(s) for which the company is organized and proposes to conduct business in Illinois (see Note 2):
Inpatient 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 Springfield 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: August 6, 2026

Month, Day, Year


Signature

Douglas E. Coltharp, President

Name and Title (type or print)

Encompass Health Springfield Holdings, LLC

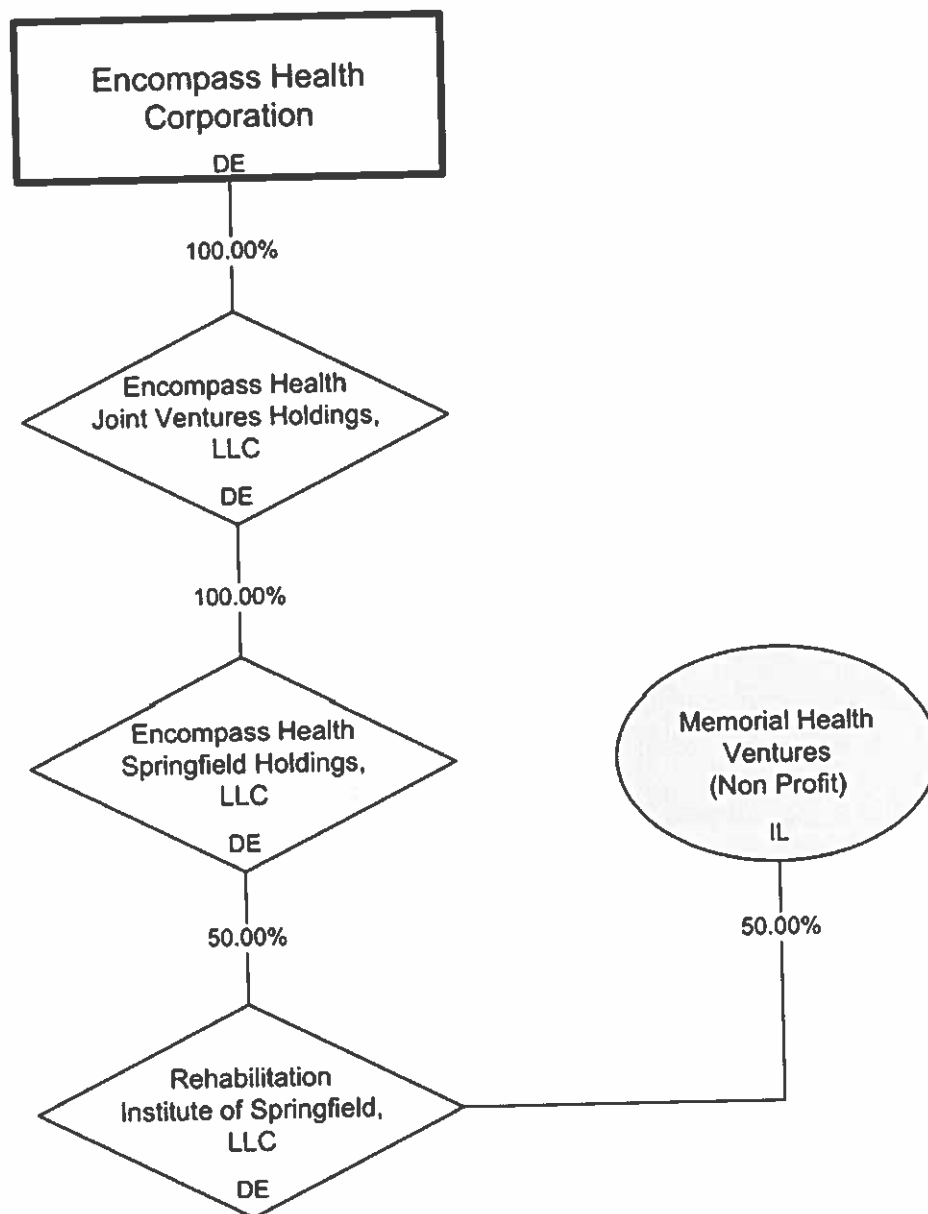
If applicant is signing for a company or other entity,
state name of company or entity.

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 "LP." However, a limited liability company that will provide services licensed by the Illinois Department of Financial and Professional Regulation must instead contain the term Professional Limited Liability Company, PLLC or P.L.L.C. in the name.

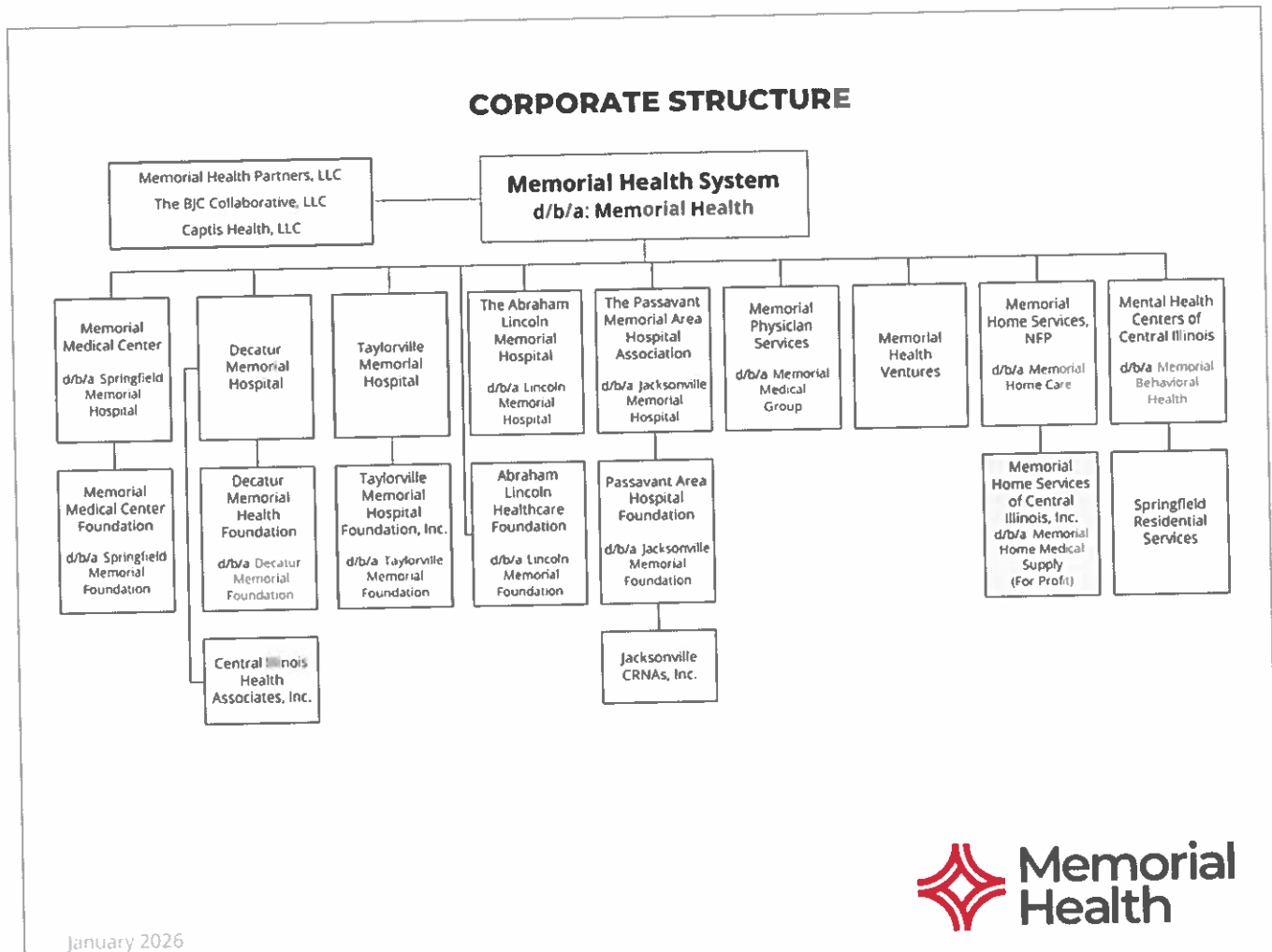
Note 2: A professional limited liability company must state the specific professional service or related professional services to be rendered by the professional limited liability company.

ATTACHMENT 4
Organizational Relationships

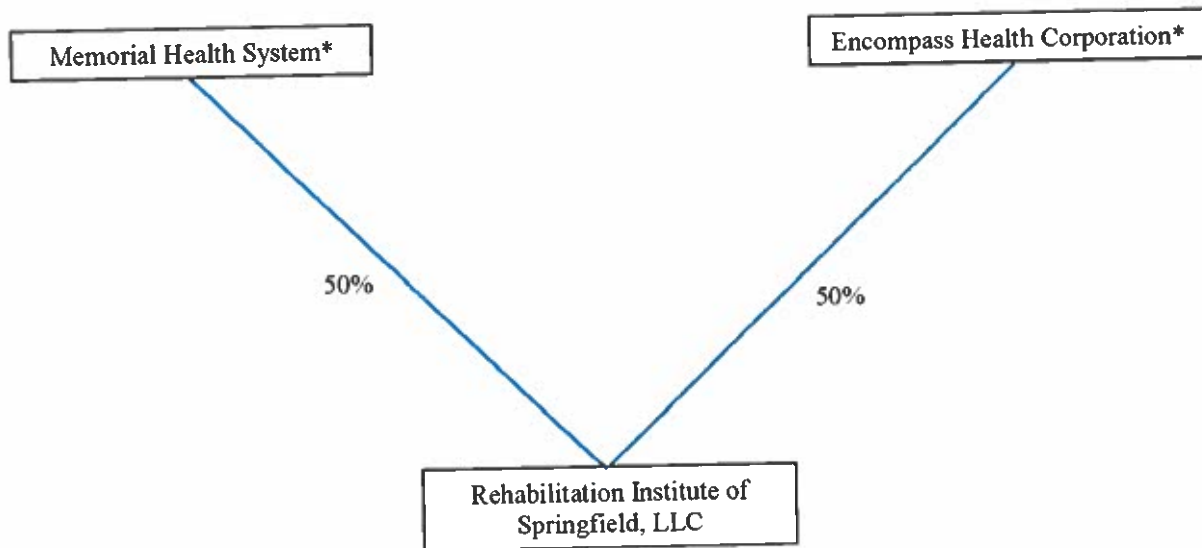
Rehabilitation Institute of Springfield, LLC



ATTACHMENT 4
Organizational Relationships



ATTACHMENT 4 **Organizational Relationships**



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

Flood Plain Requirements

Rehabilitation Institute of Springfield, LLC

**ATTACHMENT 5
Flood Plains 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 The Rehabilitation Institute of Springfield, located at 4685 Wabash Avenue Springfield, Illinois 62711 and identified as PINs 21-11.0-300-030 & 21-11.0-300-034. The proposed site for the facility complies with the requirements of Executive Order #2006-5. A map confirming such and provided by FEMA is attached.

ATTACHMENT 5 **Flood Plains Requirements**



July 27, 2026

Illinois Health Facilities And Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Subject: **Flood Plain Requirements Compliance**
Rehabilitation Institute of Springfield, LLC
Springfield, Illinois
Gresham Smith Project No. 48999.87

To whom this may concern,

This letter is in reference to the State of Illinois CON Permit Application for an inpatient physical rehabilitation facility to be located on approximately 5.8 acres of unimproved real property located at 4685 Wabash Ave., Springfield, IL 62711. The CON application requires that the referenced building is in compliance with the Flood Plain Rule under Illinois Executive Order #2006-5. At this time, according to FEMA Flood Map Service Center website, the project site is in Unshaded Flood Zone X described as Area of Minimal Flood Hazard outside the 500-year flood plain, and not in a Special Flood Hazard Area.



Genuine Ingenuity

222 Second Avenue South
Suite 1400
Nashville, TN 37201
615.770.8100

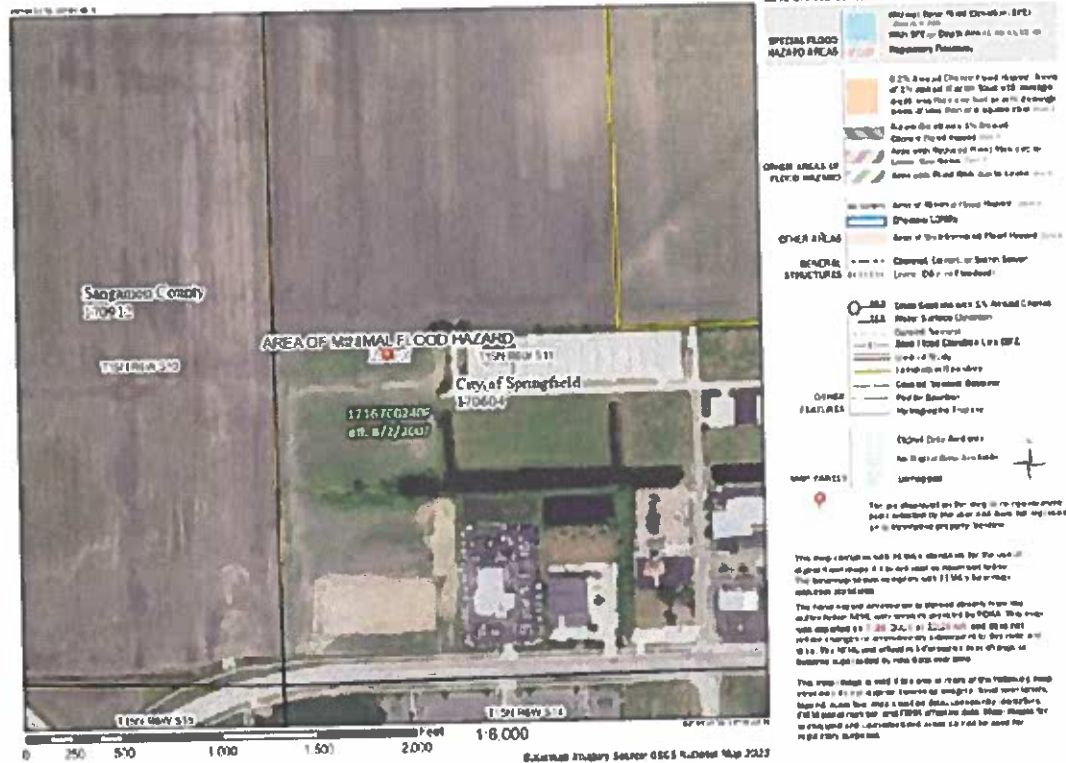
GreshamSmith.com

ATTACHMENT 5 Flood Plains Requirements



Illinois Health Facilities And Services Review Board
August 25, 2026

National Flood Hazard Layer FIRMette



Sincerely,

Brent Hughes

Brent Hughes, AIA
Architect License #001-019981

Copy - Elizabeth Mann (Encompass Health Corporate)
Leanna Albright (Gresham Smith)
Jonas Booker (Gresham Smith)

**Gresham
Smith**

Page | 2

Historic Resources Preservation Act Requirements
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 6
Historic Preservation Act Requirements

The Applicants submitted a request for determination to the Illinois Department of Natural Resources-Preservation Services Division on August 10, 2026. A copy of that request is enclosed herein. A final determination has not been received as of the filing of this application. The Applicant commits to not financially obligate the Project until a clearance letter is received from the Department. A copy of the submission is included with this attachment.

Historic Resources Preservation Act Requirements
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 6
Historic Preservation Act Requirements



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

August 10, 2026

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 the Establishment of a Hospital –
Rehabilitation Institute of Springfield, LLC**

Dear Jeffrey:

I am writing on behalf of my client, Rehabilitation Institute of Springfield, LLC ("Springfield Rehab") 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.). Springfield Rehab is submitting an application for a Certificate of Need to the Illinois Health Facilities and Services Review Board. Springfield Rehab is proposing to establish a free-standing rehabilitation hospital, located at 4685 Wabash Avenue, Springfield, IL 62704 and the property's Property Index Number is: 21-11.0-300-030 (the "Project").

The proposed Project will occupy approximately 63,250 square feet in building space and will contain 60 beds. For your reference, in this letter we have included a topographic map, an aerial map along with a rendering showing the boundaries of the proposed site, and existing lot images (Attachments 1-3) showing the general location of the Project.

29167857 v1

Historic Resources Preservation Act Requirements
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 6
Historic Preservation Act Requirements

We respectfully request 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.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP



Juan Morado, Jr.

JM:
Enclosures

29167857 v1

ATTACHMENT 6 **Historic Preservation Act Requirements**

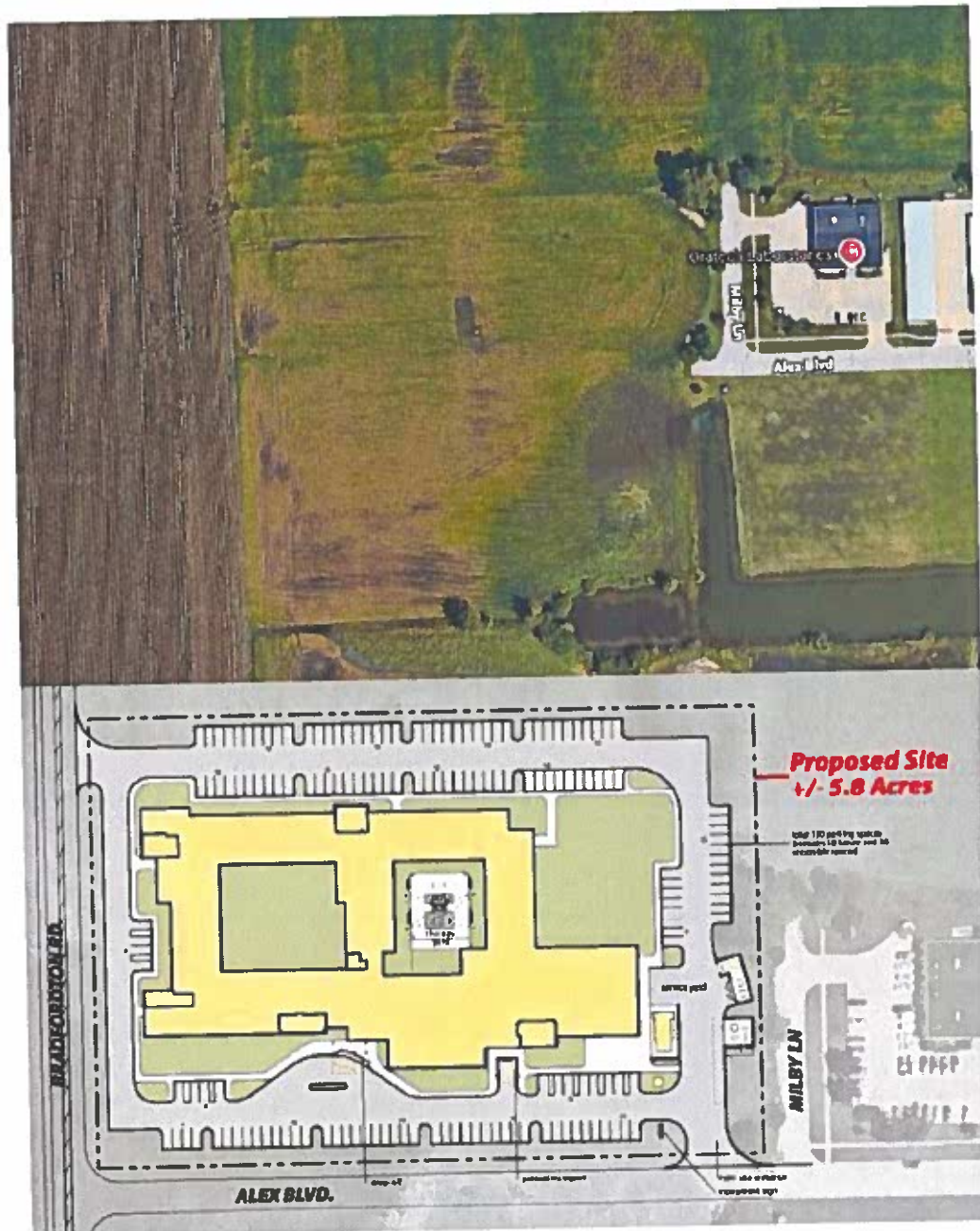
Topographic Map

(4685 Wabash Avenue, Springfield, Illinois 62704 Identified as PINs 21-11.0-300-030 & 21-11.0-300-034)



ATTACHMENT 6
Historic Preservation Act Requirements
3D Aerial Map

(4685 Wabash Avenue, Springfield, Illinois 62704 Identified as PINs 21-11.0-300-030 & 21-11.0-300-034)



ATTACHMENT 7

Project Costs and Sources of Funds

Summary of Project and Related Cost Data Assumptions

Project Costs and Sources of Funds			
Component	Clinical	Non-Clinical	Total
Site Survey and Soil Investigation	\$ 158,400	\$ 201,600	\$ 360,000
Site Preparation	\$ 1,320,362	\$ 1,680,460	\$ 3,000,822
New Construction Contracts	\$ 27,470,754	\$ 15,119,562	\$ 42,590,316
Contingencies	\$ 2,572,625	\$ 927,375	\$ 3,500,000
Architectural/Engineering Fees	\$ 1,627,500	\$ 542,500	\$ 2,170,000
Consulting and Other Fees	\$ 2,131,603	\$ 768,397	\$ 2,900,000
Movable/Other Equipment (not in contracts)	\$ 5,708,389	\$ 2,057,751	\$ 7,766,140
Other Costs To Be Capitalized	\$ 2,922,385	\$ 1,053,457	\$ 3,975,842
Total Project Cost	\$ 43,912,018	22,351,102	\$ 66,263,120

Site Preparation, including Site Survey and Soil Investigation

Project site preparation costs are based upon the proposed site location in Springfield, IL and Encompass Health and Memorial Health experience. Clinical site preparation costs, including site survey and soil investigation, are estimated to be \$1,478,762, which is 4.9% of projected clinical construction and contingency costs.

New Construction

The proposed project is a new, freestanding 60-bed comprehensive physical rehabilitation hospital located in Springfield, Sangamon County, IL. The new construction will be a single-story 63,250 square foot building. Project building costs are comprised of all costs and expenses covered under the construction contract, including major medical and other fixed equipment and contractor's overhead and profit. Construction costs are estimated based on national architectural/construction standards adjusted for Sangamon County building code compliance and Encompass and Memorial experience. Clinical construction costs are projected to be \$27,470,754, or \$434.32 per clinical square foot.

Contingencies

Project contingency costs are an allowance for unforeseeable events related to construction. Clinical construction contingencies are estimated to be \$2,572,625, or 9.4% of projected clinical new construction costs.

Architectural/Engineering fees

Clinical project cost architectural/engineering fees are projected to be \$1,627,500, or 5.4% of clinical new construction and contingencies costs. These costs are consistent with Encompass and Memorial experience.

ATTACHMENT 7

Project Costs and Sources of Funds

Consulting and Other fees

Project consulting and other fees are comprised of the following professional services and regulatory costs necessary to develop and permit the proposed facility: state and local permitting fees, including building permits, utility connection fees, and municipal impact fees; Certificate of Need application and related regulatory filing fees; construction management consulting services procured independently of the general construction contract; healthcare planning and feasibility consulting; information technology and clinical systems planning consultants; legal, financial advisory, and regulatory consulting fees.

Moveable Equipment Costs not in Building Contract

Project moveable equipment costs are estimated costs commensurate for a 60-bed facility and are based on Encompass and Memorial experience.

Other Costs that are to be Capitalized

Project other costs to be capitalized are estimated based on Encompass and Memorial experience and primarily consist of pre-operating costs.

ATTACHMENT 8
Project Costs and Sources of Funds

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

ATTACHMENT 9

Project Costs and Sources of Fund

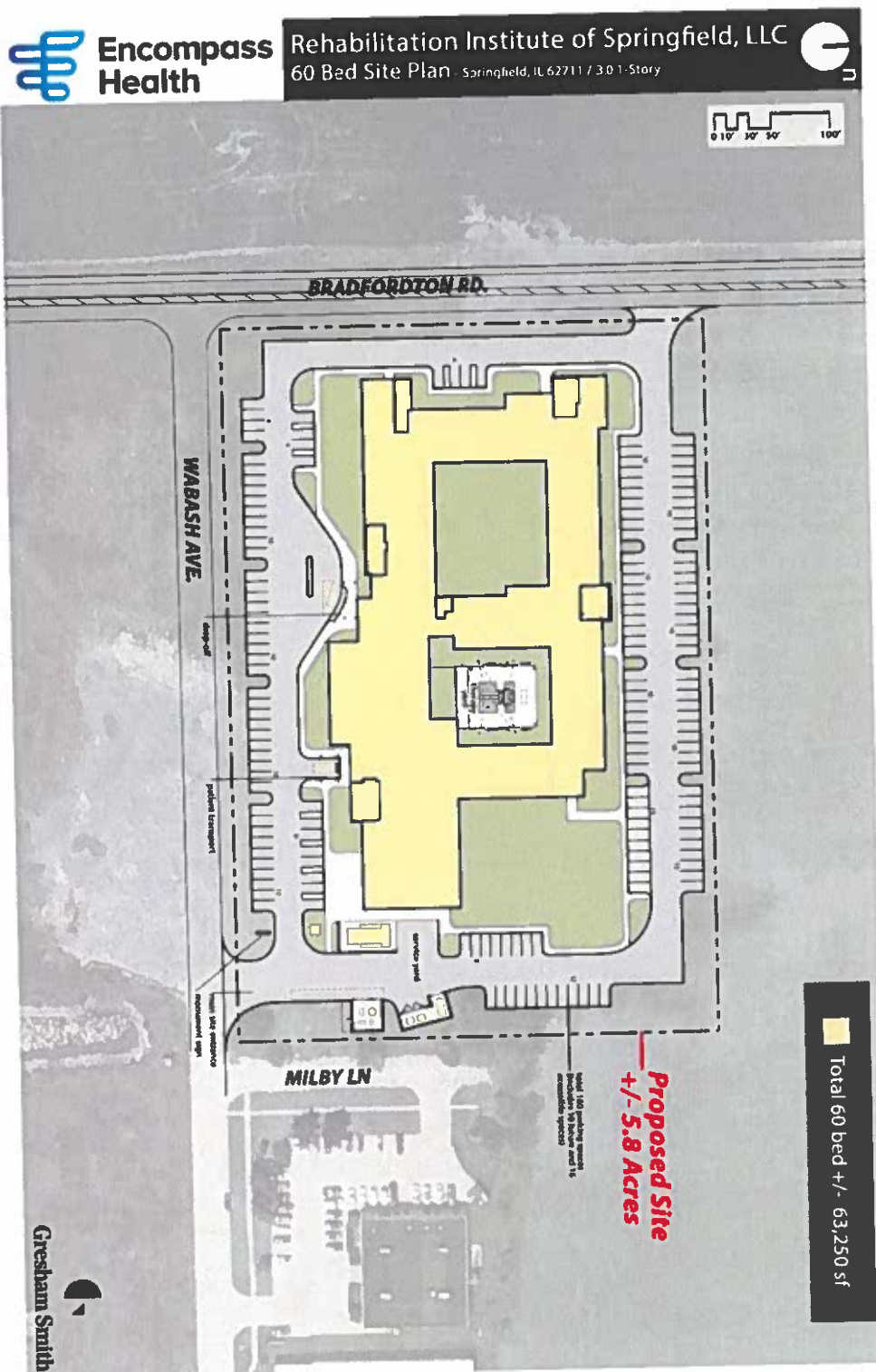
The proposed project involves the construction of a 60-bed comprehensive rehabilitation hospital with a total of 63,250 BGSF.

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Department/Area	Cost	Gross Square Feet*		Amount of Proposed Total Gross Square Feet* That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Nursing Unit	\$32,793,029	-	34,719	34,719	-	-	-
Pharmacy	\$525,150	-	556	556	-	-	-
Employee Suite	\$1,407,325	-	1,490	1,490	-	-	-
Therapy	\$7,703,648	-	8,156	8,156	-	-	-
Renal Dialysis	\$1,482,866	-	1,570	1,570	-	-	-
Total Clinical	\$43,912,018	-	46,491	46,491	-	-	-
NON REVIEWABLE							
Administrative	\$6,328,058	-	4,745	4,745	-	-	-
Dietary	\$4,343,663	-	3,257	3,257	-	-	-
Engineering	\$3,927,392	-	2,945	2,945	-	-	-
General Stores	\$1,176,242	-	882	882	-	-	-
Circulation	\$6,575,747	-	4,930	4,930	-	-	-
Total Non-clinical	\$22,351,102	-	16,759	16,759	-	-	-
TOTAL	\$66,263,120	-	63,250	63,250	-	-	-
APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

***Note: Square feet shown are Building Gross Square Feet.**

ATTACHMENT 9 Project Costs and Sources of Fund



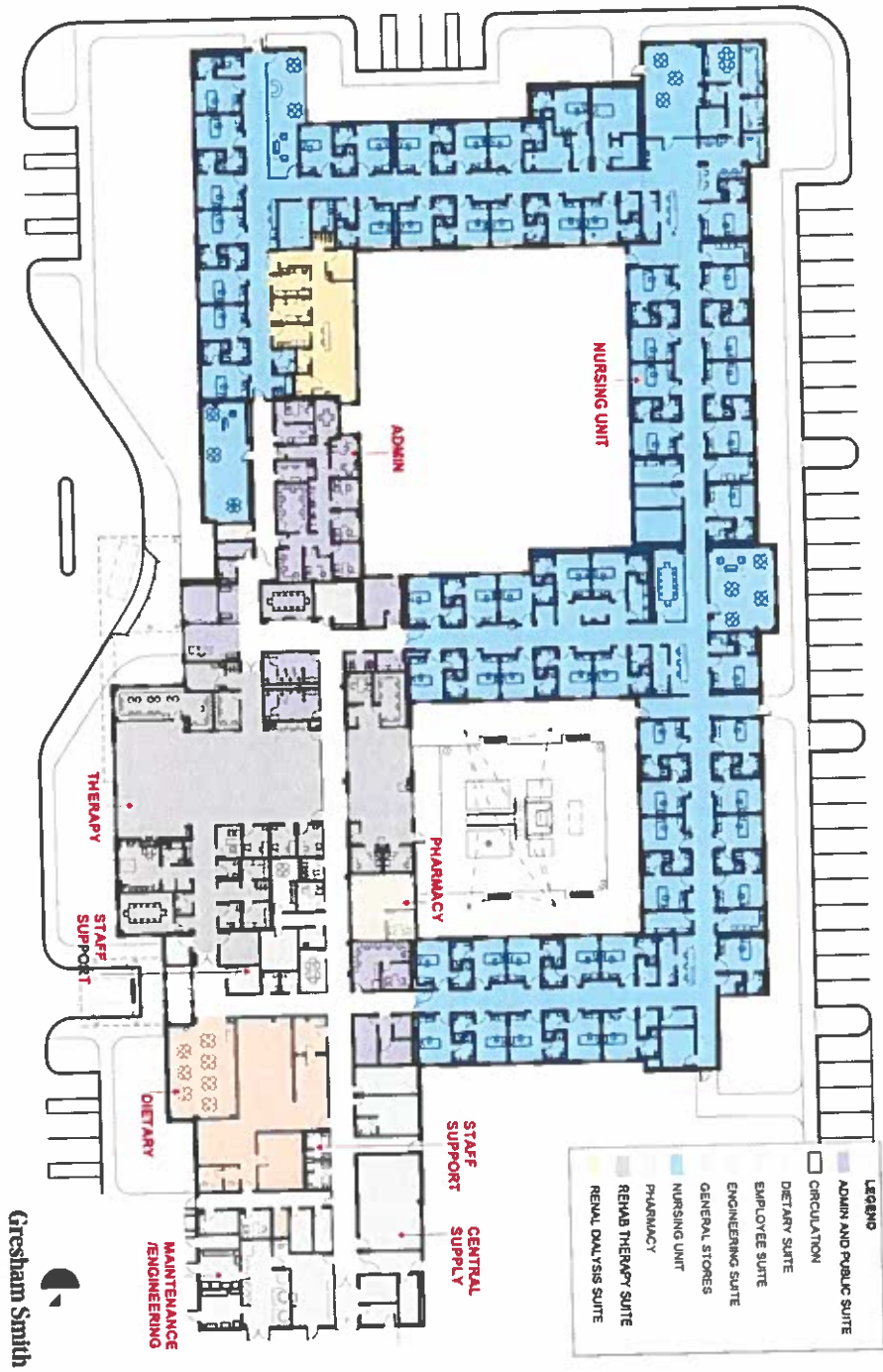
ATTACHMENT 9
Project Costs and Sources of Fund



**Encompass
Health**

Rehabilitation Institute of Springfield, LLC
60 Bed Floor Plan Springfield, IL 62/11 / 3.0 1-Story





Gresham Smith

ATTACHMENT 9
Project Costs and Sources of Fund



**Encompass
Health**

Rehabilitation Institute of Springfield, LLC
Typ. Patient Rm. Plan Springfield, IL 62711 / 301-Story



TYPICAL PATIENT ROOM
TRANSFER SHOWER
(ACCESSIBLE)

TYP PAT RM.	204 SF
TYP TLT.	53 SF
TOTAL	257 SF

TOTAL ROOM COUNT: 88

TYPICAL PATIENT ROOM
ROLL-IN SHOWER
(ACCESSIBLE)

TYP PAT RM.	222 SF
TYP TLT.	61 SF
TOTAL	283 SF

TOTAL ROOM COUNT: 9

TYPICAL INDIVIDUAL
SIZE ROOM (ISS)

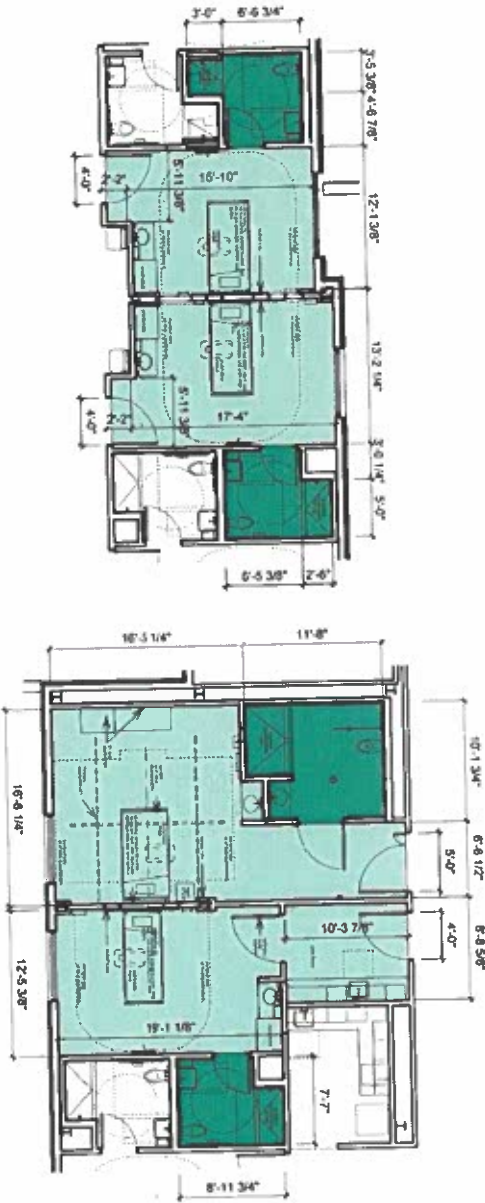
TYP PAT RM.	364 SF
TYP TLT.	105 SF
TOTAL	479 SF

TOTAL ROOM COUNT: 1

TYPICAL ISOLATION
PATIENT ROOM (ISO)

TYP PAT RM.	322 SF
TYP TLT.	61 SF
TOTAL	383 SF

TOTAL ROOM COUNT: 1



Background of the Applicant
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 11
Background of the Applicant

The following information is provided to illustrate the qualifications, background and character of the ultimate parent entities of the Applicant/Licensee and to assure the Review Board that the rehab hospital will provide a proper standard of health care service for the community.

Rehabilitation Institute of Springfield, LLC ("Rehabilitation Institute of Springfield")

The proposed project will be a 50/50 joint venture between Memorial Health System and Encompass Health Corporation. Memorial Health Ventures, an affiliate of Memorial Health, will have a fifty percent (50%) ownership interest in the Licensee, Rehabilitation Institute of Springfield, LLC. Memorial Health is an Illinois nonprofit corporation. Encompass Health also will have a fifty percent (50%) ownership interest in the Licensee, Rehabilitation Institute of Springfield, LLC. Encompass is a Delaware corporation.

Memorial Health System

Applicant Memorial Health System maintains "ultimate control" of five (5) hospitals in Illinois:

- Memorial Medical Center d/b/a Springfield Memorial Hospital, IDPH License # 0001487.
- Decatur Memorial Hospital, IDPH License # 0000471.
- Taylorville Memorial Hospital, IDPH License # 0005447.
- The Abraham Lincoln Memorial Hospital d/b/a Lincoln Memorial Hospital, IDPH License # 0005728.
- Passavant Memorial Area Hospital Association d/b/a Jacksonville Memorial Hospital, IDPH License # 0001792.

In addition, Memorial Health System holds a 50% ownership in the Rehabilitation Institute of Springfield, LLC.

Encompass Health

In addition to holding a 50% ownership in the Rehabilitation Institute of Springfield, Encompass Health Corporation, through its subsidiaries, also holds a 50% ownership in the following rehabilitation hospitals:

- Van Matre Encompass Health Rehabilitation Hospital, LLC, IDPH License # 0005215.
- The Quad Cities Rehabilitation Institute, IDPH License # 0006312.
- The Rehabilitation Institute of Southern Illinois, IDPH License # 0006270.

Additionally, Encompass Health Corporation is the ultimate parent owner of:

- Encompass Health Rehabilitation Institute of Libertyville, IDPH License # 0006288.

Encompass Health Rehabilitation Institute of Libertyville is a wholly-owned subsidiary of Encompass Health Corporation.

Encompass is the nation's leading owner and operator of inpatient rehab hospitals with 175 inpatient rehab hospitals in 39 states and Puerto Rico. As detailed later in this application, service area patients and their families will benefit from Encompass' proven high quality, cost-effective programs and services, including their rehab-specific hospital design, clinical equipment, and technology. Moreover, of note is that Encompass has a proven track record of providing quality outcomes for Illinois patients.

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:

Background of the Applicant
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 11
Background of the Applicant

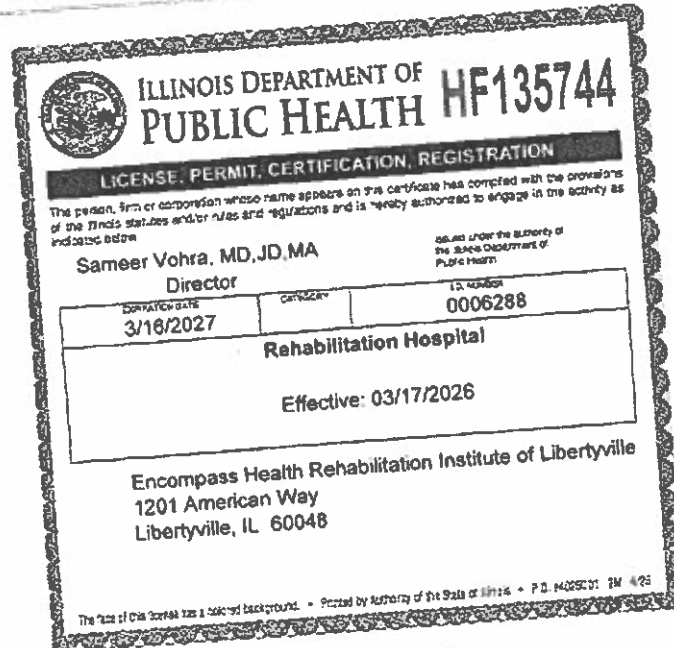
None of the three Applicants nor any subsidiary entity has had any adverse actions against it during the three (3) year period prior to the filing of this application.

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.

The following copies of the Applicants' entities IDPH licenses document that Encompass' and Memorial's hospitals are accredited.

Background of the Applicant
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 11
Background of the Applicant



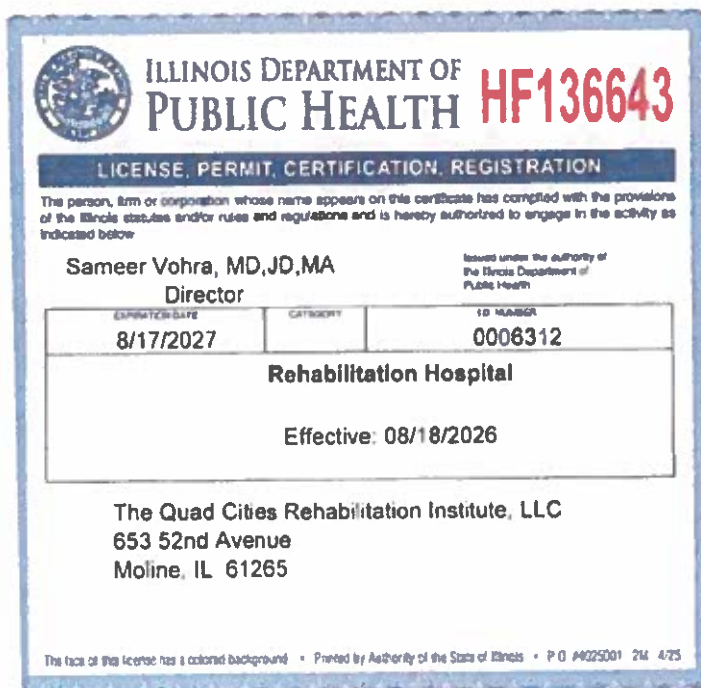
← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 3/16/2027
Lic Number 0006288

Date Printed 2/11/2026

Encompass Health Rehabilitation Instit
1201 American Way
Libertyville, IL 60048

FEE RECEIPT NO.



← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 8/17/2027
Lic Number 0006312

Date Printed 6/30/2026

The Quad Cities Rehabilitation Institute
653 52nd Avenue
Moline, IL 61265

FEE RECEIPT NO.

Background of the Applicant
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 11
Background of the Applicant

ILLINOIS DEPARTMENT OF PUBLIC HEALTH **HF135479**

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.

Issued under the authority of the Illinois Department of Public Health

Sameer Vohra, MD, JD, MA
Director

EXPIRATION DATE	CATEGORY	ID NUMBER
2/6/2027		0006270

Rehabilitation Hospital

Effective: 02/07/2026

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

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #1025001 2M 4/25

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

Exp Date 2/6/2027

Lic Number 0006270

Date Printed 12/31/2025

Validation Num

The Rehabilitation Institute of Southern

2351 Frank Scott Parkway East
Shiloh, IL 62269

FEE RECEIPT NO.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH **HF134453**

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.

Issued under the authority of the Illinois Department of Public Health

Sameer Vohra, MD, JD, MA
Director

EXPIRATION DATE	CATEGORY	ID NUMBER
10/26/2026		0005215

Rehabilitation Hospital

Effective: 10/27/2025

Van Matre Encompass Health Rehabilitation Hospital LLC
dba Van Matre Encompass Health Rehabilitation Institut
950 S Mulford Road
Rockford, IL 61108

The face of this license has a colored background. • Printed by Authority of the State of Illinois • P.O. #1025001 2M 4/25

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

Exp. Date 10/26/2026

Lic Number 0005215

Date Printed 8/20/2025

Van Matre Encompass Health Rehabili
dba Van Matre Encompass Health Reh
950 S Mulford Road
Rockford, IL 61108

FEE RECEIPT NO.

Background of the Applicant
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 11
Background of the Applicant

ILLINOIS DEPARTMENT OF PUBLIC HEALTH **HF135350**

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.

Issued under the authority of the Illinois Department of Public Health

Sameer Vohra, MD, JD, MA
Director

12/31/2026 **0001487**

General Hospital

Effective: 01/01/2026

Memorial Medical Center
dba Springfield Memorial Hospital
701 N First St
Springfield, IL 62781

The holder of this license has a colored background. Printed by Authority of the State of Illinois • P.D. #4025001 2M 4/25

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

Exp Date 12/31/2026
Lic Number 0001487
Date Printed 12/15/2025
Validation Num
Memorial Medical Center
dba Springfield Memorial Hospital
701 N First St
Springfield, IL 62781

FEE RECEIPT NO.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH **HF134954**

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.

Issued under the authority of the Illinois Department of Public Health

Sameer Vohra, MD, JD, MA
Director

12/31/2026 **0000471**

General Hospital

Effective: 01/01/2026

Decatur Memorial Hospital
2300 N Edward Street
Decatur, IL 62526

The holder of this license has a colored background. Printed by Authority of the State of Illinois • P.D. #4025001 2M 4/25

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

Exp Date 12/31/2026
Lic Number 0000471
Date Printed 10/17/2025
Validation Num
Decatur Memorial Hospital
2300 N Edward Street
Decatur, IL 62526

FEE RECEIPT NO.

Background of the Applicant
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 11
Background of the Applicant

ILLINOIS DEPARTMENT OF PUBLIC HEALTH **HF135615**

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

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
4/30/2027		0005447

Critical Access Hospital

Effective: 05/01/2026

Taylorville Memorial Hospital
201 E Pleasant St
Taylorville, IL 62568

The face of this license has a colored background • Printed by Authority of the State of Illinois • P.O. #4025001 2M 4/25

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

Exp Date 4/30/2027
Lic Number 0005447

Date Printed 1/27/2026

Taylorville Memorial Hospital
201 E Pleasant St
Taylorville, IL 62568

FEE RECEIPT NO.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH **HF135612**

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

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
4/25/2027		0001792

Critical Access Hospital

Effective: 04/26/2026

Passavant Memorial Area Hospital Association
dba Jacksonville Memorial Hospital
1600 West Walnut St
Jacksonville, IL 62650

The face of this license has a colored background • Printed by Authority of the State of Illinois • P.O. #4025001 2M 4/25

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

Exp Date 4/25/2027
Lic Number 0001792

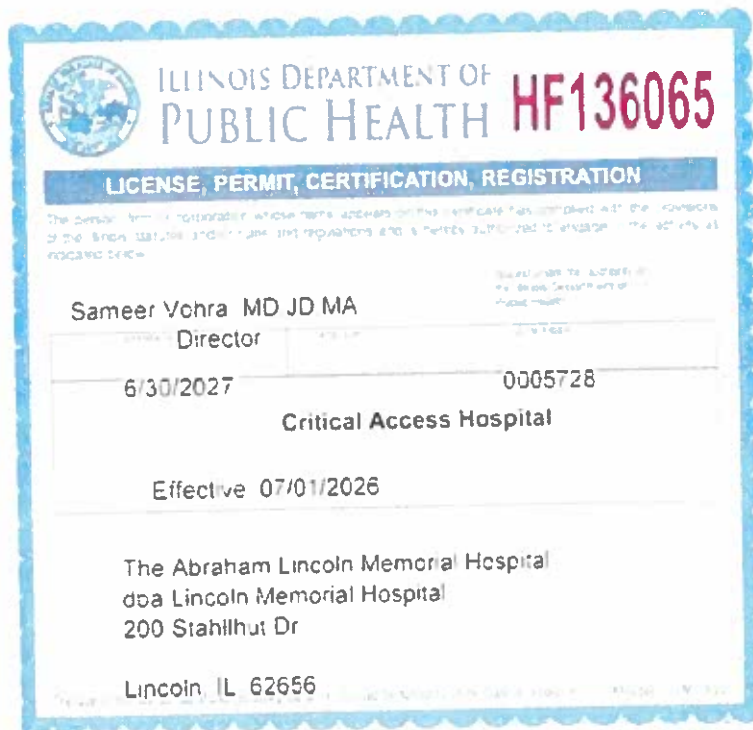
Date Printed 1/27/2026

Passavant Memorial Area Hospital Ass
dba Jacksonville Memorial Hospital
1600 West Walnut St
Jacksonville, IL 62650

FEE RECEIPT NO.

Background of the Applicant
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 11
Background of the Applicant



← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp Date 6/30/2027

Lic Number 0005728

Date Printed 3/25/2026

Vacation Num

The Abraham Lincoln Memorial Hospital
dba Lincoln Memorial Hospital
200 Stahlhut Dr
Lincoln IL 62656

FEE RECEIPT NO

ATTACHMENT 12

Purpose of the Project

Executive Summary

Rehabilitation Institute of Springfield is being proposed to enhance access to intensive inpatient rehabilitation services for HSA 3 residents. Currently, there are too few available and accessible beds in HSA 3, particularly in the most populated Sangamon County area, to ensure that patients in need of intensive post-acute inpatient rehabilitation services are able to receive that level of care. For the relatively small number of patients who are able to access IRF services at Springfield Memorial Hospital, many of those patients are delayed admission because there are simply too few available beds.

Absent a sufficient number of beds, patients in need of IRF services are often forced to choose less-intensive, and therefore less optimal, services such as skilled nursing facility ("SNF") or home health care, or forego needed post-acute care inpatient rehabilitation altogether. Neither of those options is optimal for patient care.

HSA 3 is a large geographic region consisting of 18 central Illinois counties stretching from the state's western border to Springfield. The HSA is currently home to 545,919 residents, with a significant percentage of those ages 65 and over ("65+"). The population ages 65+ is large and growing, projected to increase from 22.6% of HSA 3 population now (2026) to approximately 25% in 2031. The large and growing population ages 65+ is an important indicator of need for the proposed Rehab Institute because that population age cohort is the primary user of IRF services.

Currently, the 18-county HSA is served by two comprehensive physical rehabilitation (IRF) providers: Springfield Memorial Hospital, which has 30 CON-authorized beds and is located in Springfield, Sangamon County in the easternmost portion of the HSA; and Blessing Hospital, which has 18 CON-authorized beds and is located in Quincy, Adams County in the westernmost portion of the HSA and is located approximately 93 straight-line miles away from Springfield Memorial Hospital. Of note is that Springfield Memorial Hospital is only able to utilize 21 IRF beds because of facility limitations, and the majority of those beds (12) are in semi-private rooms.

HSA 3 residents rely on Memorial Health for the type of acute care services that most often require post-acute intensive rehabilitation services such as those proposed by Springfield Rehab Institute. Springfield Memorial Hospital is by far the single largest provider of HSA 3 residents with discharges appropriate for IRF care ("rehab-appropriate" discharges), caring for 41.2% of residents in CY25 who would likely need IRF services upon their acute care hospital discharge. Combined, Memorial's five (5) hospitals care for nearly half (45.5%) of HSA 3 residents' rehab-appropriate discharges.

As a local community-based organization, Memorial Health and its physicians recognize that there are patients discharged from HSA 3 general acute care hospitals in need of inpatient rehab services who are not receiving that care in a timely manner, if at all. Instead, patients are discharged to a less intensive setting such as a SNF or home with home health care services rather than the more appropriate inpatient rehab setting, or are foregoing needed rehab care altogether. This gap in care between what's needed and what has been historically received results in less than optimal care for HSA 3 rehab-appropriate patients, including those who rely on Memorial for health care services.

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

ATTACHMENT 12

Purpose of the Project

The proposed project will ensure that HSA 3 residents have timely access to needed services. Too few beds in HSA 3 means that patients in need of IRF services who are ultimately admitted to an inpatient rehab program must remain in the acute care hospitals longer than necessary while waiting for an IRF bed, negatively impacting both the patient ready for discharge to the inpatient rehab program and patients in need of that occupied general acute care bed (e.g., patients in the Emergency Department, surgical services, observation, etc.). Any delay discharging patients in need of IRF care adversely impacts the patient who needs that physician-prescribed intensive, interdisciplinary rehabilitation and restorative care to recover to their highest level of functioning. Moreover, delays in discharging patients to an IRF program mean that patients in need of general acute care beds are also unnecessarily delayed in receiving needed care.

Absent sufficient number of beds in the service area, patients will continue to be discharged to a less intensive setting such as a skilled nursing facility, remain in the general acute care hospitals unnecessarily long, or forego needed intensive rehab care altogether. The inability of patients in need of intensive inpatient care to receive that care negatively impacts all patients, including patients served by Memorial Health hospitals. Additionally, discharging a patient to a less intensive setting when more intensive services are needed increases the likelihood of readmission for that patient, which not only results in suboptimal outcomes but also increases costs to the patient and the health system as a whole.

Memorial Health has recognized the need for additional beds to meet the needs of HSA 3 residents, thus is partnering with Encompass Health to develop a freestanding 60-bed inpatient rehab hospital easily accessible to area residents. The combination of complementary skills and expertise of Memorial Health, an Illinois, community-based not-for-profit health system and Encompass, a national leader in inpatient rehab care, will ensure that service area residents have available and accessible rehab beds when needed.

The proposed 60-bed inpatient rehab hospital will include:

- All private rooms, including one Individuals of Size ("IoS") Room and one Airborne Infection Isolation Room ("AIIR").
- Well-equipped therapy gym with specialized equipment and an Activities of Daily Living ("ADL") suite;
- Dedicated and extensive outdoor therapy area;
- Dialysis treatment area for patients to remain on-site when dialysis is needed;
- Dedicated dining room and a separate activities / day room for patients and families; and,
- Sufficiently-sized and appropriately-designed support spaces.

The proposed Rehabilitation Institute of Springfield will be located on approximately 5.8 acres of unimproved real property located at 4685 Wabash Avenue, Springfield, Illinois, easily accessible to all residents in HSA 3 as well as to Memorial Health's existing patient population that resides in surrounding areas. The total project cost to develop the new rehab hospital is \$66,263,120. The first patient is expected to be treated on January 1, 2029, with a project completion date estimated as the same.

Memorial Health will discontinue its existing inpatient rehabilitation unit at Springfield Memorial Hospital upon the opening of the proposed new 60-bed facility. A separate Certificate of Exemption ("COE") for discontinuation of Springfield Memorial Hospital's inpatient rehab program will be submitted to the HFSRB at a later date.

ATTACHMENT 12
Purpose of the Project

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

A. Rehabilitation Institute of Springfield will improve the health care of HSA 3 residents.

1. HSA 3 residents depend on Memorial Health for inpatient services.
 - a) The planning area to be served is the 18-county HSA 3.
 - b) Memorial Health is the inpatient market share leader for HSA 3 residents.
 - c) HSA 3 residents rely on Springfield Memorial for inpatient rehabilitation services.
2. The proposed project will address a gap in care for HSA 3 residents.
 - a) Historical utilization demonstrates the gap in care.
 - b) Nursing home and home health care are not appropriate substitutes for IRF services.
3. There is a quantified need for the proposed 60-bed inpatient rehabilitation facility.
4. There are no existing alternatives to the proposed Rehabilitation Institute of Springfield.
 - a) Springfield Memorial Hospital's existing in-hospital rehab unit is not an optimal alternative.
 - b) The single other IRF in HSA 3 is too distant from Springfield's large, aging population to be a viable alternative.
 - c) Distant IRFs located outside HSA 3 are not viable alternatives.
5. Memorial's partnership with Encompass is the optimal solution to meet residents' needs.
 - a) Benefits of a local community-based hospital partnering with a national expert.
 - b) Encompass' quality outcomes are the result of proven programs, services, and facility design.
 - c) Encompass has proven success caring for patients in Illinois.
6. Memorial Health will discontinue offering inpatient rehab services on its Springfield Memorial Hospital campus.

B. The project will address the lack of available and accessible HSA 3 inpatient rehab beds.

C. Sources used in the analyses.

ATTACHMENT 12

Purpose of the Project

A. Rehabilitation Institute of Springfield will improve the health care of HSA 3 residents.

1. HSA 3 residents depend on Memorial Health for inpatient services.

a) *The planning area to be served is the 18-county HSA 3.*

The proposed project will be located in and primarily serve residents of HSA 3, an 18-county planning area anchored by Sangamon County and the Springfield metropolitan area. The HSA's large population (nearly 550,000 residents) is aging, with a projected population ages 65+ of 133,198 in 2031, representing nearly one-quarter (24.7%) of the HSA population – an increase from the current 22.6% of population that is in the population ages 65+ cohort. Of note is that the projected percentage of HSA 3 residents ages 65+ (24.7%) is higher than the statewide percentage of elderly population (22.7%) projected for 2031.

Table 1 HSA 3 Population Ages 65 and Over							
County	Total Population		Pop Ages 65 and Over			65+ Pop as a % of Total Pop	
	2026	2031	2026	2031	% Change	2026	2031
Adams	63,819	62,861	14,593	15,283	4.7%	22.9%	24.3%
Brown	6,988	7,474	1,000	1,206	20.5%	14.3%	16.1%
Calhoun	4,345	4,302	1,202	1,317	9.5%	27.7%	30.6%
Cass	12,490	12,223	2,556	2,755	7.8%	20.5%	22.5%
Christian	32,495	31,443	7,460	7,845	5.2%	23.0%	24.9%
Greene	11,286	10,853	2,689	2,974	10.6%	23.8%	27.4%
Hancock	16,587	15,863	4,654	4,851	4.2%	28.1%	30.6%
Jersey	21,661	21,891	4,965	5,437	9.5%	22.9%	24.8%
Logan	28,446	28,749	5,753	6,048	5.1%	20.2%	21.0%
Macoupin	43,435	42,356	10,607	11,430	7.8%	24.4%	27.0%
Mason	11,580	10,594	2,874	2,646	-7.9%	24.8%	25.0%
Menard	12,374	12,373	2,898	3,371	16.3%	23.4%	27.2%
Montgomery	28,160	28,144	6,546	7,144	9.1%	23.2%	25.4%
Morgan	32,875	32,884	7,318	7,742	5.8%	22.3%	23.5%
Pike	14,395	14,284	3,373	3,401	0.8%	23.4%	23.8%
Sangamon	193,651	191,895	42,245	46,658	10.4%	21.8%	24.3%
Schuyler	6,475	6,145	1,725	1,818	5.4%	26.6%	29.6%
Scott	4,858	4,762	1,144	1,273	11.2%	23.6%	26.7%
HSA 3 Total	545,919	539,094	123,604	133,198	7.8%	22.6%	24.7%
<i>State of IL</i>	<i>12,779,245</i>	<i>12,774,245</i>	<i>2,454,946</i>	<i>2,903,283</i>	<i>18.3%</i>	<i>19.2%</i>	<i>22.7%</i>

Sources: Illinois Department of Public Health, Population Projections Released May 2024.
 Note: Population projections as of July 1 for the specified years.

Sangamon County, home of the proposed project, is by far the most populated county, with its total and population ages 65+ each comprising more than one-third (approximately 35%) of the HSA 3 total and population ages 65+, respectively, now and in 2031.

ATTACHMENT 12

Purpose of the Project

The large and growing population ages 65+ is an important consideration in the evaluation of community need for the proposed project because that age cohort is the primary user of IRF services.

For example, nationally, Medicare Fee-for-Service ("FFS") beneficiaries comprise more than half (51%) of IRF stays.¹ Nationally, Medicare FFS and Medicare Advantage patients combined ("Medicare") comprise approximately 81% of Encompass Health's revenues.² Locally, Medicare patients comprise approximately 67% of Encompass Health's patients in its four (4) Illinois IRFs combined. Similarly, Medicare patients will comprise approximately two-thirds (66.7%) of the proposed Springfield Rehab Institute's patients.

b) Memorial Health is the inpatient market share leader for HSA 3 residents.

HSA 3 residents rely on Memorial Health for the type of acute care services that most often require post-acute intensive rehabilitation services, such as those proposed by Springfield Rehab Institute. As shown below, Springfield Memorial Hospital is by far the single largest provider of HSA 3 residents with rehab-appropriate discharges, caring for 41.2% of residents in CY25 who would likely benefit from IRF services upon their acute care hospital discharge. Combined, Memorial's five (5) hospitals care for nearly half (45.5%) of HSA 3 residents' rehab-appropriate discharges.

Table 2 <i>HSA 3 Residents Rely on Memorial Health for Inpatient Care</i> <i>HSA 3 Residents' Rehab-Appropriate Discharges, CY25</i>		
Hospital	Discharges	% of Total
MH SPRINGFIELD MEMORIAL	6,051	41.2%
HSJS ST JOHNS	3,980	27.1%
BLESSING HOSPITAL	2,590	17.6%
ALTON MEMORIAL HOSPITAL	265	1.8%
MH JACKSONVILLE MEMORIAL	299	2.0%
MH DECATUR MEMORIAL	219	1.5%
OSF ST FRANCIS	145	1.0%
JERSEY COMMUNITY HOSPITAL	144	1.0%
HSJS ST FRANCIS LITCHFIELD	136	0.9%
OSF ST ANTHONYS ALTON	118	0.8%
ILLINI COMMUNITY HOSPITAL PITTSFIELD	118	0.8%
MH TAYLORVILLE MEMORIAL	53	0.4%
MH LINCOLN MEMORIAL	51	0.3%
All Others	508	3.5%
Total	14,677	100.0%
<i>Memorial Health Hospitals</i>	<i>6,673</i>	<i>45.5%</i>
Source: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database.		

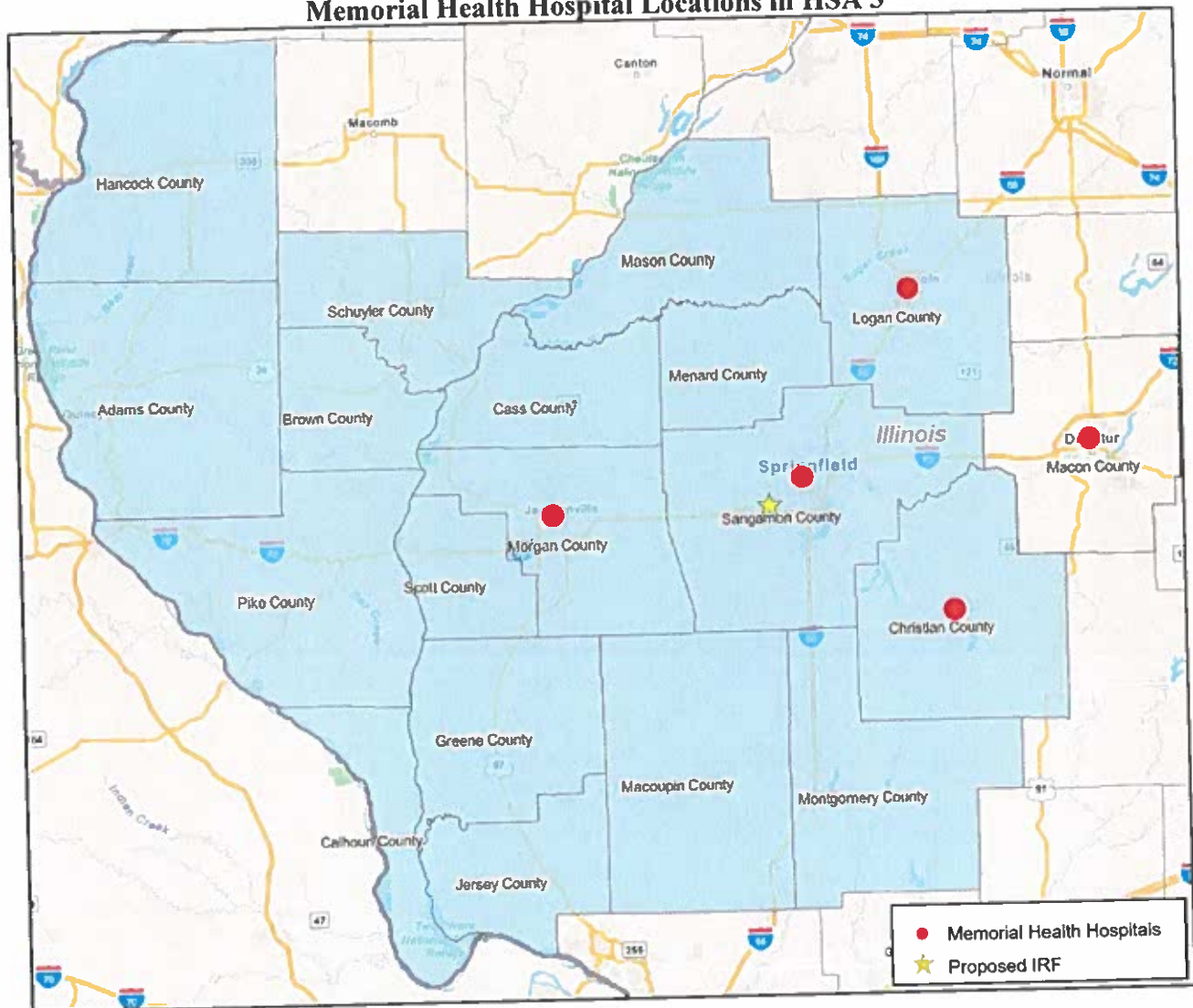
¹ Source: Report to the Congress: Medicare Payment Policy, Medicare Payment Advisory Commission (MedPAC), March 2026.

² Source: Encompass Health Investor Reference Book, Published June 25, 2025; available at <https://investor.encompasshealth.com/overview/default.aspx>.

ATTACHMENT 12 **Purpose of the Project**

The reliance of HSA 3 residents on Memorial hospitals for their healthcare service is due to many factors, including for example quality of care, relationships with physicians, and array of services offered. The location of Memorial Health hospitals is also an important consideration in terms of Memorial's accessibility and availability to its community members. The following map shows Memorial Health's hospital locations across HSA 3, which is highlighted in blue for ease of reference.

Figure 1
Memorial Health Hospital Locations in HSA 3



Source: ArcGIS.

Also of note, the location of the proposed Rehabilitation Institute of Springfield is shown on the map. The proposed IRF will be easily accessible for all HSA 3 residents and the greater Springfield area because of its close proximity and easy access to Interstates 72 and 55 as well as State Roads 97 and 29.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

In total, Memorial Health hospitals have 855 licensed inpatient beds and a comprehensive array of healthcare services. Thus, it is no surprise that HSA 3 residents rely on Memorial Health for their inpatient healthcare needs, including for services for which patients oftentimes would benefit from post-acute inpatient rehabilitation care.

- **Springfield Memorial Hospital (Springfield, Sangamon County):** A 500-bed, Level I Trauma Center and teaching hospital affiliated with SIU School of Medicine since 1970. Designated by The Joint Commission as a Comprehensive Stroke Center, the hospital houses Memorial Heart and Vascular Services, Memorial Rehab Services (CARF-accredited inpatient rehab), a Regional Cancer Center, a Regional Burn Center, Orthopedic Services, Memorial Behavioral Services, and Memorial Transplant Services. The hospital has earned four consecutive Magnet® designations for nursing excellence, and its Echocardiography and Vascular labs are Intersocietal Accreditation Commission accredited. U.S. News rates SMH high performing in spinal fusion, hip and knee replacement, and gynecological cancer surgery.
- **Decatur Memorial Hospital (Decatur, Macon County, HSA 4):** A 280-bed, Level II Trauma Center affiliated with Memorial Health System since a 2019 merger. It has more than 2,300 employees and roughly 300 physicians on staff.
- **Jacksonville Memorial Hospital (Jacksonville, Morgan County):** A 25-bed critical access hospital (formerly Passavant Area Hospital), primarily serving Morgan, Cass, Scott, Greene, and Brown counties since 1875. A twice-designated Magnet hospital, Jacksonville Memorial Hospital offers outpatient services including rehabilitation therapy and behavioral health, and is the largest employer in Jacksonville with roughly 900 employees and a 70-physician medical staff.
- **Taylorville Memorial Hospital (Taylorville, Christian County):** A 25-bed critical access hospital serving Taylorville and Christian County since 1906. It offers a Swing Bed program (round-the-clock step-down/skilled nursing care) and outpatient nursing services such as wound care, IV therapies, and immunizations.
- **Lincoln Memorial Hospital (Lincoln, Logan County):** A 25-bed critical access hospital (formerly Abraham Lincoln Memorial Hospital), built in 2011 and serving Logan and eastern Mason counties. The hospital offers inpatient, outpatient, home health, hospice, behavioral health, and primary care services, and has earned recognitions including CHIME's "Most Wired" Level 7 certification and back-to-back ANCC Pathway to Excellence® designations.

As the flagship hospital within Memorial's system, Springfield Memorial provides comprehensive, tertiary-level services for patients who oftentimes need and would benefit from intensive inpatient post-acute care rehabilitation services such as those proposed by the Springfield Rehab Institute. As shown below, Springfield Memorial's rehab-appropriate patients reside throughout the HSA (highlighted for ease of review), with the majority of the patients coming from the most populated and proximate counties to its hospital.

ATTACHMENT 12

Purpose of the Project

Table 3 Springfield Memorial Hospital Rehab-Appropriate Discharges, CY25		
County (HSA 3 highlighted)	Discharges	% of Total
Sangamon	3,569	52.7%
Morgan	496	7.3%
Macon	446	6.6%
Christian	428	6.3%
Logan	339	5.0%
Menard	279	4.1%
Macoupin	231	3.4%
Cass	166	2.4%
Montgomery	163	2.4%
Mason	110	1.6%
Greene	79	1.2%
Scott	70	1.0%
Shelby	56	0.8%
McDonough	40	0.6%
Adams	37	0.5%
Pike	36	0.5%
Moultrie	26	0.4%
DeWitt	23	0.3%
Schuyler	23	0.3%
McLean	19	0.3%
Fulton	17	0.3%
Brown	14	0.2%
Madison	13	0.2%
Champaign	11	0.2%
Peoria	11	0.2%
Hancock	10	0.1%
All Other Counties	66	1.0%
Total	6,778	100.0%
<i>HSA 3 Counties</i>	<i>6,051</i>	<i>89.3%</i>
Source: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database. Notes: SMH HSA 3 discharges include one patient from Calhoun County not shown above. Discharges exclude expired patients and patients discharged to hospice, long-term care, custodial care, psychiatric services, and swing beds.		

ATTACHMENT 12

Purpose of the Project

The proposed Rehab Institute expects to similarly serve patients from throughout HSA 3, but with the majority of those patients coming from the more populated and proximate counties to Springfield, e.g., Sangamon, Morgan, Christian, and Logan. Notably, those same counties are home to Memorial Health hospitals.

c) HSA 3 residents rely on Springfield Memorial for inpatient rehabilitation services.

Springfield Memorial Hospital has an existing IRF that cares for patients from throughout HSA 3, demonstrating the reliance that patients in HSA 3 have on the hospital for acute care *and* post-acute care services. For example, in CY2025, approximately 78% of SMH's IRF patients were from HSA 3 counties, with residents of the contiguous Macon County comprising an additional 16% of the hospital's inpatient rehabilitation patients.

The importance of SMH's IRF to the planning region's patients and families is further demonstrated by the unit's YTD26 average daily census (ADC) of 15.3 patients, which is a YTD occupancy of 73.1% of operational beds. As shown below, despite SMH's IRF being comprised primarily of semi-private beds, the hospital unit has consistently been well-utilized, reaching maximum capacity each year since 2023.

Table 4 Springfield Memorial Hospital Comprehensive Physical Rehabilitation Utilization				
Utilization	CY23	CY24	CY25	YTD26
Beds Set up & Staffed	21	21	21	21
Inpatient Days	6,081	6,153	5,417	2,778
Admissions	459	439	401	198
ALOS	13.2	14.0	13.5	14.0
ADC	16.7	16.8	14.8	15.3
Occupancy	79.3%	80.1%	70.7%	73.1%
Peak Daily Census	21	21	21	21
Source: 2023-2025 Annual Hospital Questionnaires and internal YTD26 data (through June). Note: CY24 ADC and occupancy are based on 366 days because 2024 was a Leap Year.				

As noted previously, Springfield Memorial Hospital is only able to utilize 21 of its 30 licensed IRF beds because of facility limitations. Of the 21 operational beds, 12 are in semi-private rooms, with the remaining nine (9) beds in private rooms. None of the patient rooms have a bath or shower; only a toilet and sink are in the rooms. Moreover, all rooms, particularly the semi-private rooms, are undersized. As one would expect, patients' family members cannot stay overnight in any of the semi-private rooms if both beds are occupied.

Moreover, because of facility limitations, the IRF's gym is located on a different floor than patient rooms, which is less than optimal for transport of patients and staff efficiencies. Beyond its location on a different floor, the gym's design is negatively impacted by SMH's structural limitations. For example, the ceiling of the gym has structural limitations, so that it is not strong enough to support an overhead track, which would benefit patients and staff by providing assistance to patients relearning to walk.

ATTACHMENT 12

Purpose of the Project

Because of SMH's semi-private rooms, SMH must consider the patient's gender, age, medical condition and/or complexity, care intensity and/or equipment needs, infection control status, and visitor patterns before admission. Thus, there are inherent limitations and delays in admissions for a unit such as SMH's that has a relatively high number and percentage of semi-private rooms.

Delayed admissions negatively impact patients in need of the prescribed intensive inpatient therapy. Unfortunately, the percentage of patients delayed admission at SMH's IRF is material and increasing, with approximately 10% of IRF admissions delayed in FY25 increasing to approximately 12% this year to-date (FYTD26). The increasing delayed admissions demonstrates that there are too few IRF beds available in HSA 3 to timely admit patients in need of intensive inpatient rehabilitation care.

Notably, despite SMH IRF's facility limitations and admission delays, the hospital provides high quality IRF services, as demonstrated by the following quality metrics from the Centers for Medicare & Medicaid Services (CMS) Care Compare³ website.

Table 5 Springfield Memorial Hospital's IRF Provides High Quality Care		
	Springfield Memorial Hospital	National Average
Successful return to home or community <i>(higher is better)</i>	73.25%	67.29%
Rate of potentially preventable hospital readmissions 30 days after discharge from an IRF <i>(lower is better)</i>	7.98%	9.21%
Rate of potentially preventable hospital readmissions during the IRF stay <i>(lower is better)</i>	3.82%	4.74%
Source: Medicare.gov Care Compare website. Data shown for 10/01/2022 – 09/30/2024, the most recent data available as of August 19, 2026. https://www.medicare.gov/care-compare/details/inpatient-rehabilitation/14T148?city=Springfield&state=IL&zipcode=		

The proposed JV partnership with Encompass will ensure that HSA 3 patients continue to receive high quality IRF services in Springfield, and can do so in a timely manner because the new 60-bed facility will have a sufficient number of beds, all of which will be private rooms with private baths adequately sized for patients and families.

³ Source: Medicare.gov Care Compare website as of August 19, 2026. <https://www.medicare.gov/care-compare/details/inpatient-rehabilitation/14T148?city=Springfield&state=IL&zipcode=>

ATTACHMENT 12

Purpose of the Project

2. The proposed project will address a gap in care for HSA 3 residents.

a) *Historical utilization demonstrates the gap in care.*

The inability of patients to access needed IRF services in a timely manner, if at all, is demonstrated not only by the delays facing patients admitted to SMH's IRF, but also by the abysmally low utilization rates of inpatient rehab services for HSA 3 residents, which illustrates that too few beds are available for patients in need.

As shown in the following table, HSA 3 residents are utilizing IRF services at significantly lower rates than Illinois and the nation. For example, Sangamon County's Medicare residents' rate of inpatient rehab discharge is approximately one-third (36%) of the statewide rehab discharge rate (4.3 discharges for Sangamon County residents divided by 11.8 discharges statewide). Of note is that many counties did not have enough residents' IRF discharges to report, as reflected by zero (0) discharges per 1,000 Medicare FFS beneficiaries.

Table 6
IRF Discharges per 1,000 Medicare FFS Beneficiaries by Year

HSA 3 Counties	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2024 County Rate as % of State Rate
Adams	12.5	13.5	13.6	11.6	11.6	12.0	10.1	13.0	13.2	9.7	12.3	104%
Brown	0.0	0.0	0.0	0.0	18.9	0.0	0.0	0.0	0.0	0.0	0.0	--
Calhoun	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	--
Cass	0.0	0.0	0.0	6.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	--
Christian	5.1	5.3	4.8	5.0	3.9	6.3	4.7	3.0	4.5	3.0	0.0	--
Greene	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	--
Hancock	4.5	6.3	5.7	5.0	7.3	4.9	6.2	5.1	6.4	6.8	6.6	56%
Jersey	4.3	5.3	7.4	5.7	4.9	5.3	6.3	4.9	7.5	6.8	10.7	90%
Logan	4.9	4.5	2.9	3.6	4.9	3.2	3.9	5.4	0.0	0.0	3.7	32%
Macoupin	5.6	4.6	6.3	4.1	5.4	4.0	4.6	5.8	6.8	8.0	8.5	72%
Mason	0.0	0.0	0.0	6.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	--
Menard	0.0	0.0	7.0	0.0	0.0	0.0	0.0	11.2	0.0	0.0	0.0	--
Montgomery	2.4	2.9	2.5	2.9	0.0	3.1	0.0	2.6	0.0	2.6	4.0	34%
Morgan	2.7	3.7	3.0	4.6	5.1	4.7	4.1	2.9	0.0	2.7	4.2	35%
Pike	7.8	6.8	8.4	4.8	12.3	6.3	11.0	7.8	9.4	6.4	9.7	82%
Sangamon	5.1	5.6	5.1	5.8	5.3	5.1	5.5	5.6	5.0	4.4	4.3	36%
Schuyler	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	--
Scott	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	--
Statewide Avg	11.8	11.7	11.3	10.9	10.8	10.7	9.5	9.7	10.0	11.2	11.8	N/A
National	10.9	11.0	10.9	11.0	11.3	11.5	10.5	11.1	11.9	13.4	14.7	N/A

Source: CMS Geographic Variation Public Use File.

Note: CMS suppresses values when total users are less than 11; thus, the counties where no IRF discharges are shown are less than 11 discharges for all Medicare FFS beneficiaries in that county, if any at all.

ATTACHMENT 12

Purpose of the Project

The significant disparity between HSA 3 counties' inpatient rehab discharge rates and the state as a whole (as well as the nation) demonstrates a gap in care for HSA 3 patients in need of intensive inpatient rehab care. This gap in care is consistent with SMH's experience in patients' admissions being delayed, if at all, because they have too few available IRF beds.

As shown in the table above, the gap in care is not a new phenomenon for service area residents. Rather, the gap in care is long-term and increasing, as demonstrated for example, by the increasing gap in IRF utilization for Sangamon County residents which has increased from 43.2% of the statewide average (5.1 ÷ 11.8) and 46.7% of the national average (5.1 ÷ 10.9) in 2014, respectively, to 36.4% of the statewide average (4.3 ÷ 11.8) and 29.3% of the national average (4.3 ÷ 14.7), respectively. Absent approval of additional IRF beds, the historical gap between Sangamon County's IRF utilization rates and state and national rates will only increase (worsen) as the county and surrounding area's population ages.

Given that there are too few IRF beds available to the HSA 3 population, the question then becomes "Where are patients getting post-acute rehabilitation services, if they receive that care at all?". As shown below, HSA 3 Medicare FFS beneficiaries are utilizing SNF services at proportionately higher rates than residents in Illinois overall and when compared to the national average. Please note that the data is provided only for the counties in which there are sufficient numbers of IRF discharges for CMS to publish the data.

Table 7 SNF Discharges per 1,000 Medicare FFS Beneficiaries, 2024		
HSA 3 Counties	2024	Ratio: SNF to IRF
Adams	64.0	5.20
Hancock	63.3	9.55
Jersey	54.7	5.13
Logan	65.4	17.50
Macoupin	55.9	6.55
Montgomery	64.4	16.06
Morgan	56.1	13.50
Pike	55.4	5.71
Sangamon	55.7	13.07
Statewide Avg	58.4	4.94
National	50.7	3.46
Source: CMS Geographic Variation Public Use File. Notes: CMS suppresses values when total users are less than 11; thus, the counties where no IRF discharges are shown are less than 11 discharges for all Medicare FFS beneficiaries in that county, if any at all. Ratios may not calculate exactly as shown due to rounding.		

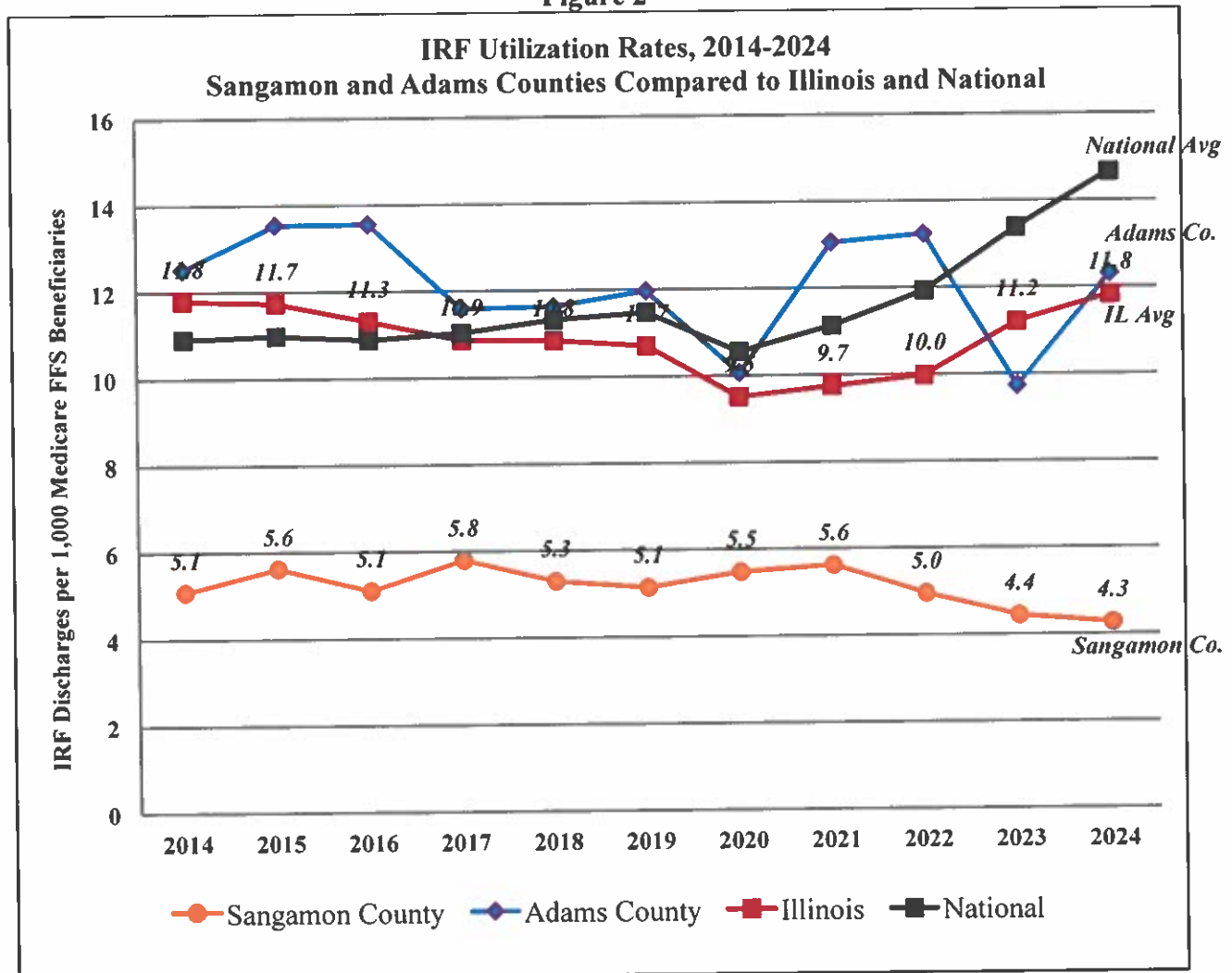
ATTACHMENT 12

Purpose of the Project

As demonstrated above, Sangamon County residents' ratio of SNF to IRF usage (13.07) is significantly higher than Adams County residents using of SNF to IRF (5.20), which is more closely aligned with the statewide ratio of 4.94 SNF to IRF utilization for Medicare FFS patients. The distinct differences between accessibility to IRF services for residents in Sangamon County and residents in Adams County is noteworthy because both of those counties are the home counties of IRF providers.

As shown below, Adams County residents, home of Blessing Hospital's 18-bed IRF, have significantly greater access and utilization of IRF services than residents in Sangamon County, as reflected by Medicare FFS beneficiaries' discharge rates.⁴ The annual IRF utilization numbers for the two HSA 3 counties that are home to the two HSA 3 IRF providers are shown on the graph.

Figure 2



Source: CMS Geographic Variation Public Use File.

⁴ As noted previously, Medicare FFS beneficiaries are the largest users of IRF services, thus is an appropriate indicator of need for the proposed service. Moreover, Medicare FFS data is publicly-available at the county level by post-acute care setting, thus can be compared across setting, years, and geographic areas.

ATTACHMENT 12

Purpose of the Project

As demonstrated above, there is a gap in care between Sangamon County residents IRF utilization and Adams County, Illinois, and the Nation. The 60-bed Rehab Institute is being proposed to address this gap in care so that residents in and around Sangamon County have available and accessible IRF beds when needed.

b) Nursing home and home health care are not appropriate substitutes for IRF services.

The lack of available and accessible IRF beds in the HSA means patients are oftentimes forced to choose less intensive (and therefore less optimal) post-acute care services such as a SNF or home health services in lieu of inpatient rehab when intensive inpatient rehab care is needed. The distinct differences between SNF and home health post-acute care services and the proposed, more intensive IRF services follow. As documented, these post-acute care services are not appropriate substitutes for the proposed IRF services to be provided at Rehabilitation Institute of Springfield.

The differences between comprehensive inpatient rehab services in an IRF and therapies offered in a SNF are illustrated below. As shown, two significant differences are the much higher number of therapy hours per day that a patient receives in the IRF setting compared to a SNF and the involvement and direction of a physician leading the multidisciplinary team. The national data demonstrate that IRFs have a much higher rate of patients discharged to the community than SNFs, with IRFs returning approximately 68% of their patients to the community and SNFs returning approximately 52%. Patients who receive care at an Encompass Health facility are even more likely to be discharged back to their community, with Encompass discharging approximately 70% of its Medicare FFS patients to their home or community.

Figure 3

	Inpatient Rehabilitation Hospital 	Nursing Home 
Required by Medicare		
Minimum Stay at the Acute	None	3 days
Physician Visits	Min. 3 times per week	Min. ~1x/month or every 30 days
Rehabilitation Program	Min. 3 hours per day, 5 days a week or 15 hours over 7 days	Not required
Multi-Disciplinary Team Approach/ Coordinated Program of Care	Required	Not required
MD or DO Rehabilitation Director	Required	Not required
RN Oversight and Availability	24 hours per day	Min. 8 consecutive hours per day
Nursing Training and Expertise	Rehabilitation Specialty Expertise	None
Discharge to Community (Industry Avg.)	67.5%	51.5%
	Encompass Health 70.3%	

Sources & Notes: CMS regulations; Encompass Health CY25 data; and Report to the Congress: Medicare Payment Policy (MedPAC), March 2026. Inpatient Rehabilitation Hospital and SNF discharges to community (industry avg.) based on most recent CMS data available, reflecting the national median risk-standardized rates of successful discharge to the community for FY23 and FY24 combined. Data exclude readmissions within 30 days. Encompass Health's discharge data (calculated from CMS data and also excluding readmissions within 30 days) reflects CY25 data.

ATTACHMENT 12

Purpose of the Project

That same 2026 MedPAC report found that 10.7% of Medicare SNF patients experienced potentially avoidable re-hospitalizations during their patient stay compared with 9.2% of Medicare IRF patients.⁵

The differences between the comprehensive IRF setting and the nursing home setting is also documented by a 2014 study which found that “when patients are matched on demographic and clinical characteristics, rehabilitation in IRFs leads to lower mortality, fewer readmissions and ER visits, and more days at home (not in a hospital, IRF, SNF or LTCH) than rehabilitation in SNFs for the same condition. **This suggests that the care delivered is not the same between IRFs and SNFs. Therefore, different post-acute care settings affect patient outcomes.**”⁶ [Emphasis added.] Although SNFs play an important role in post-acute care, less intensive SNF rehabilitation services are not an appropriate substitute for the more comprehensive, intensive inpatient rehabilitation care provided in an IRF when such intensive inpatient rehabilitation care is needed.

A number of other highly-regarded studies have also demonstrated that not only do a variety of patients receive significant benefit from intensive medical rehabilitation services after a general acute care stay, but that comparatively intensive medical rehabilitation services provided in a comprehensive IRF are superior to the care provided in other post-acute care settings.

The *American Heart Association/American Stroke Association's 2016 Guideline for Adult Stroke Rehabilitation and Recovery* makes it clear that patients who have suffered from a stroke have the best chance to achieve their full potential if they receive sustained and coordinated rehabilitation care. Notably, the research also recognizes that though inpatient rehabilitation services may in the short term be more costly than other post-acute services, the positive clinical results of IRF services such as reduced downstream medical morbidity and additional costs associated therewith must be considered. These guidelines have been endorsed by the American Academy of Physical Medicine and Rehabilitation and the American Society of Neurorehabilitation. Excerpts from the study follow.

“Results: Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient and his or her goals, family and friends, other caregivers (eg, personal care attendants), physicians, nurses, physical and occupational therapists, speech-language pathologists, recreation therapists, psychologists, nutritionists, social workers, and others. Communication and coordination among these team members are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline. Without communication and coordination, isolated efforts to rehabilitate the stroke survivor are unlikely to achieve their full potential.

Conclusions: As systems of care evolve in response to healthcare reform efforts, post acute care and rehabilitation are often considered a costly area of care to be trimmed but without recognition of their clinical impact and ability to reduce the risk of downstream medical morbidity resulting from immobility, depression, loss of autonomy, and reduced functional independence. The provision of comprehensive rehabilitation programs with adequate resources, dose, and duration is an essential aspect of stroke care and should be a priority in these redesign efforts.” (Stroke. 2016;47:e98-e169. DOI: 10.1161/STR.0000000000000098.)

⁵ See MedPAC March 2026 Report to Congress, available at <https://www.medpac.gov/document/march-2026-report-to-the-congress-medicare-payment-policy/>.

⁶ Source: Joan E. DaVanzo, Ph.D., M.S.W., Al Dobson, Ph.D., Audrey El-Gamil, Justin W. Li, and Nikolay Manolov, Ph.D.; Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities and After Discharge; 2014.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

Specific to Encompass, the importance of caring for stroke patients (among other patient types as well) is illustrated by Encompass' **national partnership with the American Heart Association/American Stroke Association** to increase patient independence after a stroke and reduce stroke mortality through community outreach and information campaigns. Encompass entered into this multi-year project to accelerate adoption of the AHA/ASA Stroke Rehabilitation Guidelines, increase patient awareness of post-stroke options, and provide practical support to patients and their families to improve recovery outcomes.

The benefits of rehabilitative care following injury was the focus of research by the University of Washington in conjunction with the State of Washington's Department of Health. The research, titled "*Acute Rehabilitation after Trauma: Does it Really Matter?*", demonstrated improved functional outcomes of injured patients following admission at designated trauma rehabilitation services in Washington as well as the positive impact inpatient rehabilitation services have on improving functional outcomes and limiting disabilities for trauma patients. The relevance of this research is that Encompass provides a wide array of services to patients, including those who have experienced severe trauma. Encompass' wide array of services to patients in need of intensive inpatient rehab is distinctly different than SNFs (and home health) providers. Excerpts from the study follow.

"Trauma is the most common cause of significant functional impairment, disability, and mortality worldwide. According to the CDC, the annual work-lost cost in the United States for injured patients who survive to hospital discharge is an astonishing \$150 billion. These injured patients are typically motivated and productive members of society who almost universally desire recovery of functional independence and return to community living and work. Helping them regain their functional independence has the potential to improve their quality of life considerably, and also decrease the socioeconomic impact of their injuries. The care of these injured patients does not end on discharge from the acute care hospital, and many of these patients require ongoing rehabilitation after discharge. This rehabilitation can occur in one of several settings, including an inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), or in the outpatient setting.

Our data would suggest that post-discharge care at an IRF rather than a SNF has the potential to profoundly improve functional outcomes for acutely injured patients.

Conclusions: Acute trauma patients should be recognized as an underserved population that would benefit considerably from inpatient rehabilitation services after discharge from the hospital." (J Am Coll Surg 2016;223:755e763.© 2016 by the American College of Surgeons. Published by Elsevier Inc. All rights reserved.)

An additional study, published on the Journal of the American Medical Association ("JAMA") Network Open, compared functional status improvements of stroke patients receiving post-acute care at IRFs (or IRFs) to SNFs. The findings were similar to the previously-cited AHA/ASA Guidelines: inpatient rehabilitation in IRFs for patients with stroke was associated with substantially improved physical mobility and self-care function compared with rehabilitation in SNFs. Excerpts from the study follow.

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

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." (JAMA Network Open. 2019;2(12):e1916646. doi:10.1001/jamanetworkopen.2019.16646.)

ATTACHMENT 12

Purpose of the Project

The consistent findings in the above referenced research are that patients receiving post-acute care in a IRF setting while recovering from an acute injury or stroke display higher levels of functionality and reduced disabilities than patients receiving services in other post-acute care environments, including SNFs.

While SNFs most definitely have an important role as a post-acute care provider, the inappropriate substitution of less intensive SNF rehab services for the more comprehensive, intensive inpatient rehab care provided in a IRF when intensive inpatient rehab care is needed and a patient can participate in and benefit from same, is not one of them.

Home Health Care is Not a Substitute for IRF Services

The very nature of IRF services compared to SNF is a primary reason for the different outcomes, *i.e.*, the more intensive and specialized care the patient receives, the higher the likelihood the patient will recover more functionality, all things being equal. Thus, when comparing IRF to home health care and the complete absence of intensive therapy three hours per day (at least five days per week) and lack of specialized equipment (such as an overhead track system to help the patient recover his/her gait and balance while on a treadmill or specially-designed platforms; virtual reality augmented sEMG biofeedback technology that enables patients to relearn how to swallow; or a robot that assists in improving motor control and motor skills of a patient's arms and hands following a stroke or injury), it is clear that patients undergoing intensive inpatient rehabilitation therapy will regain more function and independence than comparable patients receiving intermittent, less intensive therapy at home without specialized equipment and staff.

ATTACHMENT 12

Purpose of the Project

3. There is a quantified need for the proposed 60-bed inpatient rehabilitation facility.

The following analysis quantifies the number of HSA 3 patients who should have received rehab services but were unable to receive that optimal level of care, regardless of the reason.

First, the number of relevant or rehab-appropriate discharges for HSA 3 residents was determined. For the most recent 12-month period (CY2025), HSA 3 residents had a total 14,677 rehab-appropriate discharges from any hospital, regardless of hospital location (*i.e.*, includes hospitals outside of HSA 3). The number of HSA 3 rehab-appropriate discharges for 2031 was projected using the historical actual growth of rehab-appropriate discharges for the most recent three full calendar years (2023 – 2025). As shown below, the projected 2031 HSA 3 rehab-appropriate discharges is 20,585.

Next, the expected discharge rate to inpatient rehab was applied to the projected HSA 3 CY2031 rehab-appropriate discharges to determine the HSA 3 patients who needed, and thus would benefit from, inpatient rehab services. This 8% target rate is based on Encompass' experience in the Central US market, which is a reasonable basis to project patients in need of inpatient rehab services. Moreover, this same 8% target discharge rate was used in two prior Encompass CON applications approved by this Board: The Rehabilitation Institute of Southern Illinois, LLC Project No. 19-021 (HSA 11) and The Quad Cities Rehabilitation Institute, LLC Project No. 19-059 (HSA 10). A third Encompass application was approved using an 8.3% target discharge rate: Encompass Health Rehabilitation Hospital of Libertyville, LLC Project No. 19-036 (HSA 8). Thus, the 8% target discharge rate is reasonable, with the same or a slightly higher target discharge rate accepted in prior applications.

Of note is that the following bed need methodology is the same methodology that was used in all three approved Encompass applications for new freestanding IRFs.

Because Memorial Health and other HSA 3 hospitals care for patients residing outside HSA 3, an in-migration factor of 10% was used to determine total patients in need of rehab services. This in-migration rate reflects the in-migration of rehab-appropriate discharges at the three HSA 3 hospitals with the highest rehab-appropriate discharges in CY25, *i.e.*, Springfield Memorial, HSHS St. John's and Blessing Hospital. (See Table 2 above.)

As shown in the following table, there is a projected need for **34 additional inpatient rehab beds** to be located in and serve the residents in HSA 3. The proposed project will be comprised of 60 beds, 30 new, additional beds in the HSA and 30 beds contributed by Memorial Health. Thus, there is a projected need for more beds than the Applicants propose to add to HSA 3.

Calculations follow.

ATTACHMENT 12

Purpose of the Project

Table 8 Projected Rehab Bed Need Based on HSA 3 Discharges from All Hospitals & In-Migration to HSA 3, CY2031	
Calculations	2031 Need
HSA 3 Residents' Rehab-Appropriate Discharges	20,585
<i>Multiplied by Expected (or Target) Discharge Rate to Inpatient Rehab</i>	8.0%
<i>Equals Estimated HSA 3 Residents Discharged from Acute Care in Need of Rehab Bed</i>	1,647
<i>Multiplied by In-migration Factor (based on 3 largest HSA 3 hospitals' in-migration)</i>	10.0%
<i>Equals Estimated In-migration Discharges</i>	165
<i>Total Estimated HSA 3 Discharges in Need of Rehab Bed</i>	1,811
<i>Multiplied by CY2025 Illinois Statewide Rehab Average Length of Stay</i>	14.0
<i>Equals Projected Rehab Patient Days in Need of Rehab Bed</i>	25,360
<i>Divided by Calendar Days</i>	365
<i>Equals Inpatient Rehab Bed Need @ 100% Occupancy</i>	69.5
<i>Divided by Target Occupancy Factor</i>	85.0%
<i>Equals Gross Bed Need @ 85% Target Occupancy</i>	82
<i>Minus Existing Licensed Rehab Beds in HSA 3 (including SMH's 30 licensed beds)</i>	48
<i>Equals Net Bed Need, HSA 3</i>	34
Sources: Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database, CY2023-CY2025; and HFSRB 2025 Illinois Statewide Hospital Summary. Notes: numbers may not calculate exactly as shown due to rounding. The existing beds include 30 licensed beds at Springfield Memorial Hospital and 18 licensed beds at Blessing Hospital. SMH will delicense its 30 beds upon opening of the proposed new facility.	

Clearly, the proposed project is needed to meet the inpatient rehab needs of HSA 3 residents and the greater Springfield area's residents who depend on Memorial Health hospitals for their healthcare needs. As discussed above, the analysis is based on the following assumptions:

- Rehab-appropriate discharges exclude expired patients and patients discharged to hospice, long-term care, custodial care, psychiatric services, and swing beds.
- The 8% target rehab discharge rate for HSA 3 patients is based on Encompass' experience in the U.S. Central Region, a multistate area including Illinois and five other states, and the approved three (3) CON applications to establish new freestanding hospitals in HSAs 8, 10, and 11.
- The majority of discharges (approximately 90%) driving the need for the new facility are from the HSA 3 service area, with an additional approximate 10% expected to be for residents in-migrating to the proposed inpatient rehabilitation hospital for care.

The forecasted utilization of the new 60-bed hospital further supports the need for the project, as demonstrated on the following page.

ATTACHMENT 12

Purpose of the Project

Table 9 Rehabilitation Institute of Springfield Projected Utilization		
Indicator	Year 1	Year 2
Discharges	935	1,347
Patient Days	11,610	16,718
Average Daily Census	31.8	45.8
Occupancy	53.0%	76.3%

Rehabilitation Institute of Springfield recognizes that the documented gap in care and its quantified need for additional beds in HSA 3 differs from the Board's numeric need projection, shown below for ease of review. The difference is primarily due to the Applicants' use of a target utilization (discharge rate) of rehab-appropriate patients in need of IRF services compared to the HFSRB's use of historical utilization as an indicator of future need. In short, the Applicants focus on and attempt to quantify the *gap in care* between need and historical utilization of IRF services while the Board's methodology equates historical utilization with future need.

Figure 4

STATE SUMMARY REVISED BED NEED DETERMINATIONS 05/031/2026					
REHABILITATION BEDS					
REHAB SERVICE AREA	APPROVED EXISTING BEDS	CALCULATED BED NEED	ADDITIONAL BEDS NEEDED	EXCESS REHAB BEDS	
HSA 1	65	65	0	0	
HSA 2	64	40	0	24	
HSA 3	48	35	0	13	
HSA 4	60	52	0	8	
HSA 5	40	32	0	8	
HSA 6	563	410	0	153	
HSA 7	476	395	0	81	
HSA 8	145	88	0	57	
HSA 9	99	97	0	2	
HSA 10	40	15	0	25	
HSA 11	84	33	0	51	
ILLINOIS TOTAL	1,684	1,262	0	422	

Source: IDPH Monthly Hospital Inventory Update, May 2026; HFSRB, Department of Public Health.

ATTACHMENT 12

Purpose of the Project

4. There are no existing alternatives to the proposed Rehabilitation Institute of Springfield.

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

As mentioned previously, Springfield Memorial Hospital operates fewer inpatient rehab beds (21) than for which it is licensed (30), which negatively impacts HSA 3 residents' accessibility to needed inpatient rehab services. Of the 21 operational beds, 12 are in semi-private rooms, with the remaining nine (9) beds in private rooms. None of the patient rooms have a bath or shower; only a toilet and sink are in the rooms. All patient rooms, particularly the semi-private rooms, are undersized. As one would expect, patients' family members cannot stay overnight in any of the semi-private rooms if both beds are occupied.

The unit is located on the third floor of the main hospital tower in space originally designed and constructed for general medical/surgical patients. Moreover, the hospital itself was designed and constructed in the late 1960's so is nearly 60 years old. The use of renovated, outdated space to house specialty inpatient rehab services contrasts significantly with the proposed construction of a new state-of-the-art freestanding rehab hospital designed and built solely to care for patients in need of inpatient rehab services.

Because of facility limitations, the IRF's gym is located on a different floor than patient rooms, which is less than optimal for transport of patients and staff efficiencies. Beyond its location of a different floor, the gym's design is negatively impacted by SMH's structural limitations. For example, the ceiling of the gym has structural limitations that do not allow for an overhead track to be installed, which would benefit patients and staff by providing assistance to patients relearning to walk.

Beyond the facility limitations mentioned above, the facility's age and original design for general medical/surgical services has resulted in the following space constraints for the rehab unit:

- **Overall Space Limitations:** The therapy gym, patient dining area, and support space are located in former patient rooms and staff offices that have been redesigned to meet the unit's needs, limiting the amount of space available for any of these important components. Lack of available space also limits the variety of patient therapy equipment that can be utilized on the unit as well as the development of a full Activities of Daily Living ("ADL") suite.
- **Lack of Sufficiently-Sized and Designed Amenities:** As noted above, the main hospital tower in which the inpatient rehab unit is located was originally built in the late 1960's, therefore lacks many of the infrastructure upgrades found in newer facilities such as expanded electrical and technology networking capacity to meet the demands of patients and visitors. Also, community space, and family conference space, and waiting areas for family members are all limited within the confines of the former medical/surgical acute care floor.

Because of SMH's semi-private rooms, SMH must consider the patient's gender, age, medical condition and/or complexity, care intensity and/or equipment needs, infection control status, and visitor patterns before admission. Thus, there are inherent limitations and delays in admissions for a unit such as SMH's that has a relatively high number and percentage of semi-private rooms.

Delayed admissions negatively impact patients in need of the prescribed intensive inpatient therapy. Unfortunately, the percentage of patients delayed admission at SMH's IRF is material and increasing, with approximately 10% of IRF admissions delayed in FY25 increasing to approximately 12% this year to-date (FYTD26). The increasing delayed admissions demonstrates that there are too few IRF beds available in HSA 3 to timely admit patients in need of intensive inpatient rehabilitation care.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

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

In addition to adding capacity for inpatient rehabilitation services in the IRF setting, the proposed project will provide that capacity in private rooms. Select research documenting the benefits of private rooms to patients, with key findings noted, include the following:

Do Cost Savings From Reductions in Nosocomial Infections Justify Additional Costs of Single-Bed Rooms in Intensive Care Units? A Simulation Case Study; Hessam Sadatsafavi, PhD, Bahar Niknejad, MD, Rana Zadeh, PhD, Mohsen Sadatsafavi, MD, PhD; Journal of Critical Care, 2015.
<http://dx.doi.org/10.1016/j.jcrc.2015.10.010>

"Conclusions: This case study shows that although single-patient rooms are more costly to build and operate, they can result in substantial savings compared to open-bay rooms by avoiding costs associated with nosocomial infections."

Single-Patient Rooms for Safe Patient-Centered Hospitals; Michael E. Detsky, MD, Edward Etchells, MD, MSc, JAMA, August 27, 2008.

The physician authors highlight the benefits of private rooms when it comes to safety, dignity, privacy and ensuring patient-centered care. The benefits of facility design in reinforcing patient safety, including the ability to clean and decontaminate a private room compared to the challenges associated with the same activities in a partially occupied semi-private room, are discussed.

The Use of Single Patient Rooms versus Multiple Occupancy Rooms in Acute Care Environments; Habib Chaudhury, PhD, Atiya Mahmood, PhD, Maria Valente of Simon Fraser University, Vancouver, BC, Canada, 2004.

This study's comprehensive and extensive review of existing literature identifies a number of clinically beneficial outcomes associated with private rooms including enhanced infection control, the ability to isolate patients who are contagious or may be a high-risk for infection. The study also highlights improved communication between patients, family members and providers, which is critical in the inpatient rehabilitation setting where family members actively participate in the patient's recovery, rehabilitation, and discharge planning.

This study also identifies other beneficial characteristics of private patient rooms that enhance the patient healing environment. These characteristics include increased patient privacy, noise reduction, fewer sleep disturbances, and an overall increase in patient satisfaction. In sum, the study showed that a patient's sense of control of their environment in a private room results in a significant reduction in overall stress during their stay.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

The Role of the Physical Environment in the Hospital of the 21st Century: A Once-in-a-Lifetime Opportunity; Roger Ulrich of Texas A&M University and Craig Zimring of the Georgia Institute of Technology and reported to The Center for Health Design; September 2004.

"To summarize briefly, there is a convincing pattern of evidence across many studies indicating that single-bed rooms lower nosocomial infection rates. Singles appear to limit person-to-person and person-surface-person spread of infection in part because they are far easier to decontaminate thoroughly than multibed rooms after patients are discharged. Also, single rooms with a conveniently located sink or alcohol-gel dispenser in each room may heighten hand washing compliance compared to multibed rooms with few sinks. Finally, single rooms are clearly superior to multi-bed rooms with respect to reducing airborne transmission of pathogens."

Thus, as demonstrated, the Rehab Institute will address the need for additional inpatient rehabilitation services and do so with the provision of private rooms that have evidence-based benefits to patients.

b) The single other IRF in HSA 3 is too distant from Springfield's large, aging population to be a viable alternative.

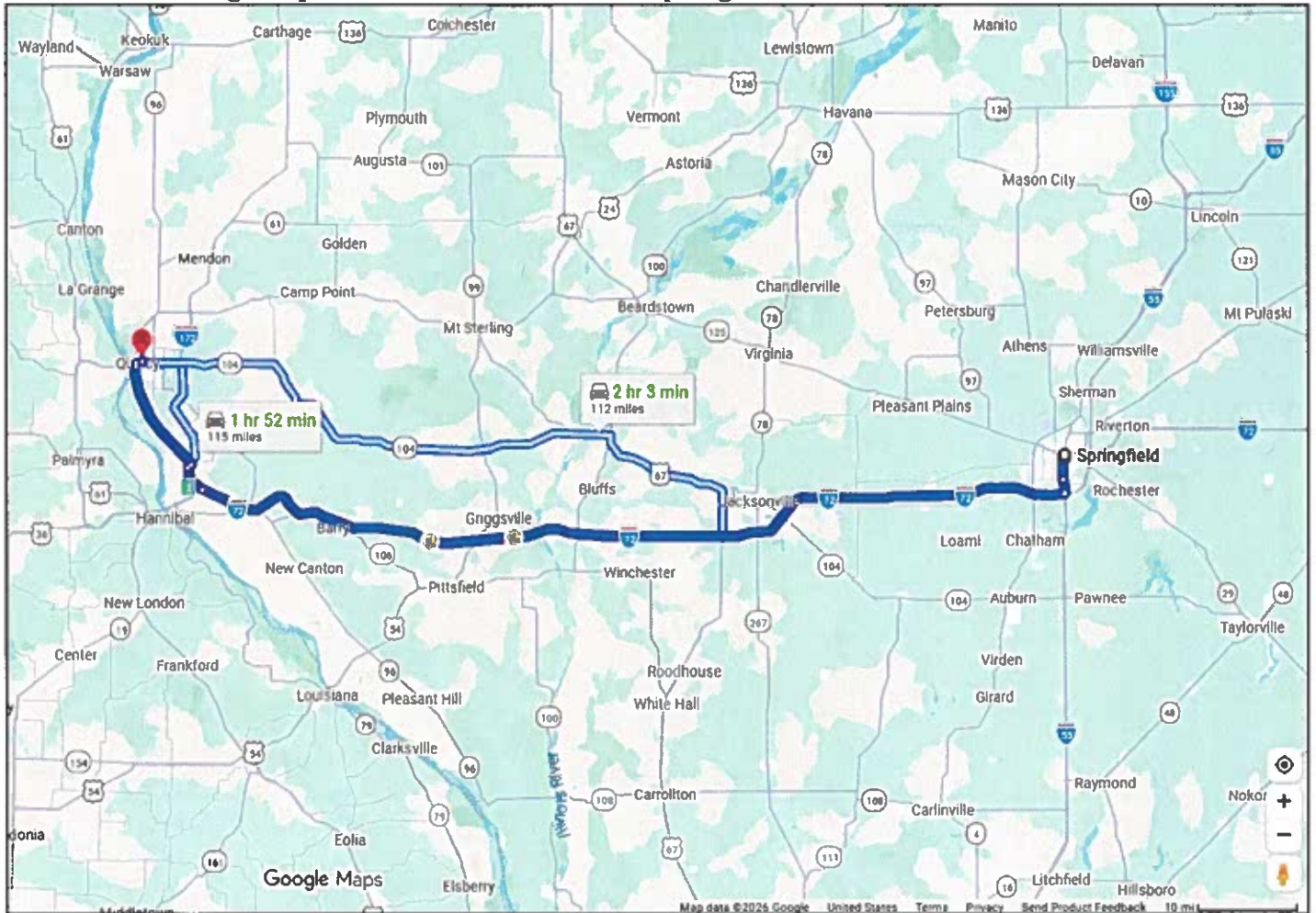
The only other IRF within the entirety of the 18-county HSA is Blessing Hospital's 18-bed in-hospital inpatient rehab facility. However, as shown on the following map, that facility is too distant from the majority of HSA 3 residents generally, and Springfield (as the population and medical hub) specifically, to be a viable alternative.

The fastest route from Springfield to Blessing Hospital is 1 hour, 52 minutes and 115 miles (approximately 93 miles straight-line distance), which is too distant and burdensome for the large, aging population residing in and around Springfield (Sangamon County) to travel to an approximate 2-week inpatient stay.

As noted previously, the ability of the patient's family to actively participate in the patient's care plan and provide support to the patient enhances quality of care for patients and prepares the patient for the ultimate goal of returning to his/her home or community. For elderly family members particularly, the ability to participate in the care without having to travel significant distances on a daily basis means more participation and involvement in the patient's care.

ATTACHMENT 12 **Purpose of the Project**

Figure 5
Blessing Hospital's IRF is Too Far from Springfield to be a Viable Alternative



Source: Google maps. Drive time and route shown is for a Thursday afternoon around 3:30p CDT, departing from Springfield and traveling to Blessing Hospital, Quincy, IL.

Proximity to the proposed inpatient rehab services in Springfield for HSA 3 residents in the western portion of the service area is critically important given the need for patients to have access to both community providers (e.g., their primary care physician, cardiologist, et al) as well as the support network of family and friends.

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

- Participation in developing the patient's care plan and goals for discharge, which leads to greater involvement encouraging and supporting the patient's recovery goals upon discharge.
- Frequent visitation with the patient during his/her inpatient stay, facilitated by sufficiently-sized:

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

- Private inpatient rooms that allow for caregivers and family members to interact with the patient comfortably; and,
 - A therapy gym that affords caregivers and family members the opportunity to attend the patient's daily rehabilitation.
- Working with the case manager prior to the patient's discharge to receive training to help care for the patient after discharge.
 - Interacting with the case manager when s/he visits the patient's home prior to discharge to identify and then address any special needs (such as equipment) the patient will have upon returning home.

Thus, the proposed project is needed to ensure active participation by the patient's family and caregivers.

c) Distant IRFs located outside HSA 3 are not viable alternatives.

Setting aside the need for Sangamon and contiguous county patients to be close to their medical hub (Springfield) and community providers (e.g., their primary care physician, cardiologist, et al) as well as the support network of family and friends, the 'closest' IRFs outside HSA 3 are simply too far to be viable alternatives to the proposed project.

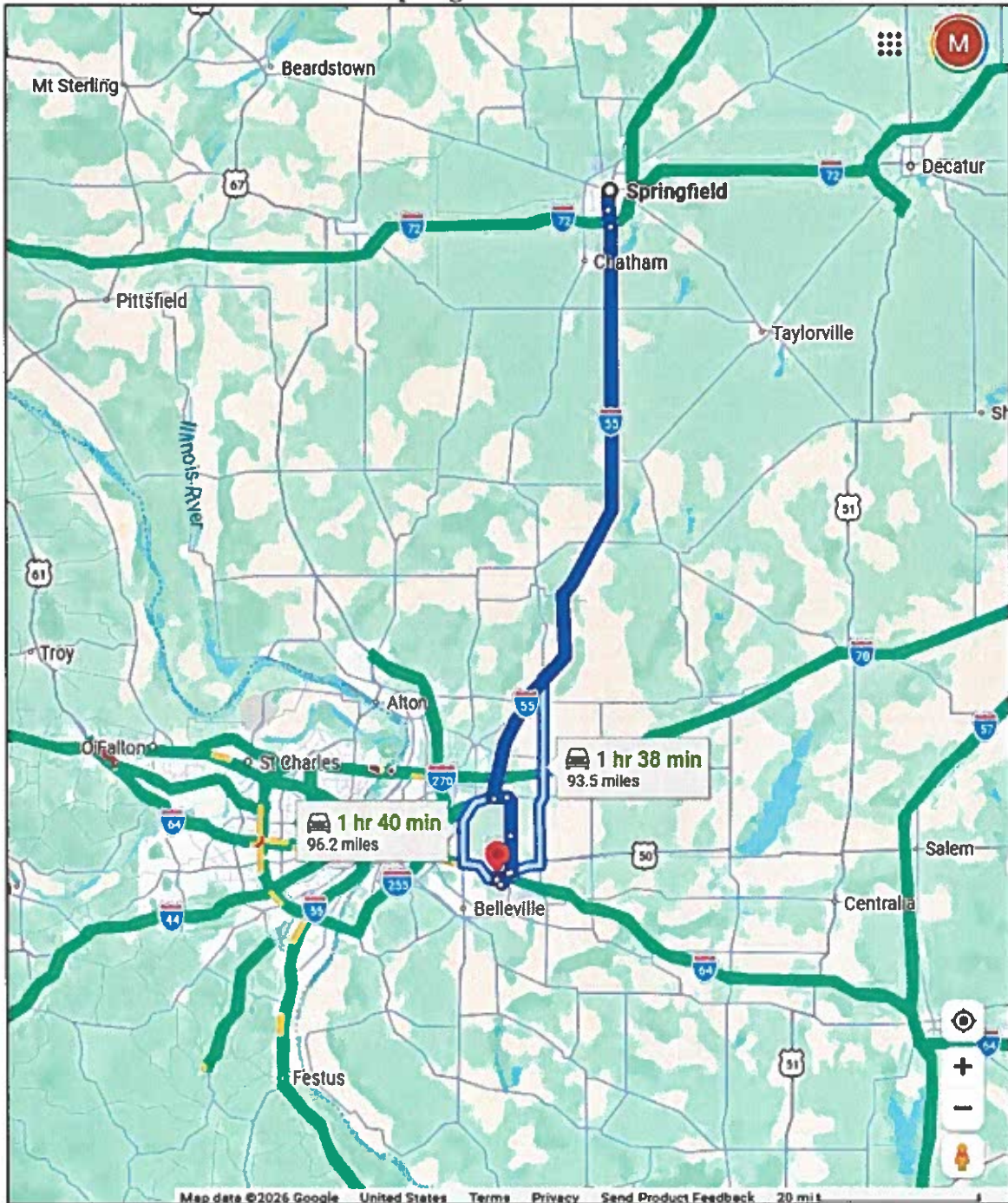
As shown below, the fastest route from Springfield to The Rehabilitation Institute of Southern Illinois in Shiloh (St. Clair County, HSA 11) is 1 hour, 38 minutes and approximately 94 miles, which is too distant and burdensome for the large, aging population residing in and around Springfield (Sangamon County) to travel to participate in the patient's approximate 2-week inpatient stay.

Moreover, the Rehabilitation Institute of Southern Illinois is highly-utilized, so would likely not have available capacity for patients traveling from HSA 3 to its facility. As noted previously, this facility was recently awarded a CON application to expand its 40-bed capacity by 20 additional beds because of its high and increasing utilization.

ATTACHMENT 12

Purpose of the Project

Figure 6
Encompass' Shiloh IRF (Rehabilitation Institute of Southern Illinois)
is Too Far from Springfield to be a Viable Alternative

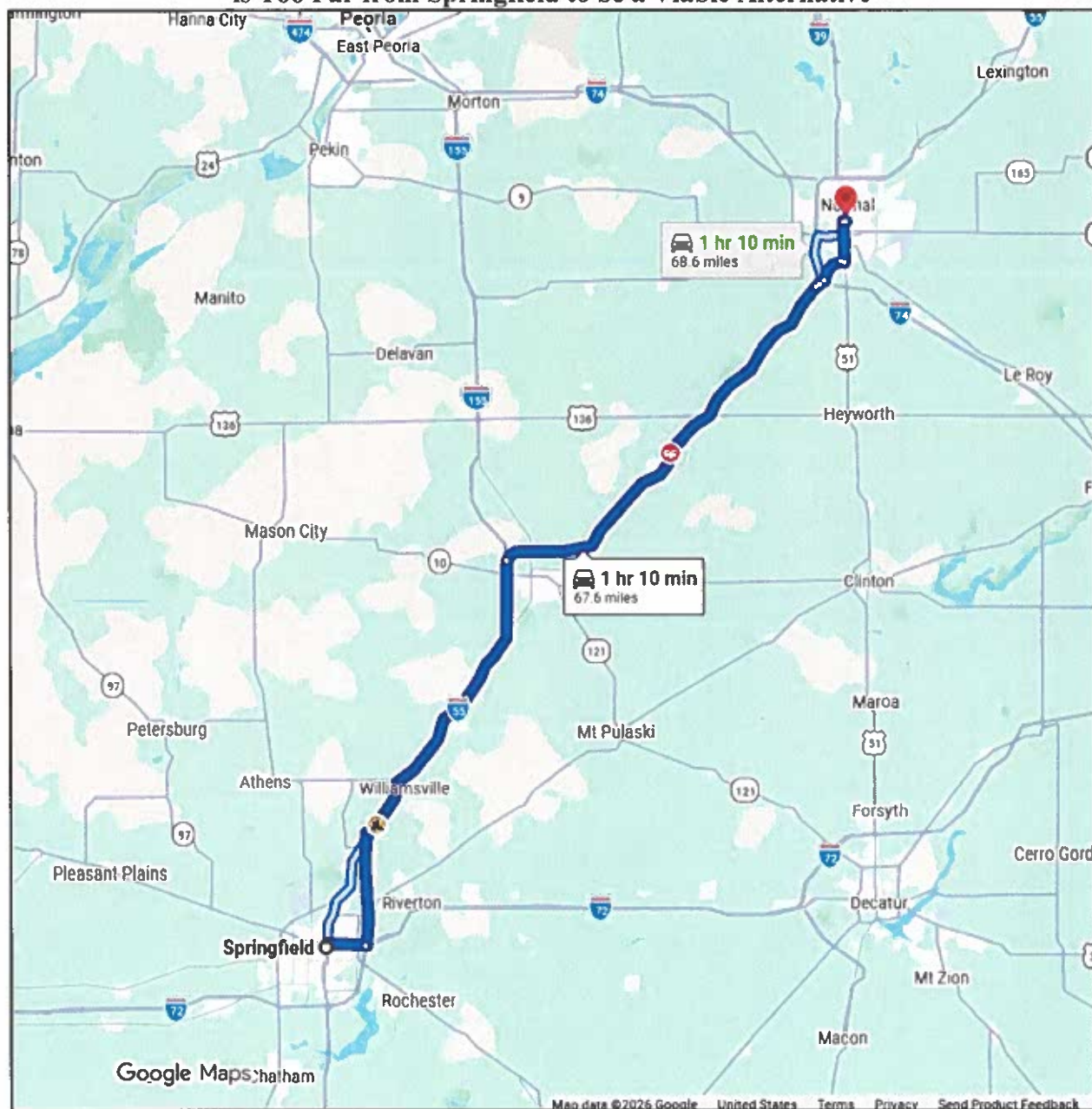


Source: Google maps. Drive time and route shown is for a Thursday afternoon around 4:00p CDT, departing from Springfield and traveling to The Rehabilitation Institute of Southern Illinois, Shiloh, IL.

ATTACHMENT 12 **Purpose of the Project**

Another 'closest' IRF outside HSA 3 is located in HSA 4: Carle BroMenn Medical Center's 15-bed in-hospital unit located in Normal (McLean County), which is 1 hour, 10 minutes and approximately 68 miles from Springfield, as shown in the figure below.

Figure 7
Normal IL IRF (Carle BroMenn Medical Center)
is Too Far from Springfield to be a Viable Alternative



Source: Google maps. Drive time and route shown is for a Thursday afternoon around 4:00p CDT, departing from Springfield and traveling to Carle BroMenn Medical Center, Normal, IL.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

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

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

The proposed project will be owned and operated as a 50/50 joint venture project. Consistent with the HFSRB rules regarding joint ventures⁷, the combination of complementary skills and expertise of Memorial Health, a local community-based health system, and Encompass, a national leader in inpatient rehab care, will ensure that HSA 3 residents have available and accessible rehab beds when needed.

As a community-based, not-for-profit organization, Memorial Health is one of the leading healthcare organizations in Illinois, providing provides a full range of inpatient, outpatient, home health, hospice, behavioral health and primary care physician services. With numerous sites of care throughout central Illinois, Memorial Health delivers high-quality, patient-centered care in support of our mission to improve lives and build stronger communities through better health. The system includes five (5) hospitals, over seventy (70) outpatient locations, and over one thousand (1,000+) partner providers.

As documented previously, HSA 3 residents rely on Memorial Health hospitals for their health care needs, with Memorial Hospital serving the largest percentage of HSA 3 rehab-appropriate discharges.

(See Table 2 above.) Memorial hospitals, particularly Springfield Memorial Hospital, also serve residents of the contiguous Macon County who travel to Springfield for rehab-appropriate medical care. (See Table 3 above.) Thus, Memorial Health, particularly Springfield Memorial Hospital, is an important health care provider currently located in and serving residents of HSA 3.

Encompass Health is the nation's leading owner and operator of inpatient rehab hospitals with 175 inpatient rehab hospitals in 39 states and Puerto Rico. HSA 3 residents will benefit from Encompass' proven high quality, cost-effective programs that extensively utilize specialized staff and technology to deliver higher than expected clinical outcomes. Encompass will bring its proven programs and services to the local market, including an open medical staff and community education and training, to ensure patients and their families in need of intensive inpatient rehab services are able to receive that care close to home.

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

- **TeamWorks** is a company-wide clinical initiative to continually improve quality of care through the identification, standardization, and implementation of best-practices across all of Encompass' hospitals. Just two of the many ways this program has benefitted patients include (1) a quicker admission process and (2) greater coordination pre-admission and post-discharge between community health care providers and Encompass hospitals.
- **Patient Safety Task Force** is comprised of employees across all regions and disciplines who are primarily responsible for identifying changes and/or improvements in processes, policies, or programs to increase patient and staff safety in Encompass hospitals.

⁷ 77 Illinois Administrative Code Section 1100.350

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

- **Post-Acute Innovation Center** is an example of Encompass' ongoing efforts to continually enhance quality of care. The Center was established in 2017 as a partnership with Cerner Corporation to develop clinical decision support tools that can more effectively and efficiently manage patients across multiple care settings, thus enhancing care coordination between a patient's providers, regardless of the provider's location.
- **National partnership with the American Heart Association/American Stroke Association** to increase patient independence after a stroke and reduce stroke mortality through community outreach and information campaigns. This multi-year project is expected to accelerate adoption of the recent AHA/ASA Stroke Rehabilitation Guidelines, increase patient awareness of post-stroke options, and provide practical support to patients and their families to improve recovery outcomes.
- **Participation in The Joint Commission's Disease-Specific Care Certification Programs** has resulted in 145 of Encompass Health's inpatient rehab hospitals currently holding one or more disease-specific certifications from The Joint Commission's Disease-Specific Care Certification Program in areas such as stroke, brain injury, or hip fracture rehabilitation.
- **Advanced Technology** includes rehab-specific clinical equipment and technologies such as the standard equipment included in all new hospitals (presented at the end of this response), as well as the following corporate-wide information technology.
 - Predictive data analytic programs ReAct and Sepsis Alert enhance patient quality of care by closely monitoring even the most subtle changes in a patient's status, reducing readmissions to acute care hospitals, and ultimately enhancing quality of care.
 - A proprietary rehab-specific clinical information system (ACE-IT) interfaces Encompass patients' clinical information with acute care hospitals' clinical information systems to facilitate patient transfers, reduce readmissions, and enhance outcomes.
 - An internally-developed, real-time management reporting system (BEACON) enhances clinical and business processes to ensure that the high quality care provided by Encompass hospitals is delivered in the most cost-efficient manner.
- **Financial Resources and Strength** of Encompass provide its local hospitals with sufficient means to purchase needed equipment and technology, ensure the appropriate complement and number of staff are in place to care for patients, and the facility is designed and well-maintained with all of the latest amenities – all of which combine to enhance quality of care for the patient and family, as evidenced by Encompass Health's existing facilities.

Thus, Memorial and Encompass Health will leverage demonstrated best practices, proven staffing models, comprehensive information technology, centralized administrative functions, supply chain efficiencies, and economies of scale to ensure that the new 60-bed hospital consistently provides the highest clinical outcomes in the most cost-effective manner.

ATTACHMENT 12

Purpose of the Project

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

Quality Outcomes for a Wide Array of Patient Diagnoses Served

Rehabilitation Institute of Springfield will offer proven programs and services to patients recovering from a wide array of injuries and illnesses, including not only stroke, spinal cord injury, and hip or femur fracture, but also amputations, cardiac episodes, and pulmonary conditions, to name a few. Thus, the proposed project will ensure that patients with a wide array of diagnoses in need of inpatient rehabilitation have available and accessible services close to home.

For reference, the overall mix of patients nationally (average for all Encompass hospitals) follows. The proposed HSA 3 rehab hospital expects to serve a similarly wide array of patient types, thus expanding the services locally available to HSA 3 patients and their families.

Figure 8
Encompass Health National RIC Distribution

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 %

Source: Investor Reference Book, June 25, 2025, Encompass Health.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

Notably, an integral component in the provision of services to a wide array of patient diagnoses (or Rehabilitation Impairment Categories) is Memorial's and Encompass' **open medical staff model** which ensures that community-based physicians are available to care for patients' medical needs alongside the Physiatrists or Physical Medicine and Rehabilitation ("PMR") physicians caring for their physical rehabilitative needs. Nationally, Encompass works with community-based Internal Medicine physicians, Hospitalists, and other specialties (e.g., Neurology) to ensure that their inpatients have access to medical specialists as needed during their inpatient stay. The open medical staff model and direct communication between Encompass and community-based physicians also means that patients return to their primary and specialty care physicians upon discharge from Encompass with no interruption or gap in care.

It is important for patients and families to have a choice of rehab providers close to home. As noted previously, the ability of the patient's family to actively participate in the patient's care plan and provide support to the patient ultimately enhances quality of care for patients. For elderly family members particularly, the ability to participate in the care without having to travel significant distances or into another state daily basis means more participation and involvement in the patient's care.

The mere addition of beds is not sufficient, however, to ensure that the proposed project will provide health services that improve the health care of the service area population. It is proven programs, services, staff, and facility design that are integral to the delivery of high-quality care. The high-quality care at the proposed Rehabilitation Institute of Springfield will reflect the proven programs and services of Encompass, regardless of how quality is defined.

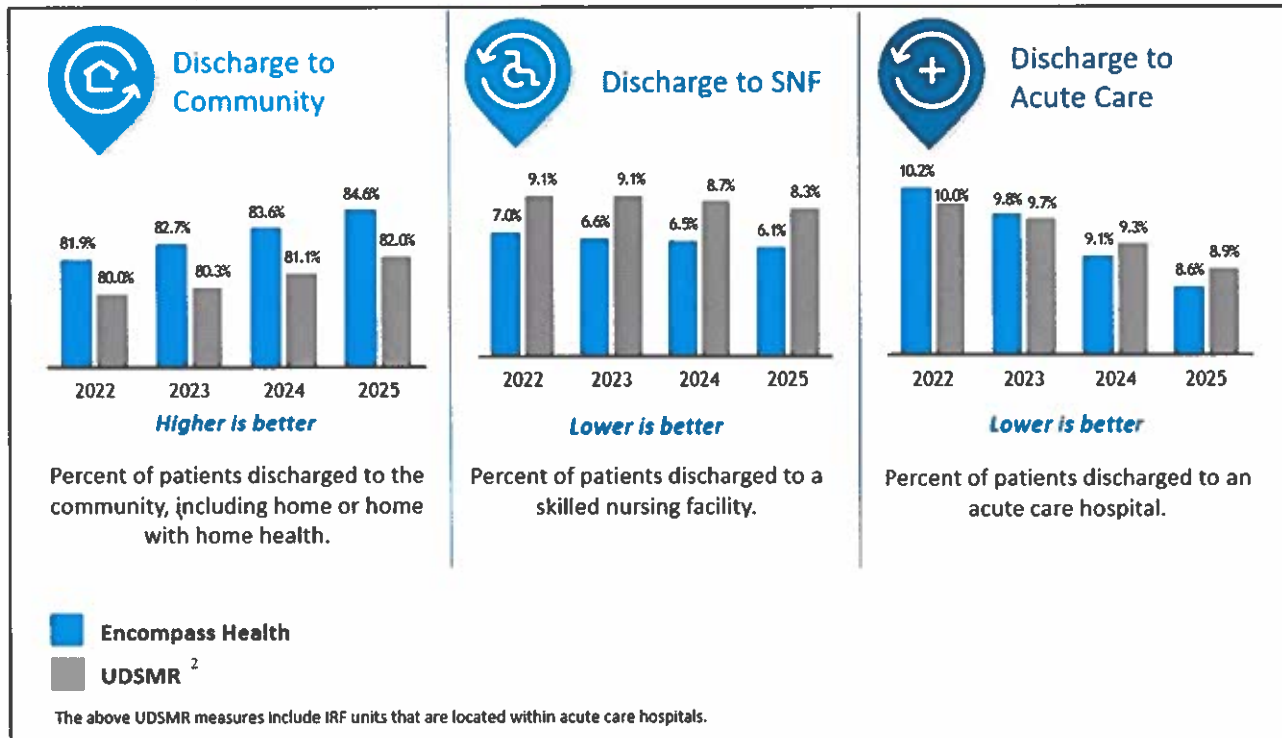
Currently, a total of 145 of Encompass Health's inpatient rehab hospitals hold one or more disease-specific certifications from The Joint Commission's Disease-Specific Care Certification Program in areas such as stroke, brain injury, or hip fracture rehabilitation. Encompass' Van Matre Rehabilitation Hospital in Rockford, Illinois, for example has earned Disease-Specific Care Certifications for its stroke, amputee, spinal cord, and brain injury rehabilitation programs.

Further evidence of Encompass Health's provision of quality care is the percentage of patients discharged to the community versus to a SNF or acute care hospital. As shown below, Encompass has a proven track record of returning approximately 84.6% of its patients back to their home/community, outperforming other providers nationally. The proposed new rehab hospital will utilize Encompass Health's proven programs to ensure high quality care is provided to its patients.

ATTACHMENT 12 Purpose of the Project

Figure 9

Encompass' Quality Measures Exceed National Standards in Multiple Categories



(2) Data compares Encompass Health IRFs to IRFs comprising the Uniform Data System for Medical Rehabilitation ("UDSMR"), part of Netsmart, a data gathering and analysis tool for the rehabilitation industry which represents approximately 80% of the industry, including Encompass Health sites. Data is adjusted by applying Encompass Health IRF case-mix to non-Encompass Health UDS IRFs. Includes rehabilitation facilities with FY2025 data.
Source: Encompass Health.

Encompass hospitals across the nation continually engage in primary research to determine the best practices and protocols for a variety of diagnoses so that patients will always have the highest level of outcomes and quality care.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12

Purpose of the Project

A listing of select current research at Encompass hospitals nationally follows.

- Western PA Patient Registry
- Audiology & Speech Language Registry
- Psych and Neuro of Spatial Cognition
- SDM-Stroke
- SDMM-Geriatric
- Incontinence Study
- Project Steady
- Speed and Distance
- Stroke Studies (several separate studies are underway at various facilities)
- Review of Stroke Patients that Return to Acute
- Stroke Rehabilitation Disparities
- C. Diff EIP
- Flexor Tendon Repair
- Fitness to Drive in Older Adults
- Home Modifications
- AO Spine
- Prolonging Safe Driving - Stroke
- Prism Adaptation Therapy
- Step-Hi
- Tele-rehab vs in-clinic therapy
- The Impact of Falls Prevention Education on Fall Rates
- Is The Ability To Detect A Foreign Accent Located In The Right Hemisphere?
- Bleeding in tracheotomy patients
- Dynamic Body-weight Support (DBWS) on Inpatient Rehabilitation
- Predicting D/C Destination in Hip Fractures
- IM Impact on Falls
- Acuity rating project
- MMJ Study
- Amputee Rehab Outcome Research

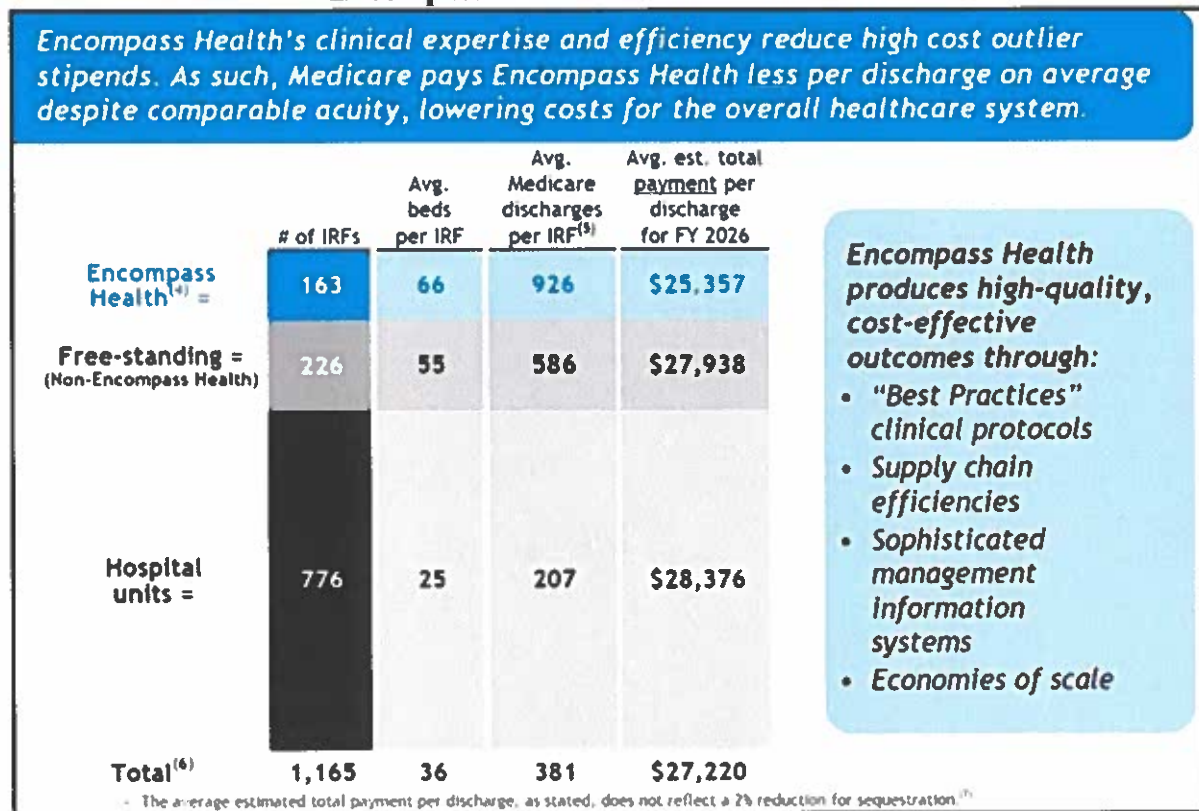
Notably, all of these programs and services are provided in a cost-effective manner. As shown below, the implementation and use of Encompass' proven programs and services results in efficient and cost-effective care. Thus, the proposed project will allow for the most efficient functioning of the health care system possible.

Moreover, the proposed project will ensure HSA 3 residents have a sufficient number of available and accessible beds close to home. The availability of IRF beds ensures that patients are discharged to the right setting at the right time in the right place rather than being discharged to a less intensive setting when more intensive services are needed, thus reducing the likelihood of readmission for that patient, which results not only in optimal outcomes for the patient but also reduces the costs to the patient and the health system as a whole.

ATTACHMENT 12

Purpose of the Project

Figure 10
Encompass Provides Cost-Effective Care



Source: *Encompass Health Investor Reference Book, Published June 25, 2025, pg. 15 and 60-62 for end notes* (<https://investor.encompasshealth.com/company-profile/default.aspx>).

Proven Programs, Services, and Staffing to Ensure High Quality Outcomes

The proposed project will implement the following programs, services, and facility amenities specific to Encompass Health hospitals throughout the nation, and in place at Encompass' four IL hospitals.

The success of the following programs and services is due in large part to the synergy of Encompass Health's comprehensive team approach to rehabilitation services and use of the latest technology and treatments available. (See Exhibit A for rehab-specific technology that will be used to care for patients in the rehab hospital.)

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

Specific **programs and services** to be offered at Rehabilitation Institute of Springfield address a wide range of diagnosis including, but not limited to, the following.

- Stroke
- Brain injury
- Neurological conditions
- Joint replacement
- Orthopedic
- Hip fracture
- Spinal cord injury
- Amputee
- Parkinson's Disease
- Multiple sclerosis
- Burns
- Pulmonary/respiratory
- Pain management

The success of these programs and services is due in large part to the highly-qualified and specially-trained **physicians and staff members** who comprise a **comprehensive, multidisciplinary team** including:

- **Medical Director:** A Physical Medicine and Rehabilitation ("PMR") physician who frequently meets with the patient during the patient's inpatient stay, and is ultimately responsible for implementing the patient's care plan as the multidisciplinary team leader.
- **Rehabilitation nursing:** Implements each patient's medical care program as directed by his or her physician.
- **Occupational therapy:** Designs and delivers activity-based therapy to promote independence in the areas of self-care, home management and community reintegration.
- **Physical therapy:** Evaluates and designs a treatment program to address limitations in physical function, mobility and safety.
- **Respiratory therapy:** Ensures proper respiratory function through services such as oxygen supplements and aerosol treatments.
- **Speech-language pathology:** Assesses and treats individuals with communication and comprehension disorders, cognitive difficulties and swallowing disorders.
- **Dietary and nutritional counseling:** Supervises all meals to ensure patients meet their required nutritional needs.
- **Case management:** Coordinates with the physician to ensure the patient's needs are met and involves the family and other caregivers in the patient's rehabilitation. The Case Manager is also responsible for:
 - Working with the family prior to the patient's discharge to provide training to help family members care for patients after discharge.
 - Visiting the patient's home prior discharge to identify and then address any special needs (such as equipment) the patient will have upon returning home.
 - Coordination and collaboration of services between the patient and community service providers who will be responsible for providing care to the patient post-discharge.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

Patients benefit not only from the extensive array and number of staff members in place at Encompass Health hospitals, such as that proposed for the new Springfield facility, but also from the unique patient-centric programs staff members institute at their facilities to ensure patients receive high quality care.

A few **employee-driven patient-centric programs** that are expected to be implemented at Rehabilitation Institute of Springfield, as they are at existing Encompass facilities, include the following.

- **No Pass Policy** which ensures that any and all staff members must never pass by a patient's room when the nurse call light is on or when it is clear that, even without the call light on, the patient would benefit from assistance. Notably, this operational mandate applies to all staff members, not just nursing staff, so that any and all staff members ensure that patients and families' needs are the highest priority at all times.
- **Welcome Announcement** is one small way in which the staff members can make a new patient feel welcome and know that his/her admission to the hospital is recognized by all staff members as a new beginning. While the patient's name isn't announced so that the patient's privacy is protected, the announcement makes clear that a new patient in a specific room number has arrived, and will join the other patients in his/her journey along the road to rehabilitation and recovery.
- **Patient's in-room information board** is an often overlooked ubiquitous aspect of an inpatient's room at virtually every acute care hospital in the U.S. However, the staff members at Encompass recognized the full potential and importance of the in-room board to the patient, family, and staff members and so have focused on this tool as a means to enhance patient involvement, and thus ultimately quality of care.
 - For example, each patient can refer to the board for that day's rehabilitation schedule, any special daily activities in the Day Room, and a photograph of the physician who is responsible for his/her care during the inpatient stay, among other items. The patient and staff will also see reminders of any special precautions or needs, e.g., indication that an alarm will sound when the patient gets out of bed. In this way, the patient and staff have a visible reminder of the patient's activities and specific needs that goes beyond the typical in-room information board of general acute care hospitals, improving it to specifically meet the needs of inpatient rehab patients.
- **Victory Bell** that is in place at the entrance to the Therapy Gym is another way that the staff recognize individual patients and their success in rehabilitation. The Victory Bell is used by patients when they are being discharged from the hospital, signaling to other patients and all staff members that the patient has passed a significant milestone in his/her life, and that the other patients can too. (The Encompass Health hospital's Victory Bell is similar to the "Survivor Bell" that many oncology programs have in place for their patients to ring to announce the successful end of their treatment.)

ATTACHMENT 12

Purpose of the Project

Encompass' Proven Facility Design Benefits Patients and their Families

The **facility design** has been designed specifically and solely for inpatient rehabilitation services, including the use of extensive rehabilitative equipment and technology by specially-trained staff in a patient-centered environment. Notably, the proposed rehab hospital will be comprised of all private rooms. (See Attachment B for pictures of typical Encompass hospital facilities.)

The proposed facility includes the following amenities.

- Sixty (60) private wheelchair accessible patient rooms with wheelchair accessible private bathrooms, and sufficient space bedside for caregivers and family members to interact with the patient comfortably. Notably, all patient rooms are designed with full capability of acute care inpatient rooms, *e.g.*, head walls and gases are incorporated into the design, reflecting the medical complexity of patients served.
- One of the patient rooms is designed as a private Individuals of Size ("IoS") Room (f/k/a bariatric rooms), providing larger and specially-designed rooms to care for bariatric patients who require additional space in both the patient room and bathroom in addition to specialized equipment, *e.g.*, overhead track system with lift capability.
- One of the rooms is an Airborne Infection Isolation Room ("AIIR") with negative air pressure flow to meet the special needs of patients with communicable diseases.
- A dialysis treatment area with four patient bays for patients requiring dialysis care during their inpatient stay.
- A Therapy Gym with specialized equipment and of sufficient size ensures that patients and staff members have appropriate space to work for the patient to complete his/her daily rehabilitation, and affords family members and caregivers the opportunity to attend the patient's therapy session.
 - For comparison purposes, proposed rehab hospital's Therapy Gym is nearly double the size of the typical therapy gym/inpatient rehab area offered in general acute care hospitals that have dedicated inpatient rehabilitation beds.
 - A listing and brief description of the hospital's planned clinical rehab equipment and technology that will be included in the Therapy Gym is provided later in this Attachment.
- A dedicated and separate Activities of Daily Living ("ADL") Suite within the Therapy Gym provides patients and their families a home-like setting where the patient can relearn ADL activities in order to live as independently as possible when returning home. The ADL Suite includes a kitchen with a stove, sink, refrigerator, dishwasher, cabinets, and tables and chairs; a laundry room with a washer and dryer; and a homelike bathroom intentionally designed with a small, non-compliant American with Disabilities Act ("ADA") doorway since that is what most patients will face when they return to their home/community.
- A dedicated Outdoor Therapy Area, adjacent to the large indoor Therapy Gym, with specialized ramps, surfaces, curbs, and seating for rehab patients to use in order to practice navigating the various settings a patient will face when s/he returns to the community.
- A large Dining Area where patients engage in communal dining as part of their ongoing rehabilitation and restoration.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12 Purpose of the Project

- Dayroom Activity Areas that are used for socialization and rehabilitation of patients, including special activities involving family and/or community members.
- Sufficiently-sized and appropriately-designed support functions such as the nursing unit area, in-house pharmacy, dietary services, medical records, environmental services, and central supply to ensure that the specialized needs of the rehabilitation patients are met.
- Overall facility design that includes sufficiently-wide corridors for easy navigation of patients, families, and staff members and designated spaces along those hallways to store equipment out of the way of patients and families but in close proximity to staff members.
- Additional features specific to the local community include the use of interior design themes, colors, and photographs consistent with and reflective of the area, e.g., local landmarks, landscapes, and events, to provide a sense of community to the patients and also to enhance the mental acuity of patients through recognition of familiar sites and images throughout the hallways.

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

- **Color-coded hallways** at Encompass rehabilitation hospitals does not simply mean that there is a color-coded stripe painted down the hallway or a doorway is painted a certain color, as is sometimes the case in other facilities. Rather, the entire inpatient unit, including all walls and hallways, is painted a consistent and distinct color from those used in other inpatient hallways so that patients can easily find their way to and from their rooms and the therapy gym, dining room, and/or day room during their inpatient stay. Staff members' experience is that all patients, not just those suffering from a neurological episode, benefit from this patient-centric facility design feature that will be implemented at the proposed new hospital.
- **Electronic patient status/nurse call boards throughout the inpatient hallways** ensures that all staff members can at all times see when a patient in his/her inpatient room has requested assistance, and thus timely respond to the patient's needs. This facility design feature goes hand-in-hand with the No Pass Policy implemented at all Encompass hospitals, ensuring that patients' needs are immediately known and responded to by staff members.
- **Patient-centered inpatient units** are intentionally-sized based upon best-practices to promote high quality care and staff efficiency and effectiveness. Specific design features include:
 - *All private rooms*, with each room standardized in design and support space allocation. Patient rooms are designed to improve quality of care and support patient healing, provide family support, and enhance clinical efficiency and effectiveness. Patient rooms are acuity-adaptable and standardized to allow care of all diagnosis groups and to facilitate efficient processes, from patient care to cleaning and maintenance.
 - *Clear sight lines of nursing units to inpatient rooms* to ensure patient safety and high quality care. The clear sight lines from staff to patient and staff to staff enhance staff interaction with patients, increase responsiveness of staff to patients, and mitigate falls and other injuries, thus ultimately enhancing quality of care.

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

ATTACHMENT 12

Purpose of the Project

c) *Encompass has proven success caring for patients in Illinois.*

Encompass operates four (4) IRFs in Illinois, three of which are joint ventures with non-profit community health systems based in Illinois and one of which is wholly owned by Encompass Health. Illustrative of Encompass' commitment to high quality care are the Joint Commission Disease-Specific Care Certifications for Encompass' Illinois hospitals listed below.

Hospital	Disease-Specific Certifications
Van Matre Encompass Health Rehabilitation Institute	Stroke, Brain Injury, Amputee, Spinal Cord Injury
The Rehabilitation Institute of Southern Illinois	Stroke, Amputee
The Quad Cities Rehabilitation Institute	Stroke
Encompass Health Rehabilitation Institute of Libertyville	Stroke

Consistent with Encompass' success nationally in returning patients to their home/community upon discharge, Encompass Health's Illinois IRFs have discharge to community rates, *i.e.*, post-acute care ("DTC-PAC"), at or above the national average, as shown in the following table.⁸ Also known as *Successful Return to Home or Community* on the Medicare.gov Care-Compare site, this metric reflects the rate at which patients returned to home or community from a PAC setting (in this instance IRF) and remained alive without any unplanned hospitalizations in the 31 day following discharge.

⁸ Please note that while both Figure 9 and Table 10 address Encompass hospitals' discharge rates to home/community, the data, methodology, and time period in each analysis differs. Figure 9 is based on calendar year data for all patients / payors whereas Table 10 is based on Medicare Fee-for-Service patients only and is for an aggregated 2-year time period.

ATTACHMENT 12
Purpose of the Project

Table 11 <i>Encompass has Higher Functional Outcome Measures than National Average</i> Percent of Patients Who are At or Above an Expected Ability to Care for Themselves and Move Around at Discharge		
Encompass Illinois IRFs	County, HSA	Rate
Van Matre Encompass Health Rehabilitation Institute	Winnebago, HSA 1	84.49%
The Rehabilitation Institute of Southern Illinois	St. Clair, HSA 11	86.52%
The Quad Cities Rehabilitation Institute	Rock Island, HSA 10	83.78%
Encompass Health Rehabilitation Institute of Libertyville	Lake, HSA 8	86.44%
National Rate		66.02%
Source: CMS (Medicare.gov) Inpatient Rehabilitation Facility (IRF) Compare. Data for 10/01/2024 - 09/30/2025; the most recent data available as of August 21, 2026. https://www.medicare.gov/care-compare/compare?providerType=InpatientRehabilitation&providerIds=143031,143030,143032&state=IL .		

6. Memorial Health will discontinue offering inpatient rehab services on its Springfield Memorial Hospital campus.

Springfield Memorial Hospital will delicense its 30-bed inpatient rehab program upon the opening of the proposed new 60-bed facility. A separate Certificate of Exemption ("COE") for discontinuation of Springfield Memorial's inpatient rehab program will be submitted to the HFSRB at a later date.

Notably, the proposed new inpatient rehab hospital will not only provide needed services to HSA 3 patients, but the closing of the Springfield Memorial inpatient rehab unit will free up much-needed space for the hospital to use in support of future care needs.

B. The project will address the lack of available and accessible HSA 3 inpatient rehab beds.

As documented throughout this application, there are two primary existing problems facing HSA 3 residents that will be addressed by the proposed project:

- (1) Lack of a sufficient number of available and accessible inpatient rehab beds in HSA 3 to meet the needs of patients with clinical conditions appropriate for intensive inpatient rehab services.
- (2) Inability of Memorial Health's Springfield Memorial Hospital to renovate and expand to meet HSA 3 rehab-appropriate patients' need for intensive inpatient post-acute rehab care close to home.

In sum, the proposed project will address the current gap in utilization, offering local and accessible intensive inpatient rehab services to HSA 3 patients in need.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12

Purpose of the Project

C. Sources used in the analyses.

As documented in the various tables previously presented, the following sources were used in the analyses:

- Illinois HFSRB State Summary Revised Bed Need Projection, 05/31/2026.
- Illinois HFSRB Inventory of Health Care Facilities and Services and Need Determinations, 12/17/2023.
- Illinois HFSRB Annual Hospital Questionnaires (2023-2025) and Illinois HFSRB Statewide Hospital Profile Aggregate Data, 2024.
- Illinois Department of Public Health, Illinois Health Facilities and Services Review Board, Certificate of Need Population Projections Project, May 2024.
- Illinois Hospital Association, COMPdata Informatics Inpatient Discharge Database.
- CMS Geographic Variation Public Use File, March 2024 (most recent data available).
- CMS Care Compare (Medicare.gov website).
- Internal records from Memorial Health.
- Internal records from Encompass Health.
- Google maps.

ATTACHMENT 12 **Purpose of the Project**

Exhibit A

REHABILITATION Equipment & Technology



Clinical technologies are invaluable tools in the therapy process and offer patients an exciting and enjoyable experience during their road to recovery. Encompass Health's Therapy Innovations Committee (TIC) evaluates the most cutting-edge, innovative clinical technologies on the market today. The committee establishes and maintains technology standards for new hospitals and identifies best-in-class technologies for Disease Specific Certifications (DSC) to support the gold star quality of care Encompass is known for. Some examples of these technologies are as follows:

Bioness Vector Overhead Track System[®]

Bioness Vector is an overhead track and harness system that provides a safe ambulation environment for both therapist and patient. Without the fear of falling, patients can focus more fully on their tasks of gait and balance.



B.I.T.S Bioness Integrated Therapy System[®]

Using a 50" touch screen monitor, BITS is designed to improve visual abilities for a wide range of patients with visually-related learning problems, strabismus, amblyopia, and traumatic brain injury. BITS offers 16 unique programs with customizable features designed to enhance outcomes for physical and occupational therapy patients.



SaeboFlex[™]

Stroke survivors and other neurologically impaired patients use this custom-fitted hand and arm splint to increase shoulder, elbow, wrist and hand function. During therapy exercises, the splint is used to retrain the hand's grasp and release movements.



ATTACHMENT 12 **Purpose of the Project**

Exhibit A

Bioness H200®

When stroke, brain injury or spinal cord injury occur, a person's neurological abilities, like grasping, can be impaired. The innovative NESS H200 helps improve hand function and voluntary movement.



Bioness L300™

This small wireless device is worn on a patient's leg to help improve walking abilities. Through electrical stimulation, NESS L300 retrains lower leg muscles, increasing motion and blood circulation enabling the return to a more normal step.



Synchrony®

Unlike any other dysphagia rehabilitation solution available, Synchrony™ enables SLPs and patients to literally "See the Swallow" using virtual reality augmented sEMG biofeedback. This important capability helps SLPs evaluate the specific dynamics of a normal, effortful or Mendelsohn swallow in real time, while guiding a series of therapeutic exercise activities that are engaging and fun for patients.



Interactive Metronome™

Interactive Metronome is a brain-based rehabilitation assessment and training program created to improve a patient's ability to plan, organize and use language.



BURT®

BURT® is a user-friendly robot that assists in improving motor control and fine motor skills in the arms and hands. This robot contains integrated gaming software to practice movement patterns and provides customizable features to tailor to patient-specific rehabilitation treatments.



VitalStim®

For those who suffer from dysphagia, a common condition among stroke and brain injury survivors, this therapy greatly improves swallowing ability with electrical stimulation.



ATTACHMENT 12
Purpose of the Project

Exhibit B

Encompass Health recently constructed hospitals



©2025 Encompass Health Corporation 01/15/24/23

ATTACHMENT 12
Purpose of the Project

Exhibit B



©2016 Franciscan Health Corporation W786427

Spacious private rooms and baths



ATTACHMENT 12
Purpose of the Project

Exhibit B

Sample lobbies



© 2016 Encompass Health Corporation W17054.12

ATTACHMENT 12
Purpose of the Project

Exhibit B

Sample therapy gyms



©2025 Springfield Health Corporation W776-137

ATTACHMENT 12
Purpose of the Project

Exhibit B

Sample activities of daily living (ADL) suites



©2025 Springfield Health Corporation #17186412

ATTACHMENT 12
Purpose of the Project

Exhibit B

Sample nursing stations and hallway



© 2015, L. McQuinn, Health Corporation W0786432

ATTACHMENT 12
Purpose of the Project

Exhibit B

Sample outside grounds



c:\2025\Enginemas Health Corporation\7765432

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12

Purpose of the Project

Exhibit B



© 2024 Accounting Master Corporation W1786422

Sample dining room



ATTACHMENT 12 Purpose of the Project



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.

Open Access. This is an open access article distributed under the terms of the CC-BY License.

JAMA Network Open. 2019;2(12):e1916646. doi:10.1001/jamanetworkopen.2019.16646

December 4, 2019 1/12

ATTACHMENT 12

Purpose of the Project

JAMA Network Open | **Geriatrics**

Functional Status Among Patients in Inpatient Rehabilitation vs Skilled Nursing Facilities

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.

JAMA Network Open. 2019;2(12):e1916646. doi:10.1001/jamanetworkopen.2019.16646

Introduction

More than 40% of Medicare beneficiaries are discharged from acute care hospitals to postacute care each year. Reports by the National Academy of Sciences¹ and the Institute of Medicine² have found that postacute care was the largest contributor to geographic variation in Medicare costs. The 2014 Improving Medicare Post-Acute Care Transformation (IMPACT) Act³ 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 studies⁷⁻⁹ 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.

ATTACHMENT 12

Purpose of the Project

JAMA Network Open | Geriatrics

Functional Status Among Patients in Inpatient Rehabilitation vs Skilled Nursing Facilities

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 O61 to O66 (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 al¹⁴ 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.

ATTACHMENT 12 Purpose of the Project

JAMA Network Open | Geriatrics

Functional Status Among Patients in Inpatient Rehabilitation vs Skilled Nursing Facilities

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 estimation²⁰ 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.³⁰ 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.

ATTACHMENT 12

Purpose of the Project

Table 1. Characteristics of Patients Admission to IRF and SNF

Variable	Patients, No. (%)		P Value ^a
	IRF (n = 66 082)	SNF (n = 33 103)	
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)	<.001
Nonprofit	48815 (73.9)	24 848 (75.1)	
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		SNF	
	Mobility	Self-care	Mobility	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.

ATTACHMENT 12

Purpose of the Project

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

Analysis	Score, Mean (SE)				Difference	
	IRF	SNF	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. 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%; $P = .02$).

^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

ATTACHMENT 12 Purpose of the Project

(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.

ATTACHMENT 12

Purpose of the Project

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 data⁷⁻⁹ 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.³⁴ A study by Mallinson et al³⁴ 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 study³⁴ 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 al³⁶ estimated the percentage of 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 al³⁶ estimated as the percentage of patients with marginal stroke and hip fracture. Our findings and the research of Buntin et al³⁶ 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 Act³ 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

ATTACHMENT 12

Purpose of the Project

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 Act³ must avoid a payment system that shifts patients with stroke who could benefit from intensive inpatient rehabilitation to lower cost settings.

ARTICLE INFORMATION

Accepted for Publication: October 9, 2019.

Published: December 4, 2019. doi:10.1001/jamanetworkopen.2019.16646

Open Access: This is an open access article distributed under the terms of the CC BY License. © 2019 Hong I et al JAMA Network Open.

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).

ATTACHMENT 12

Purpose of the Project

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.

Statistical analysis: Hong, Kuo, Karmarkar, Lin.

Obtained funding: Reistetter, Ottenbacher.

Administrative, technical, or material support: Mallinson.

Supervision: Ottenbacher.

Conflict of Interest Disclosures: Dr Reistetter reported receiving grants from the Agency for Healthcare Research and Quality (AHRQ) during the conduct of the study. Dr Kuo reported receiving grants from the AHRQ during the conduct of the study and grants from the National Institute on Drug Abuse outside the submitted work. Dr Mallinson reported receiving grants from National Institute on Disability and Rehabilitation Research outside the submitted work. Dr Karmarkar reported receiving grants from the National Institutes of Health (NIH) and being an employee of RTI International outside the submitted work. Y.-L. Lin reported grants from National Institutes of Health during the conduct of the study. Dr Ottenbacher reported receiving grants from the NIH during the conduct of the study and personal fees from the Kessler Foundation outside the submitted work. No other disclosures were reported.

Funding/Support: This study was supported with funding from the National Institutes of Health (R01-AGO33134, P2C-HDO65702, R01-HDO69443, K01-HDO86290, P30-AG024832, K12-HDO55929, and UL1TR001439) and the Agency for Healthcare Quality and Research (R01-HSO24711, R24-HSO22134).

Role of the Funder/Sponsor: The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Additional Contributions: Sarah Toombs Smith, PhD, ELS (University of Texas Medical Branch), provided assistance in proofreading and editing the manuscript. She was not compensated for her contribution.

REFERENCES

1. Kibria A, Mancher M, McCoy MA, Graham RP, Garber AM, Newhouse JP. *Variation in Health Care Spending: Target Decision Making, Not Geography*. Washington, DC: National Academies Press; 2013.
2. Newhouse JP, Garber AM. Geographic variation in health care spending in the United States: insights from an Institute of Medicine report. *JAMA*. 2013;310(12):1227-1228. doi:10.1001/jama.2013.278139
3. Camp D. Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, 113-185 USC 128 Stat 1952 (2016). <https://www.congress.gov/bills/113/congress/house-bill/4994>. Accessed May 10, 2019.
4. Alcusky M, Ulbricht CM, Lapane KL. Postacute care setting, facility characteristics, and poststroke outcomes: a systematic review. *Arch Phys Med Rehabil*. 2018;99(6):1124-1140.e9. doi:10.1016/j.apmr.2017.09.005
5. Centers for Medicare & Medicaid Services, HHS. Medicare Program: prospective payment system and consolidated billing for skilled nursing facilities for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research: final rule. *Fed Regist*. 2016;81(151):51969-52053.
6. Medicare Payment Advisory Commission. *Healthcare spending and Medicare program*: June 2019. http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf?sfvrsn=0. Accessed September 1, 2019.
7. Giordano SH, Kuo YF, Duan Z, Hortobagyi GN, Freeman J, Goodwin JS. Limits of observational data in determining outcomes from cancer therapy. *Cancer*. 2008;112(11):2456-2466. doi:10.1002/cncr.23452
8. Sheffield KM, Riall TS, Han Y, Kuo YF, Townsend CM Jr, Goodwin JS. Association between cholecystectomy with vs without intraoperative cholangiography and risk of common duct injury. *JAMA*. 2013;310(8):812-820. doi:10.1001/jama.2013.276205
9. Stukel TA, Fisher ES, Wennberg DE, Alter DA, Gottlieb DJ, Vermeulen MJ. Analysis of observational studies in the presence of treatment selection bias: effects of invasive cardiac management on AMI survival using propensity score and instrumental variable methods. *JAMA*. 2007;297(3):278-285. doi:10.1001/jama.297.3.278
10. VanderWeele TJ, Ding P. Sensitivity analysis in observational research: introducing the E-Value. *Ann Intern Med*. 2017;167(4):268-274. doi:10.7326/M16.2607

ATTACHMENT 12 Purpose of the Project

11. Centers for Medicare & Medicaid Services. The Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Training Manual. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html>. Updated July 31, 2018. Accessed May 10, 2019.
12. Centers for Medicare & Medicaid Services. Minimum Data Set, Version 3.0 (MDS 3.0) RAI Manual. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS3ORAIManual.html>. Accessed May 10, 2019.
13. Brinjikji W, Rabinstein AA, Cloft HJ. Hospitalization costs for acute ischemic stroke patients treated with intravenous thrombolysis in the United States are substantially higher than Medicare payments. *Stroke*. 2012;43(4):1131-1133. doi:10.1161/STROKEAHA.111.636142
14. Mallinson TR, Bateman J, Tseng HY, et al. A comparison of discharge functional status after rehabilitation in skilled nursing, home health, and medical rehabilitation settings for patients after lower-extremity joint replacement surgery. *Arch Phys Med Rehabil*. 2011;92(5):712-720. doi:10.1016/j.apmr.2010.12.007
15. Masters GN. Common-person equating with the Rasch model. *Appl Psychol Meas*. 1985;9(1):73-82. doi:10.1177/014662168500900107
16. Velozo CA, Byers KL, Wang YC, Joseph BR. Translating measures across the continuum of care: using Rasch analysis to create a crosswalk between the Functional Independence Measure and the Minimum Data Set. *J Rehabil Res Dev*. 2007;44(3):467-478. doi:10.1682/JRRD.2006.06.0068
17. Hong I, Woo HS, Shim S, Li CY, Yoonjeong L, Velozo CA. Equating activities of daily living outcome measures: the Functional Independence Measure and the Korean version of Modified Barthel Index. *Disabil Rehabil*. 2018;40(2):217-224. doi:10.1080/09638288.2016.1247468
18. Eicheldinger C, Bonito A. More accurate racial and ethnic codes for Medicare administrative data. *Health Care Financ Rev*. 2008;29(3):27-42.
19. Pope GC, Kautter J, Ellis RP, et al. Risk adjustment of Medicare capitation payments using the CMS-HCC model. *Health Care Financ Rev*. 2004;25(4):119-141.
20. Rosenbaum PR, Rubin DB. The central role of the propensity score in observational studies for causal effects. *Biometrika*. 1983;70(1):41-55. doi:10.1093/biomet/70.1.41
21. Kuo Y-F, Chen N-W, Baillargeon J, Raji MA, Goodwin JS. Potentially preventable hospitalizations in Medicare patients with diabetes: a comparison of primary care provided by nurse practitioners versus physicians. *Med Care*. 2015;53(9):776-783. doi:10.1097/MLR.0000000000000406
22. Yang D, Dalton JE. A unified approach to measuring the effect size between two groups using SAS. Paper presented at: SAS Global Forum, April 22, 2012; Orlando, FL.
23. Rubin DB. Using propensity scores to help design observational studies: application to the tobacco litigation. *Health Serv Outcomes Res Methodol*. 2001;2(3-4):169-188. doi:10.1023/A:1020363010465
24. Hausman JA. Specification tests in econometrics. *Econometrica*. 1978;46(6):1251-1271. doi:10.2307/1913827
25. Kennedy GM, Brock KA, Lunt AW, Black SJ. Factors influencing selection for rehabilitation after stroke: a questionnaire using case scenarios to investigate physician perspectives and level of agreement. *Arch Phys Med Rehabil*. 2012;93(8):1457-1459. doi:10.1016/j.apmr.2011.11.036
26. Xian Y, Thomas L, Liang L, et al. Unexplained variation for hospitals' use of inpatient rehabilitation and skilled nursing facilities after an acute ischemic stroke. *Stroke*. 2017;48(10):2836-2842. doi:10.1161/STROKEAHA.117.016904
27. Magdon-Ismael Z, Sicklick A, Hedeman R, Bettger JP, Stein J. Selection of Postacute stroke rehabilitation facilities: a survey of discharge planners from the northeast cerebrovascular consortium (NECC) region. *Medicine (Baltimore)*. 2016;95(16):e3206. doi:10.1097/MD.0000000000003206
28. Bettger JP, Thomas L, Liang L, et al. Hospital variation in functional recovery after stroke. *Circ Cardiovasc Qual Outcomes*. 2017;10(1):e002391. doi:10.1161/CIRCOUTCOMES.115.002391
29. Mees M, Klein J, Yperzele L, Vanacker P, Cras P. Predicting discharge destination after stroke: a systematic review. *Clin Neurol Neurosurg*. 2016;142:15-21. doi:10.1016/j.clineuro.2016.01.004
30. Werner RM, Coe NB, Qi M, Konetzka RT. Patient outcomes after hospital discharge to home with home health care vs to a skilled nursing facility. *JAMA Intern Med*. 2019;179(5):617-623. doi:10.1001/jamainternmed.2018.7998
31. Chan L, Sandel ME, Jette AM, et al. Does postacute care site matter: a longitudinal study assessing functional recovery after a stroke. *Arch Phys Med Rehabil*. 2013;94(4):622-629. doi:10.1016/j.apmr.2012.09.033
32. Hoenig H, Sloane R, Horner RD, Zolkewitz M, Reker D. Differences in rehabilitation services and outcomes among stroke patients cared for in veterans hospitals. *Health Serv Res*. 2001;35(6):1293-1318.

ATTACHMENT 12

Purpose of the Project

33. Deutsch A, Granger CV, Heinemann AW, et al. Poststroke rehabilitation: outcomes and reimbursement of inpatient rehabilitation facilities and subacute rehabilitation programs. *Stroke*. 2006;37(6):1477-1482. doi:10.1161/01.STR.0000221172.99375.5a
34. Mallinson T, Deutsch A, Bateman J, et al. Comparison of discharge functional status after rehabilitation in skilled nursing, home health, and medical rehabilitation settings for patients after hip fracture repair. *Arch Phys Med Rehabil*. 2014;95(2):209-217. doi:10.1016/j.apmr.2013.05.031
35. Medicare Payment Advisory Commission. *Inpatient Rehabilitation Facilities Payment System*. Washington, DC: Medicare Payment Advisory Commission; 2016:1-3.
36. Buntin MB, Colla CH, Deb P, Sood N, Escarce JJ. Medicare spending and outcomes after postacute care for stroke and hip fracture. *Med Care*. 2010;48(9):776-784. doi:10.1097/MLR.0b013e3181e359df
37. Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy: March 2019. http://medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0. Accessed May 10, 2019.
38. Ottenbacher KJ, Hsu Y, Granger CV, Fiedler RC. The reliability of the functional independence measure: a quantitative review. *Arch Phys Med Rehabil*. 1996;77(12):1226-1232. doi:10.1016/S0003-9993(96)90184-7

SUPPLEMENT

- eFigure. Study Flow Diagram for the Sample
- eTable 1. Patient Characteristics Between Skilled Nursing Facility (SNF) Stays Included in the Cohort and Those Excluded Owing to Incomplete Data for Function Scores
- eTable 2. Patient Comorbidities Between Skilled Nursing Facility (SNF) Stays Included in the Cohort and Those Excluded Due to Incomplete Data for Function Scores
- eAppendix. eMethods
- eTable 3. Comparison of Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) With Minimum Data Set 3.0 (MDS) Items in the Mobility and Self-care Construct
- eTable 4. Demographics Across Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs) Before and After Inverse Probability of Treatment Weighting
- eTable 5. Stroke Comorbidities Across Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs) Before and After Inverse Probability of Treatment Weighting
- eTable 6. Additional Diagnoses Related to Cognitive Function
- eTable 7. Instrumental Variables Across Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs)
- eTable 8. Standardized Difference for Instrumental Variables
- eTable 9. E-values for Mobility and Self-care Scores and 30- to 365-Day Mortality From Hospital Discharge
- eReferences

ATTACHMENT 12

Purpose of the Project

Dobson|DaVanzo

Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities and After Discharge

Study Highlights

Authors: Joan E. DaVanzo, Ph.D., M.S.W., Al Dobson, Ph.D., Audrey El-Gamil, Justin W. Li, Nikolay Manolov, Ph.D.
Contact: Joan E. DaVanzo, joan.davanzo@dobsondavanzo.com; 703-260-1761

Synopsis of Key Findings

We found that patients treated in IRFs had better long-term clinical outcomes than those treated in SNFs following the implementation of the revised 60% Rule. We used Medicare fee-for-service claims data to compare the clinical outcomes and Medicare payments for patients who received rehabilitation in an inpatient rehabilitation facility (IRF) to clinically similar matched patients who received services in a skilled nursing facility (SNF).

- Over a two-year study period, IRF patients who were clinically comparable to SNF patients, on average:
 - Returned home from their initial stay two weeks earlier
 - Remained home nearly two months longer
 - Stayed alive nearly two months longer
- Of matched patients treated:
 - IRF patients experienced an 8% lower mortality rate during the two-year study period than SNF patients
 - IRF patients experienced 5% fewer emergency room (ER) visits per year than SNF patients
 - For five of the 13 conditions, IRF patients experienced significantly fewer hospital readmissions per year than SNF patients
- Better clinical outcomes could be achieved by treating patients in an IRF with an additional cost to Medicare of \$12.59 per day (while patients are alive during the two-year study period), across all conditions.¹

Matched IRF and SNF Patients: Number of Days during Initial Rehabilitation Stay and Number of Days Treated in the Home*

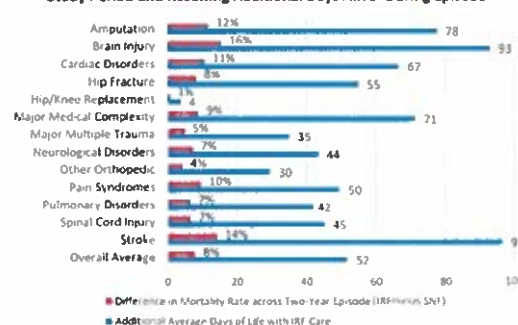


*Days treated in the home represents the average number of days per patient over two-year study period not spent in a hospital, IRF, SNF, or LTCH.

- This study serves as the most comprehensive national analysis to date examining the long-term clinical outcomes of clinically similar patient populations treated in IRFs and SNFs, utilizing a sample size of more than 100,000 matched pairs drawn from Medicare administrative claims.
- The focused, intense, and standardized rehabilitation led by physicians in IRFs is consistent with patients achieving significantly better outcomes in a shorter amount of time than patients treated in SNFs.

When patients are matched on demographic and clinical characteristics, rehabilitation in IRFs leads to lower mortality, fewer readmissions and ER visits, and more days at home (not in a hospital, IRF, SNF, or LTCH) than rehabilitation in SNFs for the same condition. This suggests that the care delivered is not the same between IRFs and SNFs. Therefore, different post-acute care settings affect patient outcomes.

Matched IRF and SNF Patients: Difference in Mortality Rate¹ across Two-Year Study Period and Resulting Additional Days Alive² During Episode*



*Difference in the mortality rate of matched IRF patients to matched SNF patients over the two-year study period. As a result of the lower mortality rate, additional average days of life represent the difference in the average episode length (after accounting for mortality) across groups (IRF average episode length in days minus SNF).

¹ Differences are statistically significant at $p < 0.0001$.

² Differences are statistically significant at $p < 0.0001$ with the exception of the number of readmissions per year, which are significant at $p < 0.01$ for five of the 13 conditions.

³ Differences are statistically significant at $p < 0.0001$ with the exception of major multiple trauma, which is significant at $p < 0.01$.

Source: Dobson | DaVanzo analysis of research identifiable 20% sample of Medicare beneficiaries, 2005-2009.

ATTACHMENT 12 Purpose of the Project

Dobson|DaVanzo

The Issue

To qualify for Medicare payment under the IRF prospective payment system (PPS) at least 60% of an IRF's admissions in a single cost reporting period must be in one or more of 13 CMS specified clinical conditions ("known as the "60% Rule").¹ As a result of this policy, some Medicare beneficiaries with certain conditions previously treated in the IRF are now treated in an alternative setting, such as a SNF. The Medicare Payment Advisory Commission (MedPAC) found, for instance, that the proportion of IRF patients treated for lower joint replacements decreased by 16%, while SNF admissions of this diagnosis increased by the same rate between 2004 and 2011.²

There is a significant difference in medical rehabilitation care practices between the two settings.³ Treatment provided in IRFs is under the direction of a physician and specialized nursing staff.⁴ Care plans are structured, focused, and time sensitive to reflect the pathophysiology of recovery, avoid patient deconditioning, and maximize potential functional gain. On the other hand, SNFs exhibit greater diversity in practice patterns with lower intensity rehabilitation,⁵ possibly due to limited presence of an onsite physician and no regulatory rehabilitation standards.

The implication of the 60% Rule on long-term beneficiary health outcomes and health care utilization has not been thoroughly investigated.

Despite limited information concerning the rule's effect on beneficiaries, policymakers are considering revisions to IRF payment policy. One revision would raise the current compliance threshold from 60% to 75%, a more restrictive standard. Under a second proposal, MedPAC is developing a recommendation to reduce the difference in Medicare payments between IRFs and SNFs by reimbursing IRFs the SNF payment rate for three specific clinical conditions, some of which are included in the 13 conditions under the 60% Rule: major joint replacement without complications or comorbidities (CC), hip fracture with CC, and stroke with CC.

About the Study

The ARA Research Institute (an affiliate of the American Medical Rehabilitation Providers Association – AMRPA) commissioned Dobson DaVanzo & Associates, LLC to conduct a retrospective study of IRF patients and clinically similar SNF patients to examine the downstream comparative

Conclusions in Brief:

- The care provided in IRFs and SNFs differs, as patients treated in IRFs experienced different outcomes than matched patients treated in SNFs.
- Patients treated in a SNF as a result of the 60% Rule who could have otherwise been treated in an IRF might be adversely affected by an increased risk of death, increased use of facility-based care, and more ER visits and hospital readmissions.
- Continuation or expansion of the 60% Rule or aligning the payment across the SNF and IRF PPSs without understanding the impact on patient outcomes is ill advised and could negatively impact Medicare beneficiaries.

utilization and effectiveness of post-acute care pathways, as well as total cost of treatment for the five years following implementation of the 60% Rule.

Using a 20% sample of Medicare beneficiaries, this study analyzed all Medicare Parts A and B claims across all care settings (excluding physicians and durable medical equipment) from 2005 through 2009. Patient episodes were created to track all health care utilization and payments following discharge from a post-acute rehabilitation stay in an IRF and a SNF. Patients admitted to an IRF following an acute care hospital stay were matched to clinically and demographically similar SNF patients. Patient outcomes were tracked for two years following discharge from the rehabilitation stay. This study period allowed us to capture the long-term impact of the rehabilitation, including meaningful differences in mortality, use of downstream facility-based care, and patients' ability to remain at home.

To aid in the interpretation and clinical validation of this analysis, the Dobson | DaVanzo team worked with a clinical expert panel comprised of practicing post-acute care clinicians.

Study Limitations

Medicare fee-for-service claims do not include care covered and reimbursed by Medicaid and third-parties or detailed clinical information. Therefore, non-Medicare services, such as long-term nursing home stays, are not captured in this analysis. This omission may have overestimated the calculated number of days a patient remained at home, and underestimated the cost of their health care to the federal and state governments.

Additionally, the results of this study are not generalizable to the universe of SNF patients within the studied clinical conditions. Analyses suggest that SNF patients who are clinically similar and matched to IRF patients have different health care utilization and Medicare payments than those who were not matched.

¹ The compliance threshold was originally set at 75% and was to be phased in over a three-year period, but compliance was capped at 60% following the Medicare, Medicaid, and SCHIP Extension Act of 2007. While the policy has retained its name as the "75% Rule" despite the cap at 60%, this study refers to it as the "60% Rule."

² Medicare Payment Advisory Commission (MedPAC). 2013. *Report to Congress: Medicare Payment Policy*. Washington, D.C.

³ Keith RA. (1997). Treatment strength in rehabilitation. *Arch Phys Med Rehabil* 90: 1269-1283.

⁴ Harvey RL. (2010, January). Inpatient rehab facilities benefit post-stroke care. *Managed Care*.

⁵ DeJong G, Hsieh C, Gassaway J, et al. (2009). Characterizing rehabilitation services for patients with knee and hip replacement in skilled nursing facilities and inpatient rehabilitation facilities. *Arch Phys Med Rehabil* 90: 1269-1283.

ATTACHMENT 12 Purpose of the Project

Acute Rehabilitation after Trauma: Does it Really Matter?



Deepika Nehra, MD, Zeynep A Nixon, PhD, MPH, Claudia Lengenfelder, MN, RN, CRRN, Eileen M Bulger, MD, FACS, Joseph Cuschieri, MD, FACS, Ronald V Maier, MD, FACS, Saman Arbabi, MD, MPH, FACS

- BACKGROUND:** The impact of post-discharge rehabilitation care for the trauma patient remains poorly investigated. Here we describe the functional outcomes of trauma patients discharged to an inpatient rehabilitation facility (IRF), and compare the likelihood of discharge home, 1-year rehospitalization, and 1-year mortality between patients discharged to an IRF and a propensity score-matched cohort of patients not discharged to an IRF.
- STUDY DESIGN:** The Washington State Rehabilitation Registry was used to collect data for all trauma patients discharged to an IRF between 2011 and 2012. These charts were linked to the Washington State Trauma Registry and the Comprehensive Hospital Abstract Reporting System database to obtain detailed patient, injury, and mortality data. Propensity score matching was used to identify a control group of patients who were not discharged to an IRF. Primary outcomes measures were improvement in Functional Independence Measure score with inpatient rehabilitation and the likelihood of discharge home, 1-year rehospitalization, and 1-year mortality.
- RESULTS:** Nine hundred and thirty-three trauma patients were discharged to an IRF between 2011 and 2012. Total functional independence measure scores improved from 63.7 (SD 20.3) to 92.2 (SD 20.9) ($p < 0.001$) with care at an IRF. When patients discharged to an IRF were compared with the propensity score-matched control patients, rehabilitation was found to significantly increase the likelihood of discharge to home (odds ratio = 9.41; 95% CI, 6.80–13.01) and to decrease 1-year mortality (odds ratio = 0.60; 95% CI, 0.39–0.92).
- CONCLUSIONS:** Acute trauma patients should be recognized as an underserved population that would benefit considerably from inpatient rehabilitation services after discharge from the hospital. (J Am Coll Surg 2016;223:755–763. © 2016 by the American College of Surgeons. Published by Elsevier Inc. All rights reserved.)

Trauma is the most common cause of significant functional impairment, disability, and mortality worldwide. According to the CDC, the annual work-lost cost in the

United States for injured patients who survive to hospital discharge is an astonishing \$150 billion.¹ These injured patients are typically motivated and productive members of society who almost universally desire recovery of functional independence and return to community living and work. Helping them regain their functional independence has the potential to improve their quality of life considerably, and also decrease the socioeconomic impact of their injuries. The care of these injured patients does not end on discharge from the acute care hospital, and many of these patients require ongoing rehabilitation after discharge. This rehabilitation can occur in one of several settings, including an inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), or in the outpatient setting. The impact of rehabilitation care for the trauma patient in these varied settings is not completely understood.

CME questions for this article available at
<http://jacsme.facs.org>

Disclosure Information: Authors have nothing to disclose. Timothy J Eberlein, Editor-in-Chief, has nothing to disclose.

Presented at the American College of Surgeons Committee on Trauma 2015 Resident Trauma Paper Competition. The paper won first prize in the clinical research category.

Received July 14, 2016; Revised September 7, 2016; Accepted September 7, 2016.

From the Department of Surgery, Harborview Medical Center, University of Washington (Nehra, Bulger, Cuschieri, Maier, Arbabi), Department of Psychology, Franciscan Health System (Lengenfelder), Seattle, and Washington State Department of Health, Olympia (Nixon), WA.
Correspondence address: Saman Arbabi, MD, MPH, FACS, Harborview Medical Center, 325 9th Ave, Box 359796, Seattle, WA 98104. email: sarbabi@uw.edu

ATTACHMENT 12

Purpose of the Project

Abbreviations and Acronyms

AIS	=	Abbreviated Injury Score
CMS	=	Centers for Medicare and Medicaid Services
FIM	=	Functional Independence Measure
IRF	=	inpatient rehabilitation facility
ISS	=	Injury Severity Score
LOS	=	length of stay
RR	=	rehabilitation registry
SNF	=	skilled nursing facility
TBI	=	traumatic brain injury
TR	=	trauma registry

Over the past 20 years, there has been a nearly 50% decrease in the number of trauma patients discharged to rehabilitation centers in the state of Washington, with a similar trend on the national level. Today, only approximately 6% of all hospitalized trauma patients in Washington State are discharged to an IRF.¹ No studies to date have evaluated the effect of inpatient rehabilitation after traumatic injury on functional outcomes and the likelihood of subsequent discharge home. Recent evidence does, however, demonstrate that the post-acute care setting can be predictive of long-term outcomes for trauma patients. Specifically, Davidson and colleagues,² demonstrate that trauma patients discharged to a SNF are more likely to die after discharge compared with patients discharged home. In contrast, patients discharged to an IRF do not have an increased risk of post-discharge mortality. Despite this, we know from Ayoub-Chee and colleagues,³ that in the recent past there has been a considerable increase in the number of trauma patients discharged to SNFs compared with IRFs.

In the state of Washington, we now have in place a unique rehabilitation registry that contains demographic and functional outcomes data for all trauma patients discharged to any one of the state's 14 IRFs. Empowered with the ability to track the progress of trauma patients through their rehabilitation course, we sought to describe the characteristics and immediate outcomes of a cohort of trauma patients who received care at an IRF, and to determine the likelihood of eventual discharge home and the likelihood of rehospitalization and death within 1 year for trauma patients who received post-discharge care at an IRF compared with a cohort of propensity score-matched patients who did not receive post-discharge care at an IRF.

METHODS

We performed a retrospective cohort study of injured patients of any age who were treated inclusively at any of the 14 IRFs within the state of Washington during

the 2-year period between 2011 and 2012. These data were recorded in a unique Washington State trauma rehabilitation registry (RR) that includes basic demographic data and functional outcomes as measured by the Functional Independence Measure (FIM) score. Patient records from the RR were linked to the Washington State trauma registry (TR), which contains more detailed data for all injured patients admitted to a state-designated trauma hospital (Levels I to V). Washington State does not require that isolated hip fractures in patients older than age 65 years be reported, and primary burn patients were excluded.

The FIM score is a widely used functional assessment scale and has been well validated in the trauma population.^{4,5} It consists of 13 motor (eating, grooming, bathing, upper body dressing, lower body dressing, toileting, bladder management, bowel management, bed to chair transfer, toilet transfer, shower transfer, locomotion, stairs) and 5 cognitive (cognitive comprehension, expression, social interaction, problem solving, memory) items designed to assess the amount of functional assistance required for a person to perform basic life activities. Each activity is scored on a scale of 1 to 7, resulting in a total FIM score from 18 to 126, a motor FIM score from 13 to 91, and a cognitive FIM score from 5 to 35. Admission and discharge FIM scores were available for patients in the RR. The modified FIM score is a simplified version of this functional assessment that consists of a 4-point scoring scale assessing locomotion, feeding, and expression, resulting in a total modified FIM score of 3 to 12.⁶ The modified FIM score is a variable encoded in the TR and was available for all patients at the time of hospital discharge.

Patient demographics, injury-specific data, and details about the initial inpatient hospitalization were recorded for all injured patients discharged to an IRF in Washington State between 2011 and 2012. This was compared with all trauma patients in the TR during the same period. For patients treated at an IRF after discharge from the hospital, ICD-9 codes from the TR were manually translated into one of several injury categories: traumatic brain injury (TBI), orthopaedic injury (vertebral fracture and/or extremity injury), thoracic injury, abdominal injury, and spinal cord injury. For patients treated at an IRF after discharge from the hospital, FIM scores at the time of admission to, and discharge from, rehabilitation were recorded.

Propensity score matching was used to identify a comparison cohort of patients within the TR who did not receive care at an IRF, despite the same propensity to receive care at an IRF as those who did. Factors used for the propensity score matching included age, insurance

ATTACHMENT 12 Purpose of the Project

Vol. 223, No. 6, December 2016

Nehra et al Rehabilitation after Trauma

757

status, mechanism, Injury Severity Score (ISS), Abbreviated Injury Score (AIS), emergency department Glasgow Coma Scale, Charlson Comorbidity Index, number of operative procedures, mechanical ventilation, ICU admission, hospital length of stay (LOS), and modified FIM at discharge from the hospital.

The RR and TR were linked to the Comprehensive Hospital Abstract Reporting System database and to the Washington state death registry using Link Plus, a probabilistic record linkage software program developed at the CDC. Multiple imputation was used to account for any variable that was missing with a frequency of >5%. Multivariable regression analyses were used to determine the effect of several factors (ie age, mechanism, ISS, AIS, emergency department Glasgow Coma Scale, Charlson Comorbidity Index, number of operative procedures, mechanical ventilation, blood product transfusion, ICU admission, hospital LOS, modified FIM at discharge, and discharge to an IRF) on the likelihood of discharge home and the incidence of 1-year unplanned rehospitalization and mortality. Logistic regression with odds ratio was used to predict the discharge outcomes. To account for deaths in the rehospitalization analysis, a competing risk regression analysis was performed using post-discharge deaths as the competing risk factor, and adjusted sub-hazard ratios were calculated. Post-discharge mortality was assessed using a Cox proportional hazard model to provide an adjusted hazard ratio.

All statistical analyses were performed using STATA software, version 13.0 (Stata Corp). Two-sided tests of significance (Z-test and Student's *t*-test) were used when appropriate, and results were considered significant with a *p* value <0.05.

RESULTS

In the 2-year period from 2011 to 2012, there were 1,283 patients recorded in the TR as being discharged to an inpatient rehabilitation center after hospitalization for injury. During the same time period, the RR had records of 2,646 patients categorized as being cared for at a rehabilitation facility after an acute injury. The discrepancy was largely due to some erroneous reporting of noninjured patients to the RR by a few rehabilitation centers. These records were screened and truly injured patients reported in the RR were linked to specific patients within the TR. With this, a total of 1,011 injured patients from the RR were successfully linked to the TR. After excluding 18 patients with isolated burns, there were 993 trauma patients that could be reliably tracked from their initial injury through their inpatient rehabilitation. During the same time period, there were 51,464 total patients

hospitalized for treatment of a traumatic injury in the state of Washington.

Descriptive characteristics of patients discharged to an inpatient rehabilitation facility compared with the general Washington State trauma population between 2011 and 2012

Table 1 compares basic patient characteristics for all trauma patients and those who received care at an IRF in Washington State between 2011 and 2012. The mean (SD) age of patients discharged to an IRF was 50.5 (23.5) years. The vast majority of patients had suffered a blunt injury (94.9%). The most common injury was TBI, with 595 (34.2%) patients sustaining an isolated TBI and another 240 (25.7%) suffering a TBI in conjunction with another major injury. Mean (SD) ISS for patients discharged to a rehabilitation facility was 19.8 (11.8) with 53.9% having an ISS between 9 and 24 and 36.0% having an ISS of >25. Head AIS was >3 for 46.9% of patients discharged to an IRF; and AIS for the thorax, abdomen, and extremity was ≤3 for the vast majority of patients. Basic demographic characteristics were similar between those patients discharged to an IRF and the general population during the same time period. However, those discharged to an IRF were more severely injured with higher ISS, body region AIS, and a higher likelihood of being intubated and admitted to the ICU. Additionally, patients admitted to an IRF had lower modified FIM scores at the time of hospital discharge compared with the general trauma population.

Mean (SD) length of inpatient rehabilitation stay was 19 (36) days. Patients having sustained a combined TBI and spinal cord injury had the longest inpatient rehabilitation stay at 54 (97) days (Fig. 1).

Outcomes for trauma patients discharged to an inpatient rehabilitation facility

The FIM scores at admission to and discharge from an IRF were used to determine improvement in functional status with rehabilitation. Total FIM scores (SD) improved by 29 (17.0) points (45%), from 63.7 (20.3) to 92.2 (20.9) (*p* < 0.001) with the majority of this improvement occurring in the motor category (mean [SD] Δ motor FIM 24.6 [14.6], 60% increase; *p* < 0.001) compared with the cognitive category (mean [SD] Δ cognitive FIM 4.6 (5.7), 20% increase; *p* < 0.001) (Fig. 2). Improvements in FIM scores with rehabilitation were notable across injury types (Fig. 3). The vast majority of patients (78.2%) admitted to an acute rehabilitation center after trauma were successfully discharged to home.

Purpose of the Project
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 12
Purpose of the Project

758

Nehra et al

Rehabilitation after Trauma

J Am Coll Surg

Table 1. Characteristics of All Trauma Patients, Those Discharged to an Inpatient Rehabilitation Facility and a Propensity Score-Matched Cohort of Patients Not Discharged to an Inpatient Rehabilitation Facility in Washington State Between 2011 and 2012

Characteristic	All trauma (n = 61,464)		IRF* (n = 993)		IRF propensity score-matched cohort (n = 731)		No IRF propensity score-matched cohort (n = 631)	
	n	%	n	%	n	%	n	%
Sex, male	30,644	59.5	678	68.3	494	69.3	390	61.8
Age								
0 to 14 y	6,978	13.6	36	3.6	28	3.9	53	8.4
15 to 34 y	12,421	24.1	272	27.4	189	26.5	136	21.6
35 to 54 y	10,371	20.2	221	22.3	155	21.7	134	21.2
55 to 74 y	10,636	20.7	261	26.3	191	26.8	165	26.2
75 to 84 y	5,274	10.3	138	14.0	101	14.2	66	10.5
>85 y	5,779	11.2	65	6.6	49	6.9	77	12.2
Unknown	5	0.01	0	0	0	0	0	0
Insurance								
Commercial	19,699	38.3	379	38.2	284	39.8	259	41.1
Medicare	13,511	26.3	290	29.2	216	30.3	187	29.6
Medicaid	9,998	19.4	247	24.9	166	23.3	144	22.8
None	6,428	12.5	61	6.1	47	6.6	41	6.5
Unknown	1,828	3.6	16	1.6	0	0	0	0
Mechanism								
Blunt	45,638	88.9	942	94.9	676	94.8	598	94.8
Penetrating	3,384	6.5	41	4.1	31	4.4	26	4.1
Other	2,309	4.4	9	0.9	6	0.8	7	1.1
Unknown	75	0.1	1	0.1	0	0	0	0
Injury Severity Score								
0 to 8	29,614	57.5	100	10.1	61	8.6	80	12.7
9 to 15	14,599	28.4	262	26.4	164	23.0	143	22.7
16 to 24	4,182	8.1	273	27.5	181	25.4	152	24.2
25 to 75	2,702	5.3	357	36.0	307	43.1	254	40.4
Unknown	367	0.7	1	0.1	0	0	2	0.3
AIS score								
Head AIS >3	3,869	7.4	466	46.9	335	47.0	265	42
Thorax AIS >3	1,098	2.1	85	8.6	60	8.4	48	7.6
Abdominal AIS >3	608	1.2	43	4.3	24	3.4	22	3.5
Extremity AIS >3	519	1.0	24	2.4	12	1.7	6	1.0
ICU admission, yes	9,613	18.3	713	71.8	530	74.3	453	71.8
Mechanical ventilation, yes	3,267	6.2	250	25.2	169	23.7	129	20.4
Modified FIM at hospital discharge								
Mild dependence (FIM 11 to 12)	20,271	39.4	286	28.8	271	38.0	317	50.4
Moderate dependence (FIM 8 to 10)	7,437	14.5	350	35.3	327	45.9	198	31.4
Severe dependence (FIM 3 to 7)	1,338	2.6	121	12.2	114	16.0	102	16.2
Unknown	22,418	43.6	236	23.8	1	0.1	14	2.2

*Entire cohort of injured patients discharged to an inpatient rehabilitation facility.

†Injured patients discharged to an inpatient rehabilitation facility who were included in propensity score matching.

‡Injured patients not discharged to an inpatient rehabilitation facility identified as propensity score-matched cohort.

AIS, Abbreviated Injury Scale; FIM, Functional Independence Measure; IRF, inpatient rehabilitation facility.

ATTACHMENT 12

Purpose of the Project

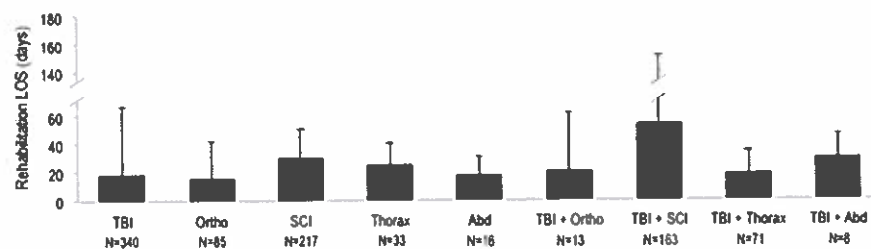


Figure 1. Rehabilitation length of stay (LOS) for trauma patients discharged to inpatient rehabilitation by injury type. All data presented as mean $\pm$ SD. Abd, abdominal injury; Ortho, orthopaedic injury (vertebral fracture and/or extremity injury); SCI, spinal cord injury; TBI, traumatic brain injury; Thorax, thoracic injury.

Comparing patients discharged to an inpatient rehabilitation facility with a propensity score-matched cohort of patients who did not receive care at an inpatient rehabilitation facility

With the propensity score matching, 631 patients who did not receive care at an IRF were identified as a propensity score-matched cohort of control patients for comparison with 731 patients who did receive care at an IRF. Characteristics of both groups are shown in Table 1.

Likelihood of discharge home

Multivariable logistic regression analyses were conducted on the combined cohort of patients who received care at an IRF and the propensity score-matched cohort to identify predictors of eventual discharge home. Older age, penetrating trauma, hospital LOS, and moderate or severe dependence on the modified FIM score at hospital discharge were all associated with a lower likelihood of discharge home. The only factor associated with a higher

likelihood of discharge home was post-hospital discharge treatment at an IRF, with an OR of 9.41 (95% CI, 6.80–13.01; $p < 0.001$) (Table 2). Additionally, post-hospital discharge care at an IRF significantly increased the likelihood of eventual discharge home for trauma patients of all age groups (15 to 34 years old: OR = 41.46; 95% CI, 14.85–115.77; 35 to 54 years old: OR = 8.50; 95% CI, 3.18–22.73; 55 to 74 years old: OR = 12.70; 95% CI, 6.75–23.90; and 75 years and older: OR = 13.55; 95% CI, 6.88–26.67).

Unplanned rehospitalization within 1 year

Looking at the cohort of patients who received inpatient rehabilitation and the comparison propensity score-matched cohort, multivariable competing risk regression analysis with death as the competing risk showed that older age and having sustained a ground-level fall or penetrating trauma compared with a non-ground-level fall blunt trauma were associated with a higher likelihood of rehospitalization within 1 year. Care at an IRF did not affect the likelihood of rehospitalization within 1 year (Table 2).

1-Year mortality

Looking at the cohort of patients who received inpatient rehabilitation and the comparison cohort of propensity score-matched patients, multivariable Cox regression analysis was used to identify factors predictive of mortality at 1 year. Older age, penetrating trauma, longer hospital LOS, and severe dependence on the modified FIM at hospital discharge were associated with a higher 1-year mortality. Care at an IRF was the only factor associated with lower 1-year mortality (Table 2).

DISCUSSION

The inpatient mortality for trauma patients has decreased, but post-discharge mortality has actually increased over time,^{7,9} which highlights the fact that short-term outcomes measures achieved during the inpatient

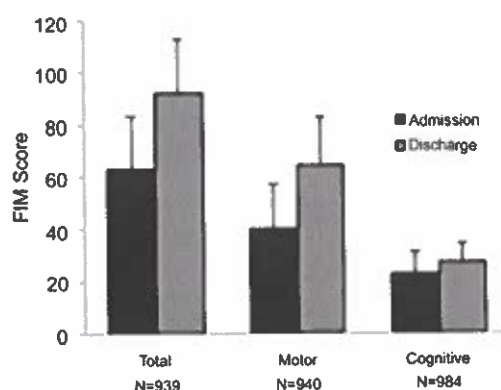


Figure 2. Total, motor, and cognitive Functional Independence Measure (FIM) scores at the time of admission to and discharge from rehabilitation for trauma patients discharged to inpatient rehabilitation. All data presented as mean $\pm$ SD.

ATTACHMENT 12

Purpose of the Project

760

Nehra et al

Rehabilitation after Trauma

J Am Coll Surg

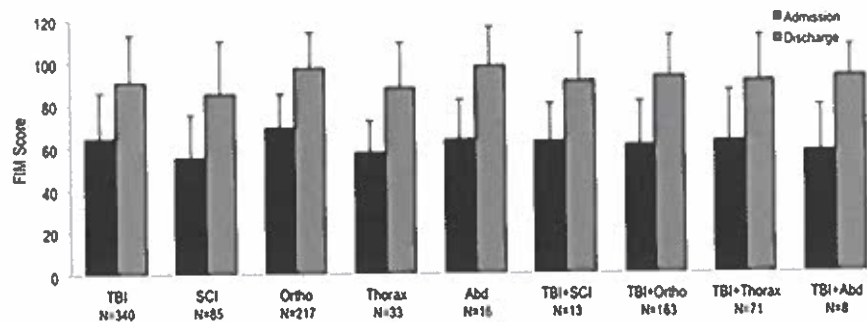


Figure 3. Total Functional Independence Measure (FIM) scores at the time of admission to and discharge from rehabilitation by injury type for trauma patients discharged to inpatient rehabilitation. All data presented as mean $\pm$ SD. Abd, abdominal injury; Ortho, orthopaedic injury (vertebral fracture and/or extremity injury); SCI, spinal cord injury; TBI, traumatic brain injury; Thorax, thoracic injury.

hospitalization of the trauma patient are simply not an adequate method for measuring trauma care success. Functional outcomes and quality of life measures are equally important, if not more important, than mortality, but have rarely been evaluated. Traumatic injury has a profound prolonged impact on quality of life and the magnitude and duration of this effect is often severely underestimated.¹⁰ This quality of life is intimately linked with the attainment of functional independence, and discharge to an IRF has the potential to increase the likelihood of functional independence and improve quality of life substantially.

Definitive studies about the optimal post-discharge rehabilitation setting for trauma patients are lacking. In this retrospective database study of adult trauma patients, we sought to gain a better appreciation of the benefits of post-discharge care of the trauma patient at an IRF. We found that injured patients who received post-discharge rehabilitation care at IRFs in Washington State experienced a considerable improvement in functional outcomes during the course of their rehabilitation, and that 78% of these patients were successfully discharged home from the IRF. This is particularly striking when one considers the fact that these are generally older and severely injured patients. We also demonstrate that, compared with a propensity score-matched cohort that did not receive post-discharge care at an IRF, those treated at an IRF had a higher likelihood of eventually being discharged home, with an associated reduction in 1-year mortality.

Previous studies demonstrate that discharge of a trauma patient to a location other than home and specifically to a SNF is an independent predictor of mortality, although patients discharged to an IRF do not have the same increased risk of post-discharge mortality.^{2,7,8} Despite this, during the last several years, there has been an

increase in the number of trauma patients being discharged to SNFs and a decrease in the number being discharged to IRFs.⁹ The data from the current study make this trend particularly concerning. Conversely, patients who suffer strokes are more likely to be discharged to an IRF in comparison with patients suffering a traumatic injury. According to the Centers for Medicare and Medicaid Services (CMS), approximately 20% of all patients who suffer a stroke are discharged to an IRF, and stroke has been the leading diagnosis among Medicare beneficiaries admitted to an IRF. The reasons for this are complex. Earlier studies have demonstrated that stroke patients discharged to an IRF have improved functional outcomes compared with patients discharged to a SNF.¹¹⁻¹⁵ This evidence has since been translated into clinical practice, and the Joint Commission has required primary stroke centers to evaluate the post-discharge rehabilitation needs for all stroke survivors.

From 2005 to 2011, the number of IRFs has generally been decreasing, with stabilization in the number of facilities between 2011 and 2012.¹⁶ A compliance threshold was created for all IRFs mandating that a certain proportion of all patients in each IRF have diagnoses specified by CMS as requiring intensive inpatient rehabilitation. The enforcement of this rule and additional restrictions has resulted in a substantial decline in the volume of Medicare patients treated in IRFs. Occupancy rates have been steady since 2002, at only approximately 62% to 63%.¹⁶ This has led CMS to declare that the number of IRF facilities and beds is adequate to meet current demand. But, are we getting the most out of this resource, and is it possible that we are depriving certain patient populations the post-discharge care that might allow them to regain enough functional independence to return to their lives? It has been established that stroke patients

ATTACHMENT 12

Purpose of the Project

Table 2. Predictors of Discharge Home, 1-Year Rehospitalization, and 1-Year Mortality on Multivariable Logistic Regression Analysis

Predictor	Discharge home			1-year rehospitalization			1-year mortality		
	Odds ratio*	95% CI	p Value	Sub-hazard ratio*	95% CI	p Value	Hazard ratio*	95% CI	p Value
Age	0.96	0.95–0.97	<0.001	1.02	1.01–1.03	<0.001	1.05	1.04–1.07	<0.001
Mechanism									
Blunt	1.00	Reference	NA	1.00	Reference	NA	1.00	Reference	NA
Ground-level fall	0.80	0.51–1.25	0.319	1.55	1.05–2.30	0.029	1.41	0.90–2.21	0.138
Penetrating	0.40	0.20–0.78	0.007	2.03	0.94–4.38	0.070	3.97	1.33–11.86	0.013
Emergency department Glasgow Coma Scale score									
14 to 15	1.00	Reference	NA	1.00	Reference	NA	1.00	Reference	NA
9 to 13	1.32	0.61–2.87	0.482	1.07	0.45–2.56	0.871	0.59	0.19–1.78	0.349
3 to 8	1.14	0.60–2.18	0.685	1.44	0.70–2.95	0.320	0.71	0.27–1.90	0.500
Injury Severity Score									
0 to 8	1.00	Reference	NA	1.00	Reference	NA	1.00	Reference	NA
9 to 15	1.30	0.73–2.31	0.370	0.55	0.31–0.98	0.044	1.53	0.66–3.53	0.317
16 to 24	0.84	0.44–1.60	0.594	0.67	0.36–1.26	0.218	1.04	0.39–2.76	0.932
25 to 75	0.68	0.34–1.36	0.279	0.81	0.43–1.52	0.510	1.05	0.37–2.99	0.929
Head Abbreviated Injury Scale score									
≤3	1.00	Reference	NA	1.00	Reference	NA	1.00	Reference	NA
>3	1.27	0.84–1.92	0.260	NA		NA	1.47	0.74–2.90	0.269
Hospital length of stay	0.98	0.97–1.00	0.014	1.00	0.99–1.01	0.684	1.03	1.02–1.03	<0.001
ICU admission									
No	1.00	Reference	NA	1.00	Reference	NA	1.00	Reference	NA
Yes	0.84	0.55–1.31	0.462	1.21	0.74–1.97	0.456	0.86	0.46–1.60	0.885
Mechanical ventilation									
No	1.00	Reference	NA	1.00	Reference	NA	1.00	Reference	NA
Yes	1.10	0.68–1.79	0.689	0.78	0.43–1.43	0.420	1.04	0.48–2.27	0.631
Modified FIM at discharge									
Mild dependence (FIM 11 to 12)	1.00	Reference	NA	1.00	Reference	NA	1.00	Reference	NA
Moderate dependence (FIM 8 to 10)	0.22	0.15–0.31	<0.001	1.01	0.69–1.48	0.950	0.99	0.60–1.62	0.958
Severe dependence (FIM 3 to 7)	0.07	0.04–0.12	<0.001	0.98	0.59–1.62	0.940	2.84	1.63–4.95	<0.001
Rehabilitation									
No	1.00	Reference	NA	1.00	Reference	NA	1.00	Reference	NA
Yes	9.41	6.80–13.01	<0.001	1.25	0.90–1.72	0.182	0.60	0.39–0.92	0.018

For total cohort, $n = 1,624$, which includes patients discharged to acute inpatient rehabilitation ($n = 993$) and propensity score-matched control ($n = 631$).
*Adjusted odds ratio, hazard ratio, and sub-hazard ratio with propensity score matching.
FIM, Functional Independence Measure; NA, not applicable.

and those with neurologic disorders are a cohort of patient that derive substantial functional benefit from inpatient rehabilitation care and this has likely contributed to the high percentage of these patients discharged to rehabilitation centers.^{11,16} Until now, the functional benefit that acutely injured patients gain from inpatient rehabilitation after hospital discharge has not been understood. Our

data would suggest that post-discharge care at an IRF rather than a SNF has the potential to profoundly improve functional outcomes for acutely injured patients.

One of the limitations of the current study is the fact that our propensity score-matched cohort of patients who did not receive care at an IRF might not be a perfect control group. This method of statistical analysis allows us

ATTACHMENT 12

Purpose of the Project

to generate a comparison cohort of patients based on factors that we deem to be important and that we are able to measure and quantify. The appropriateness of the comparison cohort depends on our ability to include all of the correct variables in the propensity score analysis. It must be recognized that we were unable to account for whether patients met CMS criteria for discharge to an IRF, which includes 3 basic components: patient must require and be reasonably expected to benefit from intensive rehabilitation therapy that consists of at least 3 hours/day at least 5 days/week; patient must require therapy in at least 2 modalities; and patient must require supervision by a rehabilitation physician. A randomized clinical trial would be the most definitive way of determining whether post-hospital discharge care at an IRF really matters; however, randomizing patients that qualify for rehabilitation to a non-treatment arm (no IRF) is neither ethical nor practical. With the caveat that a randomized controlled trial might not be possible, we believe that this propensity score analysis represents the most rigorous statistical method available to look at the question at hand.

The other potential limitation of this study is the fact that it is a retrospective cohort study and carries with it the same limitations as all other retrospective database studies. The databases used for this study, specifically the RR, TR, and Comprehensive Hospital Abstract Reporting System, are rigorously maintained registries that are continuously monitored to ensure complete and quality data. Despite this, not all data within the registries are complete, which we addressed by using the method of multiple imputations for variables that were missing in >5% of cases. This is a well-validated method of accounting for missing variables and likely results in less bias than excluding missing variables entirely from the analysis.^{17,18}

CONCLUSIONS

Inpatient rehabilitation is a scarce resource and every effort should be made to use this relatively scarce resource on patients most likely to benefit from these services. Our data suggest that acute trauma patients should be recognized as a relatively underserved population that would benefit considerably from inpatient rehabilitation services after discharge from the hospital. Given the profound functional benefit that appropriate trauma patients derive from inpatient rehabilitation, it is imperative that we more clearly define the specific cohort of trauma patients that benefits most from this service. This will allow for the development of protocols for trauma centers to consistently identify patients most suitable for rehabilitation services and to maximize the benefit of this service for injured patients.

Author Contributions

Study conception and design: Nehra, Nixon, Lengenfelder, Bulger, Cuschieri, Maier, Arbabi
Acquisition of data: Nehra, Nixon, Lengenfelder, Bulger, Cuschieri, Maier, Arbabi
Analysis and interpretation of data: Nehra, Nixon, Bulger, Cuschieri, Maier, Arbabi
Drafting of manuscript: Nehra, Nixon, Arbabi
Critical revision: Nehra, Nixon, Lengenfelder, Bulger, Cuschieri, Maier, Arbabi

REFERENCES

1. Centers for Disease Control and Prevention. Cost of injury reports. Data and statistics (WISQARS). 2010. <https://wisqars.cdc.gov/8443/cost/>. Accessed June 2016.
2. Davidson GH, Hamlat CA, Rivara FP, et al. Long-term survival of adult trauma patients. *JAMA* 2011;305:1001–1007.
3. Ayoung-Chee PR, Rivara FP, Weiser T, et al. Beyond the hospital doors: improving long-term outcomes for elderly trauma patients. *J Trauma Acute Care Surg* 2015;78:837–843.
4. Dodds TA, Martin DP, Stolor WC, et al. A validation of the functional independence measurement and its performance among rehabilitation inpatients. *Arch Phys Med Rehabil* 1993;74:531–536.
5. Hamilton BB, Laughlin JA, Fiedler RC, et al. Interrater reliability of the 7-level functional independence measure (FIM). *Scand J Rehab Med* 1994;26:115–119.
6. Gabbe BJ, Sutherland AM, Wolfe R, et al. Can the modified functional independence measure be reliably obtained from the patient medical record by different raters? *J Trauma* 2007;63:1374–1379.
7. Skaga NO, Eken T, Jones JM, et al. Different definitions of patient outcome: consequences for performance analysis in trauma. *Injury* 2008;39:612–622.
8. Claridge JA, Leukhardt WH, Golob JF, et al. Moving beyond traditional measurement of mortality after injury: evaluation of risks for late death. *J Am Coll Surg* 2010;210:788–794, 794–796.
9. Probst C, Zelle BA, Sittaro NA, et al. Late death after multiple severe trauma: when does it occur and what are the causes? *J Trauma* 2009;66:1212–1217.
10. Holbrook TL, Anderson JP, Sieber WJ, et al. Outcome after major trauma: discharge and 6 month follow-up results from the Trauma Recovery Project. *J Trauma* 1998;45:315–323; discussion 323–324.
11. Chan L, Sandel ME, Jette AM, et al. Does postacute care site matter? A longitudinal study assessing functional recovery after a stroke. *Arch Phys Med Rehabil* 2013;94:622–629.
12. Munin MC, Seligman K, Dew MA, et al. Effect of rehabilitation site on functional recovery after hip fracture. *Arch Phys Med Rehabil* 2005;86:367–372.
13. Kramer AM, Steiner JF, Schlenker RE, et al. Outcomes and costs after hip fracture and stroke. A comparison of rehabilitation settings. *JAMA* 1997;277:396–404.
14. Harvey RL. Inpatient rehab facilities benefit post-stroke care. *Managed Care* 2010;19:39–41.

ATTACHMENT 12 **Purpose of the Project**

15. Kane RL, Chen Q, Finch M, et al. Functional outcomes of posthospital care for stroke and hip fracture patients under medicare. *J Am Geriatr Soc* 1998;46:1525–1533.
16. Medicare Payment Advisory Commission. Report to the Congress. Medicare Payment Policy. Washington, DC: Medicare Payment Advisory Commission; 2014.
17. Roda C, Nicolis I, Momas I, et al. New insights into handling missing values in environmental epidemiological studies. *PLoS One* 2014;9:e104254.
18. Wood AM, Royston P, White IR. The estimation and use of predictions for the assessment of model performance using large samples with multiply imputed data. *Biom J* 2015;57:614–632.

Purpose of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 13 Alternatives

1. Renovate in-hospital space at Springfield Memorial Hospital to expand the footprint of the inpatient rehab unit to convert semi-private rooms to private rooms, utilize all 30 licensed beds, and expand all rooms to include a private shower and sufficient space to accommodate medical equipment needs and family visitation, including overnight stays.

This option was considered and rejected for a number of reasons. One such reason was that when you consider the overall facility space and infrastructure limitations of Springfield Memorial main hospital tower (a building that was originally designed and constructed for general medical/surgical patients almost 60 years ago), it is clear that this option would be less efficient and, ultimately, more costly. The use of renovated, outdated space to house specialty inpatient rehab services contrasts dramatically with the proposed construction of a new state-of-the-art freestanding rehab hospital designed and built solely to care for patients in need of inpatient rehab services. The potential impact or limitations on patient care, as well as the secondary impact of not being able to reallocate and utilize that space to meet other facility needs, undermined the attractiveness of this alternative.

Springfield Memorial Hospital is a highly-utilized general acute care hospital with a comprehensive array of tertiary-level services and a busy Emergency Department. As such, the hospital does not have existing space that can be converted to accommodate expanded IRF services. Put simply, SMH does not have room to renovate and expand its existing inpatient rehab unit.

Moreover, the proposed new inpatient rehab hospital will not only provide needed services to HSA 3 patients, but the closing of Springfield Memorial Hospital's inpatient rehab unit will free up much-needed space for the hospital to use as it modernizes and renovates its existing patient units, with the vacated rehab unit providing 'flex space' to temporarily house med/surg rooms during the hospital-wide renovation. For these reasons, this alternative was rejected.

2. "Do nothing". Instead, maintain status quo and limit availability and accessibility to adult inpatient rehab beds despite Memorial's recognition that there is a gap in care for HSA 3 patients who currently rely on Memorial Health hospitals for their healthcare needs.

There is an unquestionable need for access to these services. Maintaining the status quo would result in no enhanced access for patients currently foregoing rehab services post-discharge; choosing to utilize less intensive services such as SNF in lieu of rehab, when needed; or being delayed admission to SMH's IRF because no bed is available. The abysmally low utilization of inpatient rehab services for HSA 3 residents compared to residents statewide (and even Adams County, where the other HSA 3 IRF is located) was previously documented. Similarly, the benefits of inpatient rehab services compared to less-intensive SNF and home health care was previously documented. In both instances, it is clear that HSA 3 residents need access to, and will benefit from, the proposed project.

For the few patients who may be able and willing to travel outside their local community for inpatient rehab care, the status quo is not a viable option either. There is simply no close provider, as demonstrated previously. These patients would be forced to travel significant distances, which limits the participation of their family in their rehab and recovery process. As previously documented, the role of the patient's family is a critical component of the rehab inpatient stay. (See Attachment 12, items 4b. and 4c.)

Conversely, the approval of the proposed freestanding rehab hospital will provide service area residents with an optimal solution to their inpatient rehab needs by offering high quality, low-cost services close to home. The new hospital will be a 50/50 joint venture between Memorial and Encompass, bringing the strength and support of two health care entities to the proposed project, one of which is a national leader in the quality provision of this important care. The proposed project will be supported and strengthened by the proven policies, procedures, infrastructure, expertise, and commitment to local communities provided by both Memorial and Encompass. For these reasons, this alternative was rejected.

ATTACHMENT 13

Alternatives

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

The applicants considered the establishment of a facility of less than 60 beds, but rejected this alternative because the establishment of a facility of less than the proposed 60 beds would fail to meet the predicted need for locally available and accessible rehab services. Thus, Memorial and Encompass did not consider a facility of less than 60 beds to be a viable option, particularly considering the quantified need for 34 additional beds in the analyses presented previously. Developing a quality rehabilitation hospital within the identified cost per square foot standards established by Illinois is already incredibly difficult, and to build a smaller facility that included all of the space and equipment that is clinically necessary to provide the positive outcomes for which Memorial and Encompass strive would further exacerbate the delta between the standard and the expense.

When all factors are considered, it is clear that the only viable alternative is for service area residents to have access to the needed 60-bed comprehensive inpatient rehab facility, and that the proposed joint venture hospital between Memorial and Encompass is best positioned to address the residents' needs. For these reasons, this alternative was rejected.

4. Project as Proposed

The project, as proposed, reflects the most cost-effective, patient-centered, comprehensive means of ensuring access to quality care for patients in need of inpatient rehab services. Consistent with Ill. Admin. Code Section 1110.110 (d)(1)(b), this project will be a joint venture that brings together two healthcare leaders for a project that will meet all of the existing and future rehab needs of this community. This project was designed to meet the needs of the surrounding community and provide Illinois residents with high quality care close to home. Moreover, this project will ultimately allow for better utilization of Springfield Memorial Hospital's existing facility (another core tenet of the CON program) and meaningfully increase access to necessary and quality care, especially for underserved and indigent communities. This is the best project to meet the needs of the community, as a whole.

Size of the Project*Rehabilitation Institute of Springfield, LLC***ATTACHMENT 14
Size of the Project**

Size of the Project Proposed GSF Compared to State Board Standard						
Reviewable Service	Beds/Rooms/ Unit	Proposed GSF		State Board Std		Met Standard
		Per Bed	Total	Per Bed	Total	
Comprehensive Physical Rehab Beds	60	578.65	34,719	525-660 GSF	39,600	Yes
Pharmacy	1	22.1	556	N/A	N/A	N/A
PT/OT/ST	N/A	N/A	8,156	N/A	N/A	N/A
Renal Dialysis Suite	N/A	N/A	1,570	N/A	N/A	N/A
Employee Suite	N/A	N/A	1,490	N/A	N/A	N/A

Reviewable Space Total	46,491
------------------------	--------

Non-Reviewable Space	16,759
----------------------	--------

Total Proposed GSF	63,250
--------------------	--------

Size of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 14 Size of the Project

Rehabilitation Institute of Springfield, LLC		07/27/2026
Room Name	Area (SF)	Comments
Section 250.2440 General Hospital Standards		
a) Admin and Public Areas		
a) 1) Main Entrance		The main entrance is designed to accommodate persons with physical disabilities.
Vestibule	343	
a) 2) Lobby	628	The lobby includes a Reception, computer niche and Waiting Space. Public toilet facilities for men and women and a drinking fountain are located around the corner, adjacent to the Lobby.
Reception		Lobby includes Reception desk. Those waiting will have access to the receptionists telephone as needed.
Waiting	9*	Additional are provided in Lobby
WC Storage	70	
Men's Public Restroom	218	
Women's Public Restroom	222	
a) 3) Interview Space	259	Interviews will take place in Admin. Conference Room.
a) 4) General or Individual Office		The Admin. Suite is located adjacent to the Lobby and provides offices for administrative personnel.
HR Office	113	
HR Storage	67	
Admissions Office	109	
Admissions Office	99	
Admin. Assistant and Waiting	139	
Admissions Work Area	201	
CEO	146	
CFO	130	
Business Development	110	
Medical Director	109	
Marketing Dir	106	
Director of Quality	110	
Controller	111	
PASC	162	
a) 5) Multipurpose Room	227	The Admin multipurpose room is designated for conferences, meetings and education purposes including a TV for visual aid.
a) 6) Medical Library Facilities		Medical Resources are located in the Admin. Suite
a) 7) Storage Areas	67	Admin. Storage is located adjacent to Admin. Suite
b) Medical Records Unit (HIMS)	102	The Medical Records room provides enough space for the reviewing, dictating, sorting, recording and storage of medical records as required by the functional program.
c) Adjunct Diagnostic and Treatment		
c) 1) Laboratory Suite	94	A laboratory room is provided in the nursing unit sized accordingly to the functional program.
c) 1) A) work counter		A work counter is provided in the lab.
c) 1) B) lavatory or counter sink		A counter sink is provided for hand-washing.
c) 1) C) storage cabinet		Base and wall cabinets are provided for storage.
c) 1) D) blood storage		Provided by vendor.
c) 1) E) specimen collection		Specimen pass-through window provided between the lab and the adjacent patient toilet room.
c) 2) Morgue and Autopsy Suite		N/A
c) 3) Radiology Suite		N/A
c) 4) Pharmacy Suite	498	Pharmacy provided in the nursing unit.
c) 4) A) Administrative Functions		Work space is provided for administrative functions, including requisitioning, recording and reporting, receiving, storage (including refrigeration) and accounting.
c) 4) B) Quality Control Area		No bulk compounding or packaging functions are performed

Size of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 14 Size of the Project

c) 4) C) Locked storage for drugs and biologicals		Locked storage for drugs and biologicals is provided by shelving vendor (Coshart)
c) 4) D) Dispensing Area		A dispensing area is provided.
c) 4) E) Hand-washing facilities		Hand-washing facilities are provided.
c) 4) E) I) drug info		Users can access a drug information area for reference materials and personnel.
c) 4) E) II) sterile products		N/A
c) 5) Physical Therapy Suite		
c) 5) A) Shared Spaces		Physical Therapy and Occupational Therapy share the use of the ADL suite.
c) 5) B) i) Office Space	107	A director of therapy office is provided within the Therapy Gym
c) 5) B) ii) Waiting Space		All patient rooms are private patient rooms, patients will wait in their rooms until their pre-scheduled time.
c) 5) B) iii) Treatment Areas	80 / each Area 107 / Room	5 Treatment Areas are provided; Walls separate each individual area. Hand washing station are easily located to the treatment area and a handwash sink is provided in the Treatment Rooms.
c) 5) B) iv) Wet and Soiled Linen	74	A soiled linen room is provided for the collection of wet and soiled linen and other material.
c) 5) B) v) Exercise Area	4303	An exercise area is provided in the therapy gym and the therapy yard.
c) 5) B) vi) Storage for Clean Linen, Supplies, Equipment	93	Clean linen cabinets are provided for linen, supplies and equipment.
c) 5) B) vii) Patient Dressing Area and Toilet Rooms		This is an inpatient only hospital and therefore patients will dress in their private rooms where they will have access to a toilet room and a wardrobe. Patients have an assigned schedule time and will be ready ahead of arriving at the Therapy Gym.
c) 5) B) viii) Wheelchair and Stretcher Storage	55	Wheelchair and stretcher storage is provided outside charting.
c) 5) B) ix) Showers, Lockers, Service Sinks		Showers and lockers are not provided in the Therapy gym due to this being an inpatient only hospital and each patient has their own private shower and wardrobe storage in their room.
c) 6) Occupational Therapy Suite		An ADL Suite is provided within the Therapy Gym
c) 6) A) Shared spaces		Physical Therapy and Occupational Therapy share the use of the ADL suite.
c) 6) B) i) Office Space (Charting)	107 Dir Office 623 Charting	An office is provided for the Director of Therapy, a charting room is provided for all other Therapy Staff
c) 6) B) ii) Activities Area w/ Sink or Lavatory		A sink is provided in each room of the ADL suite
c) 6) B) iii) Stage Space for Supplies and Equipment	320	Kitchen, bathroom, bedroom, and laundry spaces are provided
c) 6) B) iv) Patient Toilet Room	68	Provided adjacent to the ADL suite.
d) Nursing Unit		
d) 1) Patient Rooms	263 / Each	(60-Bed Hospital)
d) 1) A) Windows in each patient room		Each patient room is an outside room. Windows are provided for each patient room and are not of a size less than 7.5% of the square footage of the floor of the room.
d) 1) B) Minimum room areas 100 square feet clear in one-bed rooms		Each patient room is a private patient room with a clear floor space of 164 sq. ft.
d) 1) C) Minimum 3 feet clear at foot and sides of each bed		4 feet clear at the foot and sides of the bed is provided.
d) 1) D) Access to toilet room without entering the corridor		Each patient room has access to a toilet without entering the corridor.
d) 1) E) One toilet room shall not service more than 4 beds and not more than 2 patient rooms		Each patient room is equipped with its own toilet room.
d) 1) F) Toilet room shall contain water closet and a lavatory. Lavatory may be omitted if single bedroom contains lavatory		The toilet room shall include a water closet and a lavatory. The lavatory is omitted from the toilet room that serves not more than two single bedrooms since each such single bedroom contains a lavatory.
d) 1) G) Each patient shall have a wardrobe, locker, or closet for personal effects		Each patient has a wardrobe for hanging and storing personal effects.
d) 1) H) Visual privacy for each patient bed provided in multi-bed rooms		N/A
d) 2) Nurses' Service Center		

Size of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 14 Size of the Project

d) 2) A) Nurses' Station	300	A nurses' station with a work counter, storage areas, and communications equipment is provided.
d) 2) B) Nurses' Office	104, 140	A nurses' office is provided.
d) 2) C) Hand-washing Facilities		Hand-washing facilities convenient to the nurses' station and the drug distribution station is provided. Another handwashing station is provided within the meds room (drug distribution station).
d) 2) D) Charting Facilities	232	Charting facilities are provided for nurses and doctors, including a work counter and charting racks.
d) 2) E) Staff Lounge	185, 185	Staff lounge with a bathroom is provided. Men's and Women's toilet rooms are provided.
d) 2) E) Men's Staff Ttl Room	60	Men's Locker Room and Shower Room provided central to both Nursing Units
d) 2) E) Women's Staff Ttl Room	60	Women's Locker Room and Shower Room provided central to both Nursing Units
d) 2) F) Closets or Compartments for Staff Personal Belongings		Lockers for the safekeeping of coats and personal effect of nursing personnel are provided in the staff lounge and locker rooms.
d) 2) G) Multipurpose Room	515	A multipurpose room is provided for conferences, demonstrations, and consultation. This room is located centrally to the nursing units.
d) 2) H) Exam room		This room is omitted because all patient rooms are single bedrooms.
d) 2) I) One tub or shower for each 12 beds		Not applicable as each patient room has a private toilet/shower room within their private patient room.
d) 2) J) Nourishment Station	60, 60, 60	A nourishment room with a sink equipped with hand-washing, equipment for serving nourishment between scheduled meals, a refrigerator, storage cabinets, and a unit to provide ice for patient's service and treatment is provided.
d) 2) K) Drug Distribution Station (Meds)	139, 158, 139	Within this secured access room there are self-contained Pyxis units. The first meds room is under the nursing staff's visual control due to its adjacent location to the main nurse station. The second Meds room is video monitored; both have access controls. The Meds room contains a work counter, refrigerator, and locked storage for biologicals and drugs.
d) 3) Service Area		
d) 3) A) Clean Workroom	170, 118, 118	A clean work room is provided in each Nursing Unit. The clean work room contains a work counter, hand-washing facilities, a nurse signal, and storage facilities. The clean holding room is part of a system for storage and distribution of clean and sterile supplies and
d) 3) B) Clean Linen Storage	70, 60, 90	A Clean Linen room is provided in the Therapy Gym, Back-of-House and Nurse Unit (A separate designated area within the Cleanwork room is provided for clean linen storage.)
d) 3) C) Parking for Stretchers and Wheelchairs	70, 55	Parking is provided in alcoves for stretchers and wheelchairs out of the path of normal traffic.
d) 3) D) Soiled Workroom	157, 141	A soiled workroom is provided. The soiled workroom contains a clinical sink or equivalent flushing rim fixture, a nurse signal, a hand-washing sink, a waste receptacle, and a linen receptacle. The soiled holding room is part of a system for the collection and disposal of soiled materials.
Soiled Hold	64, 74, 111	A Soiled Hold room is provided in the Therapy Gym, Back-of-House, and Nurse Unit (A separate designated area within the Soiled Workroom is provided for clean linen storage.)
d) 3) E) Equipment Storage	107, 107, 107	Rooms for the storage of equipment such as IV stands, inhalators, mattresses and walkers is provided.
d) 3) F) Emergency Equipment Storage	21, 52	An alcove is provided for the storage of required emergency equipment within the Nurse Station. This equipment shall be under the direct control of the nursing staff.
d) 3) G) Sitz baths if req by program narrative		N/A. Sitz baths are not required by the program narrative.
d) 4) Isolation Room	293 Each	Isolation room is provided for the isolation of patients with known or suspected communicable diseases. Each isolation room has an individual toilet equipped with a bedpan flushing attachment and lavatory. All Isolations rooms are private rooms and are otherwise planned as required for a standard patient room

Size of the Project

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 14 Size of the Project

Isolation Room Ante Rooms	90	Isolation Ante Rooms are provided equipped with a hand-washing sink, trimmed with valves that can be operated without the use of hands, storage spaces for clean and soiled materials, and a space for gowning.
d) 5) Rooms for Disturbed Patients	263	There is one patient room designed for a disturbed patient for a duration of less than 24 hours. The design provides close observation and shall minimize the dangers of patient escape, suicide or injury. This room is located in a private room adjacent to
e) Intensive Care Units		N/A
f) Pediatric Nursing Unit		N/A
g) Psychiatric Nursing Unit		N/A
h) Newborn Care Unit		N/A
i) Surgical Suite		N/A
j) Obstetrics and Neonatal Suite		N/A
k) Emergency Suite (program calls for minimum level of emergency services and therefore will comply only with (k)(1), (k)(4), and (k)(10) with the remaining support spaces being located within the adjacent nursing unit.)	140	Emergency Exam room is provided in the Nursing Unit for emergency care.
k) (1) entrance		A sheltered entrance at grade level is provided with pedestrian and ambulance access.
k) (4) treatment area		The treatment area contains a handwashing sink trimmed with valves that are aseptically operated (knee or foot controls), general storage cabinets, medication dispensing Pyxis units, work counters, medical suction outlets, x-ray film illuminators, and space for storage equipment
k) (10) Toilet facilities	54	Provided adjacent to the Exam room
l) Outpatient Department		N/A
m) Service Departments		
m) 1) Dietary Facilities		
m) 1) A) General		Construction, equipment and installation complies with the standards specified in the Department's Food Service Sanitation Code and the Food Service Sanitation Manual, P.H. S. 93. Dietary facility services will be provided by the functional program and designed by a contracted kitchen specialist. Services will consist of a combination of on-site conventional food preparation system and a convenience food service system. Services will be provided for
m) 1) B) Functional Elements		
m) 1) B) i) Control Station for Receiving Food Supplies	24	Area in kitchen dry storage used for receiving and unpacking.
m) 1) B) ii) Storage Space	315, 249	Adequate storage space is provided for normal and emergency supply needs, including food requiring cold storage and dry storage.
m) 1) B) iii) Food Preparation Facilities	1114	Conventional food preparation systems have adequate space and equipment for preparing, cooking and baking. Convenience food service systems, such as frozen prepared meals, bulk packaged entrees, and individual packaged portions, or systems using contractual commissary service, have space and equipment for thawing, portioning, heating, cooking and baking.
m) 1) B) iv) Hand-washing Facilities		Hand-washing facilities are located in the food preparation area.
m) 1) B) v) Patients' Meal Service Facilities (Tray Assembly and Distribution)		Facilities provided for tray assembly and distribution.
m) 1) B) vi) Dining Space	839	Dining space provided for ambulatory patients, staff, and visitors.
m) 1) B) vii) Warewashing Space	191	Warewashing space is located in a room separate from food preparation and serving areas. Commercial-type dishwashing equipment is provided. Space is also provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using areas. A hand-washing lavatory is conveniently available.
Tray Return	150	
m) 1) B) viii) Pot-Washing Facilities		Pot-washing facilities included in warewashing.
m) 1) B) ix) Storage Area		A storage area is provided for cans, carts, and mobile tray conveyors.
m) 1) B) x) Waste Storage Facilities		Waste is not stored, close proximity to dumpsters outside facilitate immediate disposal. Collection of waste is not part of the functional program.

Size of the Project
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 14
Size of the Project

m) 1) B) xi) Offices or Desk Spaces	81	An office is provided for the dietary service manager.
m) 1) B) xii) Men's and Women's Toilets Accessible to Dietary Staff	85, 84	Men's and Women's locker room and toilet rooms are directly accessible to the Dietary Staff, adjacent to the kitchen. Hand-washing facilities are immediately available.
m) 1) B) xiii) Janitors' Closet	60	The Janitors' closet is located within the dietary department. It contains a service sink and storage space for housekeeping equipment and supplies.
m) 1) B) xiv) Self-dispensing Ice-making Facilities		Ice-making facilities are provided by the contracted Kitchen vendor in their equipment.
m) 1) B) xv) Adequate Can, Cart and Mobile Tray Washing Facilities		Adequate can, cart and mobile tray washing facilities are provided directly outside the Back-of-House
m) 2) Central Stores		
m) 2) A) Off-Street Unloading Facilities		Off-street unloading facilities are provided in the service yard behind the facility
m) 2) B) Receiving Areas		A receiving area included in Central Supply per functional program
m) 2) C) General Storage Rooms	770	General storage rooms meet the needs of the hospital located in back of house and throughout facility.
m) 2) D) Office Space		Desk provided in Central Supply per functional program
m) 3) Linen Services		Linen is to be processed off site.
m) 3) A) On-site Processing		Off-site processing is used.
m) 3) B) i) Soiled Linen Holding Room w/ Hand-Washing Facilities	122	A soiled linen holding room with facilities for hand-washing is provided.
m) 3) B) ii) Clean Linen, Receiving, Inspection and Storage Rooms	65	Clean linen, receiving, inspection and storage rooms are provided.
m) 3) B) iii) Cart Storage		Cart Storage in Clean Linen in bedwing
m) 3) B) iv) Office Space	113	
m) 4) Facilities for Cleaning and Sanitizing Carts		Provided in Service Yard
m) 5) Employees' Facilities	30	Locker Room provided with lockers. Locker at staff lounge. Showers not required with functional program.
m) 6) Janitors' Closets	121	In addition to the Janitors' closets called for in certain departments, sufficient Janitors' closets are provided throughout the facility as required to maintain a clean and sanitary environment. Each contains a floor receptor or service sink and storage space for housekeeping equipment and supplies. Space for large housekeeping equipment and for back-up supplies
m) 7) Engineering Service and Equipment Areas		
m) 7) A) Rooms or separate buildings for boilers, mechanical equipment, and electrical equipment	215,174,191, 502,210	Mechanical and Electrical rooms provided. Tele/Data 12' Min. from all electrical rooms.
m) 7) B) Engineer's space		Provided in maintenance room
m) 7) C) A maintenance shop	300	A maintenance room and maintenance office are provided.
m) 7) D) A storage room or rooms for building maintenance supplies		Provided in maintenance room
m) 7) E) Yard equipment storage		Provided in Service Yard
m) 8) Waste Processing services		
m) 8) A) Storage and Disposal	35	Waste storage is provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, compaction, containerization, removal, or by a combination of these techniques. Proper handling and disposal of radioactive waste substances is provided.
m) 8) B) Incineration		N/A
m) 9) Storage	95,141,69,103	Suitable storage is provided per functional program.
Spaces Not Listed in Administrative Code 250:		
Dialysis Suite	451	Consisting of 4 Treatment Areas, Nurse Station, two handwashing sinks (one upon entry and another at the nurse station), Equipment Storage, and a linen distribution system are provided within the suite. Easily accessible Wheelchair Storage, Janitors Closet, and Staff Toilet are across the hall.
Dialysis Patient Toilet	47	Included in suite

Size of the Project*Rehabilitation Institute of Springfield, LLC***ATTACHMENT 14
Size of the Project**

Dialysis Clean and Soiled Carts	133, 117	Provided within the suite as part of a distribution system.
Speech Rooms	107	3 Provided
Bariatric Rooms	479 /Each	Bariatric Patient Rooms are provided with FGI 2022 spacing accommodations.

Project Services Utilization
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 15
Project Services Utilization

UTILIZATION					
	DEPARTMENT / SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS)	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	Rehab Hospital	N/A	11,610 Pt Days 53.0% Occ.	85%	No
YEAR 2	Rehab Hospital	N/A	16,718 Pt Days 76.3% Occ.	85%	Yes*

*The project is conservatively expected to achieve 85% occupancy in November 2030, which is Month 11 of Project Year 2. Thus, the project achieves the target occupancy by the end of Project Year 2, which complies with the service-specific standard.

The projected utilization is based on the need for 30 additional beds to be located in and primarily serve residents of HSA 3, and further supported by the physician referral letters provided in Attachment 20.

The projected utilization also considers Springfield Memorial's 15.3 YTD26 ADC and the rapid monthly build-up of Encompass' Rehabilitation Institute of Southern Illinois (Shiloh) that achieved an approximate 91% average annual occupancy in its second full fiscal year of operation.

Unfinished or Shell Space

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 16
Unfinished or Shell Space

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

Assurances

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 17
Assurances

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

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(1) Planning Area Need

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

a) Planning Area Need – Review Criterion

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (Formula Calculation)

- A) The number of beds to be established for each category of service is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.**
- B) The number of beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.**

The proposed project is for the establishment of a 60-bed inpatient comprehensive physical rehabilitation hospital needed to provide a dedicated rehab hospital as a local service for Illinois residents so that residents do not continue foregoing needed inpatient rehab care in the future, *i.e.*, close the identified gap in care for HSA 3 and surrounding areas' residents.

The need for the proposed project is illustrated by the (a) quantified bed need analyses presented previously and (b) projected utilization of the new hospital, which is expected to exceed the 85% occupancy standard by the end of Project Year 2.

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

2) Service to Planning Area Residents

- A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.**

The proposed new 60-bed hospital is being established for the primary purpose of providing needed rehab health care services to the residents in HSA 3. HSA 3 hospitals' rehab-appropriate patient origin data evidence that the vast majority of discharges (approximately 90%) will come from HSA 3. The need for the new facility and the support for the proposed project are documented in the letters of support provided by physicians and community leaders living and practicing within HSA 3.

- B) Applicants proposing to add beds to an existing Rehab service shall provide patient origin information for all admissions for the last 12- month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.**

Not applicable.

- C) Applicants proposing to expand an existing Rehab service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).**

Not applicable.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

3) Service Demand – Establishment of Comprehensive Physical Rehabilitation

The number of beds proposed to establish Rehab service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest 2-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals. The applicant shall document subsection (b)(3)(A) and either subsection (b)(3)(B) or (C).

B) Projected Referrals

An applicant proposing to establish Rehab or to establish a new hospital shall submit the following:

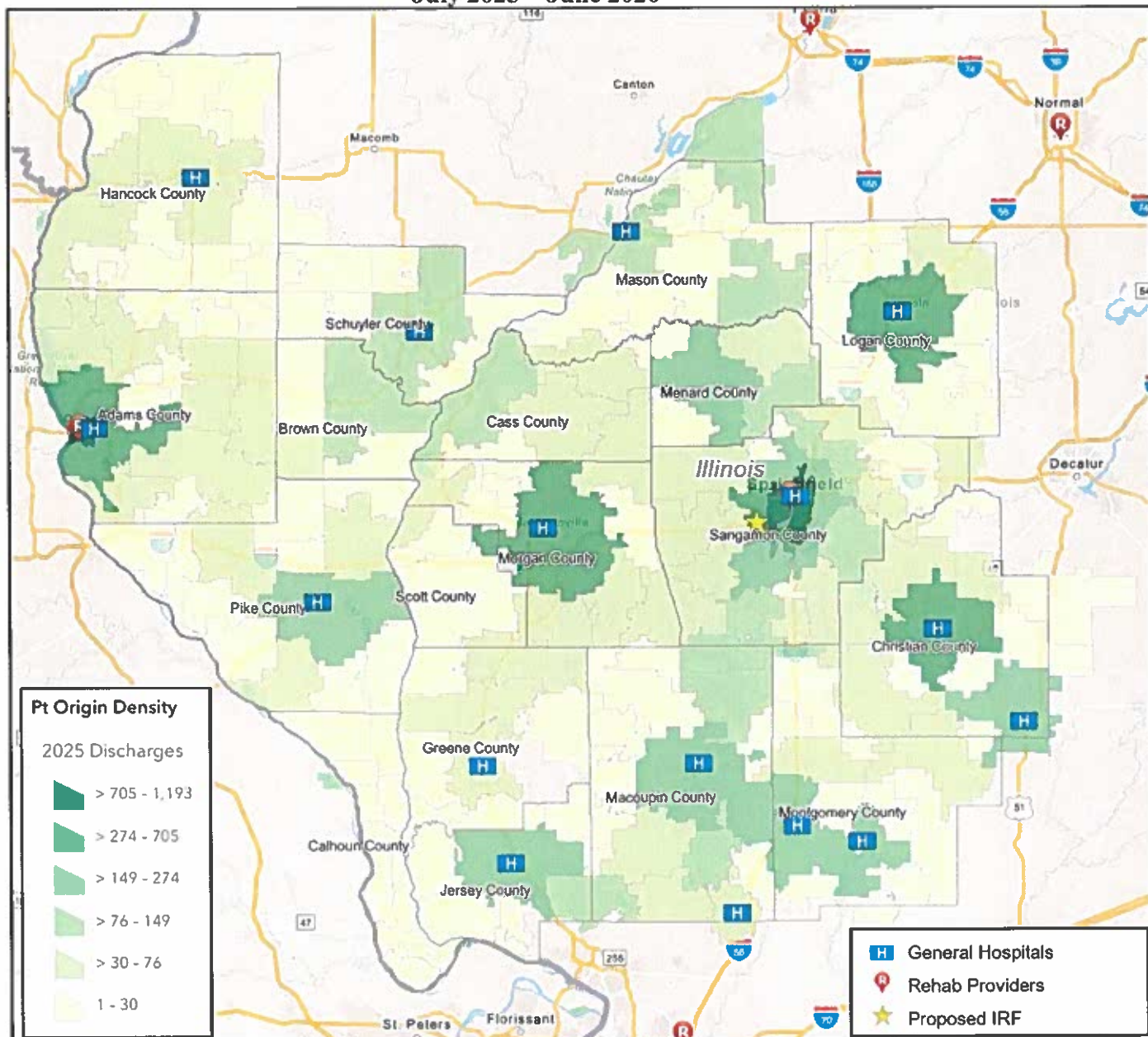
- i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;
- ii) An estimated number of patients whom the physician will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's documented historical caseload;
- iii) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty; and
- iv) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

Physicians located in and serving patients from HSA 3 and the Springfield area support the proposed project and intend to refer patients to the project, as shown in the following letters of support.

For reference, the following map shows the distribution of rehab-appropriate general acute care discharges by ZIP Code for HSA 3 residents. (*Please note: The darker the color, the greater the number of rehab-appropriate discharges in that ZIP Code.*)

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Figure 11
HSA 3 Rehab-Appropriate General Acute Care Discharges by ZIP Code
July 2025 – June 2026



Source: Illinois Hospital Association, COMPDData Informatics Inpatient Discharge Database; and ArcGIS.

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand



August 14, 2026

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

Re: Rehabilitation Institute of Springfield, LLC

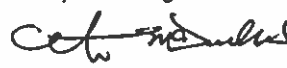
Dear Mr. Kniery,

I am the Chair of Neurology and Executive Associate Dean, Professor of the SIU School of Medicine and part of the SIU Physician Group.

This letter contains referral documentation required per Ill. Admin. Code Section 1110.205(b)(3)(A)-(B). Over the past twelve months, we referred 1,002 patients for comprehensive rehabilitation care or treated patients who would have benefitted from comprehensive rehabilitation care. A list of these referrals by patient ZIP Code of residence is attached.

Based on our historical referrals, our group would anticipate referring 301 patients each year to the Rehabilitation Institute of Springfield as proposed by the applicant, if approved.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application and that a majority of the patients reside in the proposed geographic service area. The information provided in this letter is true and accurate to the best of my knowledge.

Physician's Signature 
(Please Print/Type Name): Christopher McDowell, MD

Date 8/21/26

Notarization:
Subscribed and sworn to before me
this 21 day of August, 2026

Signature of Notary:


Seal:



SIU Medicine Department of Neurology
751 N Rutledge St - PO Box 19843 - Springfield, IL 62794-9843
217-545-8000 - Fax 217.545.1903

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Neurology Rehab Patients		
HSA3	City	Patients
62531	Edinburg	3
62089	Taylor Springs	2
62656	Lincoln	17
62712	Springfield	16
62049	Hillsboro	2
62650	Jacksonville	60
62684	Sherman	3
62558	Pawnee	3
62629	Chatham	13
62704	Springfield	90
62664	Mason City	5
62568	Taylorville	32
62626	Carlville	5
62033	Gillespie	3
62640	Girard	3
62536	Glenarm	2
62694	Winchester	6
62703	Springfield	90
62702	Springfield	108
62563	Rochester	13
62674	Palmyra	2
62615	Auburn	7
62666	Middletown	1
62691	Virginia	8
62044	Greenfield	1
62075	Nokomis	4
62635	Emden	1
62611	Arenzville	1
62088	Staunton	3
62707	Springfield	25
62633	Easton	1
62027	Eldred	2
62612	Ashland	5
62301	Quincy	3
62711	Springfield	40
62665	Meredosia	2
62675	Petersburg	11
62668	Murrayville	3
62557	Pana	9
62634	Elkhart	1
62661	Loami	2
62618	Beardstown	13
62670	New Berlin	10
62638	Franklin	1

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Neurology Rehab Patients		
62548	Mount Pulaski	1
62561	Riverton	17
62530	Divernon	2
62693	Williamsville	2
62642	Greenview	4
62546	Morrisonville	1
62613	Athens	10
62353	Mount Sterling	2
62560	Raymond	4
62692	Waverly	1
62695	Woodson	1
62540	Kincaid	3
62082	Roodhouse	8
62069	Mount Olive	1
62677	Pleasant Plains	2
62305	Quincy	3
62051	Irving	2
62378	Versailles	2
62630	Chesterfield	1
62056	Litchfield	4
62701	Springfield	2
62545	Mechanicsburg	7
62567	Stonington	5
62671	New Holland	2
62688	Tallula	1
62363	Pittsfield	3
62094	Witt	1
62621	Bluffs	3
62539	Illioopolis	2
62690	Virden	6
62570	Tovey	3
61567	Topeka	1
62708	Springfield	1
62644	Havana	5
62515	Buffalo	2
62781	Springfield	2
62649	Hettick	1
62651	Jacksonville	2
62681	Rushville	3
62520	Dawson	2
62092	White Hall	4
62625	Cantrall	3
62667	Modesto	1
62663	Manchester	2
62321	Carthage	1

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Neurology Rehab Patients		
62689	Thayer	3
62547	Mount Auburn	2
62655	Kilbourne	3
62510	Assumption	1
62555	Owaneco	3
62052	Jerseyville	1
62016	Carrollton	2
62323	Chambersburg	2
62518	Chestnut	3
62617	Bath	1
62351	Mendon	1
62376	Ursa	2
62343	Hull	1
62014	Bunker Hill	1
Subtotal, HSA3		794
All Others		
61455	Macomb	1
61401	Galesburg	1
61554	Pekin	1
61603	Peoria	1
62521	Decatur	53
62526	Decatur	53
62522	Decatur	17
61727	Clinton	2
62501	Argenta	3
62550	Moweaqua	1
62571	Tower Hill	2
61756	Maroa	2
62523	Decatur	3
62544	Macon	1
62549	Mt Zion	4
62422	Cowden	1
62535	Forsyth	5
62551	Niantic	1
61937	Lovington	2
62565	Shelbyville	1
61951	Sullivan	3
62438	Lakewood	1
61913	Atwood	3
62513	Blue Mound	2
61856	Monticello	1
62554	Oreana	2
61704	Bloomington	1
61813	Bement	1
61749	Kenney	1

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Neurology Rehab Patients		
61911	Arthur	2
62420	Casey	2
61821	Champaign	2
60950	Manteno	1
62966	Murphysboro	2
62086	Sorento	1
62901	Carbondale	1
62946	Harrisburg	1
62401	Effingham	1
62426	Edgewood	1
62414	Beecher City	1
62418	Brownstown	2
62942	Grand Tower	1
62959	Marion	1
62002	Alton	1
62208	Fairview Heights	1
62060	Madison	1
62226	Belleville	1
62249	Highland	1
Out of State/Unknown		14
Subtotal, All Others		208
Total Patients		1,002
Source: Memorial Health internal data for 12 months ending June 30, 2026.		

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand



August 14, 2026

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

Re: Rehabilitation Institute of Springfield, LLC

Dear Mr. Kniery,

I am a Board-Certified Cardiologist, Associate Professor, Division Chief Cardiology and Vice Chair of Clinical Operations at SIU School of Medicine.

This letter contains referral documentation required per Ill. Admin. Code Section 1110.205(b)(3)(A)-(B). Over the past twelve months, we referred 1,219 patients for comprehensive rehabilitation care or treated patients who would have benefitted from comprehensive rehabilitation care. A list of these referrals by patient ZIP Code of residence is attached.

Based on our historical referrals, our group would anticipate referring 244 patients each year to the Rehabilitation Institute of Springfield as proposed by the applicant, if approved.

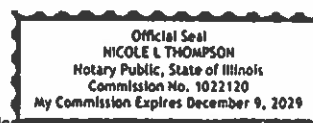
I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application and that a majority of the patients reside in the proposed geographic service area. The information provided in this letter is true and accurate to the best of my knowledge.

Physician's Signature Abhishek Kulkarni
(Please Print/Type Name) : Abhishek Kulkarni, MD

Date 8/27/26

Notarization:
Subscribed and sworn to before me
this 27 day of August, 2022

Signature of Notary:
Nicole Thompson
Seal:



SIU Internal Medicine Division of Cardiology
701 North 1st Street, MMC Suite D430, PO Box 19636, Springfield IL 62794-9636 | Fellowship Program Coordinator: Shawna Adams sadams94@siumed.edu; Office Tel: (217) 545-0191; Office Fax: (217) 545-7063 | cardiofellowship@siumed.edu

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Cardiovascular Rehab Patients		
ZIP Code	City	Patients
HSA3		
62531	Edinburg	9
62089	Taylor Springs	1
62656	Lincoln	23
62712	Springfield	23
62049	Hillsboro	5
62650	Jacksonville	54
62684	Sherman	11
62558	Pawnee	6
62629	Chatham	28
62704	Springfield	115
62664	Mason City	4
62568	Taylorville	36
62626	Carlinville	4
62543	Latham	2
62033	Gillespie	8
62640	Girard	13
62536	Glenarm	2
62694	Winchester	5
62703	Springfield	152
62009	Benld	3
62702	Springfield	132
62563	Rochester	10
62674	Palmyra	1
62615	Auburn	16
62538	Harvel	2
62666	Middletown	1
62691	Virginia	12
62044	Greenfield	1
62075	Nokomis	5
62611	Arenzville	5
62088	Staunton	1
62682	San Jose	2
62707	Springfield	28
62633	Easton	2
62612	Ashland	5
62301	Quincy	2
62711	Springfield	51
62665	Meredosia	4
62675	Petersburg	23
62668	Murrayville	2
62557	Pana	7
62634	Elkhart	2
62661	Loami	5

Page 1 of 4

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Cardiovascular Rehab Patients		
ZIP Code	City	Patients
62618	Beardstown	5
62670	New Berlin	11
61751	Lawndale	2
62638	Franklin	4
62561	Riverton	6
62530	Divernon	3
62693	Williamsville	2
62642	Greenview	5
62546	Morrisonville	2
62613	Athens	16
62560	Raymond	4
62692	Waverly	1
62540	Kincaid	4
62082	Roodhouse	6
62069	Mount Olive	3
62677	Pleasant Plains	5
62627	Chandlerville	6
62378	Versailles	1
62630	Chesterfield	1
62056	Litchfield	5
62701	Springfield	10
62545	Mechanicsburg	6
62567	Stonington	3
62673	Oakford	3
62671	New Holland	1
62688	Tallula	2
62363	Pittsfield	3
62094	Witt	1
62621	Bluffs	2
62539	Illioopolis	4
62533	Farmersville	3
62690	Virden	6
62570	Tovey	1
62644	Havana	2
62515	Buffalo	4
62651	Jacksonville	1
62681	Rushville	1
62520	Dawson	2
62092	White Hall	3
62625	Cantrall	2
61723	Atlanta	1
62663	Manchester	1
62689	Thayer	1
62547	Mount Auburn	2

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Cardiovascular Rehab Patients		
ZIP Code	City	Patients
62655	Kilbourne	3
62510	Assumption	1
62016	Carrollton	1
62643	Hartsburg	1
62351	Mendon	2
62083	Rosamond	1
62017	Coffeen	2
62320	Camp Point	1
61452	Littleton	1
62050	Hillview	1
62541	Lake Fork	1
62705	Springfield	1
61450	La Harpe	1
62019	Donnellson	1
62045	Hamburg	1
62311	Augusta	1
62306	Quincy	1
Subtotal, HSA3		1,001
All Others		
61054	Mount Morris	1
61542	Lewistown	1
61455	Macomb	2
61462	Monmouth	1
61401	Galesburg	1
61501	Astoria	2
61422	Bushnell	1
61755	Mackinaw	1
61480	Stronghurst	1
61477	Smithfield	1
61528	Edwards	1
62447	Neoga	1
62521	Decatur	34
62526	Decatur	64
62522	Decatur	26
61727	Clinton	2
61925	Dalton City	1
62571	Tower Hill	2
61756	Maroa	1
62523	Decatur	5
62431	Herrick	2
61701	Bloomington	1
62553	Oconee	1
62544	Macon	4
62549	Mt Zion	7

Page 3 of 4

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Cardiovascular Rehab Patients		
ZIP Code	City	Patients
62535	Forsyth	3
62551	Niantic	1
61937	Lovington	1
62565	Shelbyville	1
61951	Sullivan	1
62438	Lakewood	1
61920	Charleston	1
62513	Blue Mound	3
61856	Monticello	1
62554	Oreana	1
61813	Bement	1
61818	Cerro Gordo	1
60960	Rankin	1
61914	Bethany	4
61957	Windsor	1
61737	Ellsworth	1
61754	Mc Lean	1
61929	Hammond	2
61884	White Heath	1
62443	Mason	1
62471	Vandalia	4
62080	Ramsey	1
62411	Altamont	1
62414	Beecher City	1
62262	Mulberry Grove	1
62918	Cartersville	1
62885	Shobonier	1
62424	Dieterich	1
62932	Elkville	1
60302	Oak Park	2
60467	Orland Park	1
60619	Chicago	1
60646	Chicago	1
62010	Bethalto	1
62035	Godfrey	1
62025	Edwardsville	1
Out of State/Unknown		6
Subtotal, All Others		218
Total Patients		1,219
Source: Memorial Health internal data for 12 months ending June 30, 2026.		

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand



Division of Orthopedic Surgery
Michaela M Schneiderbauer, MD, MBA
Chief & Associate Professor
Austin Beeson, MD
Assistant Professor
Youssef El Bitar, MD, FAOS
Associate Professor
Q. Shawn Duszbury, MD
Associate Professor
Elizabeth Robinson, MD, FAOS
Associate Professor
John A. Shaudel, OPM, ABFAS
Assistant Professor
Shelly Flagg, MSN, FNP-BC
Nurse Practitioner
Nicole Pelsor, NP, FNP-BC
Nurse Practitioner

August 14, 2026

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

Re: Rehabilitation Institute of Springfield, LLC

Dear Mr. Kniery,

I am the Chief of Orthopedics and Associate Professor of the SIU School of Medicine Department of Surgery and part of the SIU Physician Group.

This letter contains referral documentation required per Ill. Admin. Code Section 1110.205(b)(3)(A)-(B). Over the past twelve months, we referred 586 patients for comprehensive rehabilitation care or treated patients who would have benefitted from comprehensive rehabilitation care. A list of these referrals by patient ZIP Code of residence is attached.

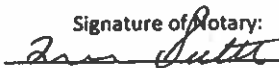
Based on our historical referrals, our group would anticipate referring 59 patients each year to the Rehabilitation Institute of Springfield as proposed by the applicant, if approved.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application and that a majority of the patients reside in the proposed geographic service area. The information provided in this letter is true and accurate to the best of my knowledge.

Physician's Signature 
(Please Print/Type Name): Michaela Schneiderbauer, MD

Date 8/21/2026

Notarization:
Subscribed and sworn to before me
this 21 day of August, 2026

Signature of Notary:

Seal:



SIU Department of Surgery, Division of Orthopedics
701 N. First St. | PO Box 19638 | Springfield, IL 62794-9638
217.545.7214 | Fax: 217.545.1793 | siumed.edu

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Orthopedic Rehab Patients		
ZIP Code	City	Patients
HSA3		
62531	Edinburg	1
62656	Lincoln	19
62712	Springfield	9
62049	Hillsboro	5
62650	Jacksonville	22
62684	Sherman	4
62558	Pawnee	2
62629	Chatham	12
62704	Springfield	53
62664	Mason City	4
62568	Taylorville	16
62626	Carlinville	6
62543	Latham	1
62033	Gillespie	7
62640	Girard	3
62536	Glenarm	1
62694	Winchester	6
62703	Springfield	41
62702	Springfield	60
62563	Rochester	7
62674	Palmyra	2
62615	Auburn	5
62538	Harvel	2
62666	Middletown	1
62691	Virginia	6
62044	Greenfield	1
62075	Nokomis	1
62611	Arenzville	1
62088	Staunton	1
62707	Springfield	12
62633	Easton	1
62612	Ashland	4
62301	Quincy	3
62711	Springfield	20
62665	Meredosia	2
62675	Petersburg	6
62557	Pana	7
62634	Elkhart	3
62661	Loami	2
62618	Beardstown	2
62670	New Berlin	6
62638	Franklin	3
62548	Mount Pulaski	3

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Orthopedic Rehab Patients		
ZIP Code	City	Patients
62561	Riverton	3
62530	Divernon	2
62693	Williamsville	4
62642	Greenview	1
62613	Athens	6
62324	Clayton	1
62560	Raymond	1
62692	Waverly	4
62695	Woodson	1
62540	Kincaid	3
62069	Mount Olive	1
62677	Pleasant Plains	2
62305	Quincy	1
62627	Chandlerville	1
62630	Chesterfield	1
62056	Litchfield	2
62701	Springfield	3
62545	Mechanicsburg	4
62567	Stonington	1
62688	Tallula	1
62621	Bluffs	2
62533	Farmersville	1
62570	Tovey	1
62644	Havana	2
62781	Springfield	1
62601	Alexander	1
62681	Rushville	3
62520	Dawson	1
62092	White Hall	3
62321	Carthage	1
62547	Mount Auburn	2
62366	Pleasant Hill	1
62016	Carrollton	2
62518	Chestnut	1
62319	Camden	1
62622	Bluff Springs	1
62098	Wrights	1
62351	Mendon	1
62032	Fillmore	1
62316	Bowen	1
62379	Warsaw	1
62014	Bunker Hill	1
62359	Paloma	1
62367	Plymouth	1

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Orthopedic Rehab Patients		
ZIP Code	City	Patients
Subtotal, HSA3		448
All Others		
61068	Rochelle	1
61455	Macomb	3
62326	Colchester	3
61415	Avon	1
61603	Peoria	1
61440	Industry	1
61615	Peoria	1
61548	Metamora	1
61755	Mackinaw	1
62447	Neoga	1
62521	Decatur	22
62526	Decatur	37
62522	Decatur	14
61727	Clinton	3
62550	Moweaqua	1
61701	Bloomington	2
62544	Macon	1
62549	Mt Zion	1
62535	Forsyth	2
62551	Niantic	1
62565	Shelbyville	2
61951	Sullivan	1
61953	Tuscola	1
61938	Mattoon	2
62554	Oreana	1
61911	Arthur	1
61818	Cerro Gordo	1
61761	Normal	1
60957	Paxton	2
61936	La Place	1
61832	Danville	1
61914	Bethany	1
61822	Champaign	1
61705	Bloomington	1
61884	White Heath	1
61847	Gifford	1
62086	Sorento	1
62471	Vandalia	3
62896	West Frankfort	1
62812	Benton	1
62927	Dowell	1
62801	Centralia	1

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Orthopedic Rehab Patients		
ZIP Code	City	Patients
61201	Rock Island	1
62294	Troy	1
62249	Highland	1
62221	Belleville	1
Out of State/Unknown		9
Subtotal, All Others		138
Total Patients		586
Source: Memorial Health internal data for 12 months ending June 30, 2026.		

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand



August 14, 2026

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

Re: Rehabilitation Institute of Springfield, LLC

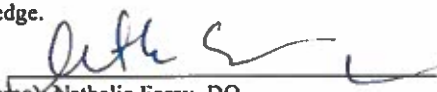
Dear Mr. Kniery,

I am a Board-Certified Pulmonologist/Critical Care, Associate Professor, Chief of Pulmonary and Critical Care Medicine at SIU School of Medicine.

This letter contains referral documentation required per Ill. Admin. Code Section 1110.205(b)(3)(A)-(B). Over the past twelve months, we referred 299 patients for comprehensive rehabilitation care or treated patients who would have benefitted from comprehensive rehabilitation care. A list of these referrals by patient ZIP Code of residence is attached.

Based on our historical referrals, our group would anticipate referring 60 patients each year to the Rehabilitation Institute of Springfield as proposed by the applicant, if approved.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application and that a majority of the patients reside in the proposed geographic service area. The information provided in this letter is true and accurate to the best of my knowledge.

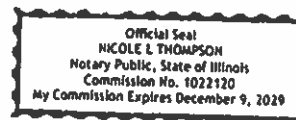
Physician's Signature 
(Please Print/Type Name): Nathalie Foray, DO

Date 8/27/26

Notarization:
Subscribed and sworn to before me
this 27 day of August, 2026

Signature of Notary:


Seal:



Division of Pulmonary & Critical Care Medicine
801 N Rutledge, Room 1269, Springfield, Illinois, 62794-9627
Academic Office phone: 217.545.0187 • Fax: 217.788.5543
siumed.edu/medicine/pulm

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Pulmonary Thoracic Rehab Patients		
ZIP Code	City	Patients
HSA3		
62656	Lincoln	5
62712	Springfield	1
62650	Jacksonville	4
62558	Pawnee	1
62629	Chatham	3
62704	Springfield	28
62664	Mason City	4
62568	Taylorville	5
62626	Carlinville	1
62033	Gillespie	2
62640	Girard	1
62536	Glenarm	2
62694	Winchester	1
62703	Springfield	52
62702	Springfield	66
62563	Rochester	3
62674	Palmyra	2
62615	Auburn	1
62691	Virginia	2
62707	Springfield	7
62612	Ashland	1
62711	Springfield	5
62675	Petersburg	3
62668	Murrayville	2
62557	Pana	2
62634	Elkhart	1
62618	Beardstown	2
62670	New Berlin	3
62638	Franklin	1
62548	Mount Pulaski	2
62561	Riverton	4
62693	Williamsville	3
62642	Greenville	1
62613	Athens	2
62353	Mount Sterling	1
62082	Roodhouse	1
62677	Pleasant Plains	1
62627	Chandlerville	1
62056	Litchfield	1
62701	Springfield	3
62545	Mechanicsburg	1
62567	Stonington	2

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

SIU Pulmonary Thoracic Rehab Patients		
ZIP Code	City	Patients
62539	Illioopolis	1
62533	Farmersville	1
62690	Virden	3
62644	Havana	1
62781	Springfield	1
62643	Hartsburg	1
Subtotal, HSA3		242
All Others		
61455	Macomb	1
62521	Decatur	16
62526	Decatur	18
62522	Decatur	6
61727	Clinton	1
61925	Dalton City	1
61756	Maroa	2
62549	Mt Zion	2
61943	Oakland	1
61749	Kenney	1
61911	Arthur	1
62573	Warrensburg	3
Out of State/Unknown		4
Subtotal, All Others		57
Total Patients		299
Source: Memorial Health internal data for 12 months ending June 30, 2026.		

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand



Springfield Clinic Main Campus
1025 South 6th Street • P.O. Box 19248
Springfield, IL 62794-9248
217.528.7541 • 800.444.7541
www.SpringfieldClinic.com

Accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC)

August 14, 2026

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

Re: Rehabilitation Institute of Springfield, LLC

Dear Mr. Kniery,

I am a Board-Certified Internal Medicine with the Springfield Clinic and practice Hospital Medicine (Hospitalist), affiliated with Springfield Memorial Hospital.

This letter contains referral documentation required per Ill. Admin. Code Section 1110.205(b)(3)(A)-(B). Over the past twelve months, we referred 891 neurological patients for comprehensive rehabilitation care or treated patients who would have benefitted from comprehensive rehabilitation care. A list of these referrals by patient ZIP Code of residence is attached.

Based on our historical referrals, our group would anticipate referring 267 patients each year to the Rehabilitation Institute of Springfield as proposed by the applicant, if approved.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application and that a majority of the patients reside in the proposed geographic service area. The information provided in this letter is true and accurate to the best of my knowledge.

Physician's Signature [Signature]
(Please Print/Type Name): Murty S. Renduchintala, MD

Date 8/21/2026

Notarization:
Subscribed and sworn to before me
this 21 day of August, 2026

Signature of Notary: [Signature]
Seal:



Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Neurology Rehab Patients		
ZIP Code	City	Patients
HSA3		
62531	Edinburg	3
62656	Lincoln	37
62712	Springfield	18
62049	Hillsboro	2
62650	Jacksonville	66
62684	Sherman	18
62558	Pawnee	13
62629	Chatham	23
62704	Springfield	79
62664	Mason City	9
62568	Taylorville	38
62626	Carlinville	2
62640	Girard	4
62536	Glenarm	2
62694	Winchester	5
62703	Springfield	73
62009	Benld	1
62702	Springfield	74
62563	Rochester	9
62674	Palmyra	2
62615	Auburn	11
62666	Middletown	1
62691	Virginia	6
62044	Greenfield	1
62075	Nokomis	6
62635	Emden	1
62611	Arenzville	3
62088	Staunton	1
62682	San Jose	1
62707	Springfield	17
62027	Eldred	1
62612	Ashland	4
62301	Quincy	2
62711	Springfield	49
62665	Meredosia	4
62675	Petersburg	19
62668	Murrayville	3
62556	Palmer	2
62557	Pana	3
62628	Chapin	3
62661	Loami	2
62618	Beardstown	9

Page 1 of 4

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Neurology Rehab Patients		
ZIP Code	City	Patients
62670	New Berlin	10
62638	Franklin	2
62548	Mount Pulaski	7
62561	Riverton	14
62530	Divernon	2
62693	Williamsville	4
62642	Greenville	8
62613	Athens	11
62560	Raymond	2
62692	Waverly	2
62540	Kincaid	2
62082	Roodhouse	4
62051	Irving	2
62378	Versailles	1
62056	Litchfield	5
62545	Mechanicsburg	5
62567	Stonington	6
62673	Oakford	1
62671	New Holland	4
62688	Tallula	6
62094	Witt	1
62621	Bluffs	3
62791	Springfield	1
62539	Illioopolis	5
62533	Farmersville	2
62690	Virden	4
62708	Springfield	2
62644	Havana	2
62515	Buffalo	4
62672	Nilwood	2
62601	Alexander	1
62519	Cornland	2
62651	Jacksonville	1
62681	Rushville	2
62520	Dawson	7
62092	White Hall	7
62625	Cantrall	4
62667	Modesto	1
62663	Manchester	2
62321	Carthage	2
62689	Thayer	2
62512	Beason	2
62340	Griggsville	2

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Neurology Rehab Patients		
ZIP Code	City	Patients
62016	Carrollton	1
62323	Chambersburg	1
62617	Bath	4
62572	Waggoner	1
62098	Wrights	1
62078	Patterson	1
62344	Huntsville	1
Subtotal, HSA3		796
All Others		
61455	Macomb	6
62326	Colchester	1
61401	Galesburg	1
61759	Minier	1
61440	Industry	1
61484	Vermont	1
61438	Good Hope	1
62447	Neoga	1
62521	Decatur	19
62526	Decatur	16
62522	Decatur	7
62501	Argenta	2
61756	Maroa	3
62523	Decatur	1
62553	Oconee	1
62544	Macon	1
62549	Mt Zion	3
62422	Cowden	1
62535	Forsyth	1
61937	Lovington	1
62565	Shelbyville	1
62534	Findlay	1
60942	Hoopeston	1
62554	Oreana	2
61749	Kenney	1
60957	Paxton	1
62514	Boody	1
61914	Bethany	1
60404	Shorewood	1
62901	Carbondale	1
62080	Ramsey	1
62401	Effingham	1
60515	Downers Grove	1
60619	Chicago	1

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Neurology Rehab Patients		
ZIP Code	City	Patients
60108	Bloomington	1
60505	Aurora	1
Out of State/Unknown		9
Subtotal, All Others		95
Total Patients		891
Source: Memorial Health internal data for 12 months ending June 30, 2026.		

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand



Springfield Clinic Main Campus
1025 South 6th Street • P.O. Box 19248
Springfield, IL 62794-9248
217.528.7541 • 800.444.7541
www.SpringfieldClinic.com

Accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC)

August 14, 2026

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

Re: Rehabilitation Institute of Springfield, LLC

Dear Mr. Kniery,

I am a Board-Certified Cardiologist with the Springfield Clinic and Department Chair of Cardiovascular Medicine at Springfield Memorial Hospital.

This letter contains referral documentation required per Ill. Admin. Code Section 1110.205(b)(3)(A)-(B). Over the past twelve months, we referred 1,913 patients for comprehensive rehabilitation care or treated patients who would have benefitted from comprehensive rehabilitation care. A list of these referrals by patient ZIP Code of residence is attached.

Based on our historical referrals, our group would anticipate referring 383 patients each year to the Rehabilitation Institute of Springfield as proposed by the applicant, if approved.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application and that a majority of the patients reside in the proposed geographic service area. The information provided in this letter is true and accurate to the best of my knowledge.

Physician's Signature N Patel

Date 8/21/26

(Please Print/Type Name): Nileshkumar J. Patel, MD

Notarization:
Subscribed and sworn to before me
this 21 day of August, 2026

Signature of Notary:

Seal:



ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Cardiovascular Rehab Patients		
ZIP Code	City	Patients
HSA3		
62531	Edinburg	11
62656	Lincoln	97
62712	Springfield	36
62049	Hillsboro	13
62650	Jacksonville	196
62684	Sherman	32
62558	Pawnee	11
62629	Chatham	79
62704	Springfield	158
62664	Mason City	25
62568	Taylorville	79
62626	Carlinville	9
62640	Girard	15
62536	Glenarm	8
62694	Winchester	16
62703	Springfield	140
62009	Benld	1
62702	Springfield	160
62563	Rochester	36
62674	Palmyra	6
62615	Auburn	38
62538	Harvel	1
62666	Middletown	2
62691	Virginia	22
62044	Greenfield	3
62075	Nokomis	6
62635	Emden	3
62611	Arenzville	8
62682	San Jose	1
62707	Springfield	48
62633	Easton	5
62612	Ashland	6
62711	Springfield	87
62665	Meredosia	4
62675	Petersburg	50
62668	Murrayville	10
62556	Palmer	1
62557	Pana	11
62634	Elkhart	8
62628	Chapin	8
62661	Loami	11
62618	Beardstown	21

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Cardiovascular Rehab Patients		
ZIP Code	City	Patients
62670	New Berlin	13
61751	Lawndale	1
62638	Franklin	7
62548	Mount Pulaski	16
62561	Riverton	17
62530	Divernon	2
62693	Williamsville	7
62642	Greenville	13
62546	Morrisonville	12
62613	Athens	21
62324	Clayton	1
62353	Mount Sterling	4
62560	Raymond	3
62692	Waverly	15
62695	Woodson	4
62540	Kincaid	6
62082	Roodhouse	13
62069	Mount Olive	2
62677	Pleasant Plains	19
62305	Quincy	1
62051	Irving	1
62627	Chandlerville	6
62378	Versailles	3
62056	Litchfield	9
62701	Springfield	3
62545	Mechanicsburg	9
62567	Stonington	7
62673	Oakford	5
62688	Tallula	3
62363	Pittsfield	2
62621	Bluffs	4
62539	Illioopolis	2
62533	Farmersville	3
62690	Virden	16
62570	Tovey	2
62708	Springfield	2
62644	Havana	5
62515	Buffalo	4
62672	Nilwood	1
62077	Panama	2
62601	Alexander	1
62649	Hettick	4
62681	Rushville	4

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Cardiovascular Rehab Patients		
ZIP Code	City	Patients
62520	Dawson	11
62092	White Hall	9
62631	Concord	4
62624	Browning	1
62625	Cantrall	5
62667	Modesto	1
61723	Atlanta	6
62663	Manchester	1
62512	Beason	1
62355	Nebo	1
62547	Mount Auburn	2
62655	Kilbourne	2
62555	Owaneco	1
62016	Carrollton	1
62518	Chestnut	1
62617	Bath	5
62012	Brighton	1
62361	Pearl	1
62517	Bulpitt	1
62054	Kane	1
62017	Coffeen	1
62014	Bunker Hill	1
Subtotal, HSA3		1,815
All Others		
61455	Macomb	1
62326	Colchester	1
61441	Ipava	2
61459	Marietta	1
62521	Decatur	11
62526	Decatur	17
62522	Decatur	8
61727	Clinton	2
62501	Argenta	2
62550	Moweaqua	5
62571	Tower Hill	1
61756	Maroa	3
61701	Bloomington	1
62544	Macon	1
62549	Mt Zion	5
62535	Forsyth	1
62565	Shelbyville	2
62554	Oreana	1
61704	Bloomington	1

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Cardiovascular Rehab Patients		
ZIP Code	City	Patients
61745	Heyworth	1
61732	Danvers	1
62440	Lerna	1
62537	Harristown	1
62086	Sorento	1
62471	Vandalia	3
62080	Ramsey	2
62916	Campbell Hill	1
62411	Altamont	1
62450	Olney	3
62278	Red Bud	1
62902	Carbondale	1
62458	Saint Elmo	1
60409	Calumet City	1
61254	Geneseo	1
62001	Alhambra	1
Out of State/Unknown		11
Subtotal, All Others		98
Total Patients		1,913
Source: Memorial Health internal data for 12 months ending June 30, 2026.		

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand



A COMMUNITY OF CARING

Springfield Clinic Main Campus
1025 South 6th Street • P.O. Box 19248
Springfield, IL 62794-9248
217.528.7541 • 800.444.7541
www.SpringfieldClinic.com

Accredited by the Accreditation Association for Ambulatory Health Care (AAAHC)

August 14, 2026

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

Re: Rehabilitation Institute of Springfield, LLC

Dear Mr. Kniery,

I am an Orthopedic Surgeon and Chairman of the Board at Springfield Clinic.

This letter contains referral documentation required per Ill. Admin. Code Section 1110.205(b)(3)(A)-(B). Over the past twelve months, we referred 999 patients for comprehensive rehabilitation care or treated patients who would have benefitted from comprehensive rehabilitation care. A list of these referrals by patient ZIP Code of residence is attached.

Based on our historical referrals, our group would anticipate referring 100 patients each year to the Rehabilitation Institute of Springfield as proposed by the applicant, if approved.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application and that a majority of the patients reside in the proposed geographic service area. The information provided in this letter is true and accurate to the best of my knowledge.

Physician's Signature _____

Date 8-31-26

(Please Print/Type Name): Christopher Wottowa, MD

Notarization:

Subscribed and sworn to before me
this 31st day of August, 2026

Signature of Notary: _____

Seal: _____



ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Orthopedic Rehab Patients		
ZIP Code	City	Patients
HSA3		
62531	Edinburg	6
62656	Lincoln	81
62712	Springfield	22
62049	Hillsboro	12
62650	Jacksonville	89
62684	Sherman	10
62558	Pawnee	9
62629	Chatham	25
62704	Springfield	83
62664	Mason City	9
62568	Taylorville	37
62626	Carlinville	3
62033	Gillespie	3
62640	Girard	4
62536	Glenarm	3
62694	Winchester	9
62703	Springfield	48
62702	Springfield	78
62563	Rochester	15
62674	Palmyra	1
62615	Auburn	9
62538	Harvel	1
62666	Middletown	3
62691	Virginia	8
62075	Nokomis	5
62635	Emden	1
62611	Arenzville	3
62707	Springfield	16
62633	Easton	3
62612	Ashland	5
62301	Quincy	1
62711	Springfield	71
62665	Meredosia	5
62675	Petersburg	17
62668	Murrayville	4
62556	Palmer	1
62557	Pana	2
62634	Elkhart	1
62628	Chapin	3
62661	Loami	1
62618	Beardstown	12

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Orthopedic Rehab Patients		
ZIP Code	City	Patients
62670	New Berlin	1
62638	Franklin	3
62548	Mount Pulaski	7
62561	Riverton	13
62693	Williamsville	4
62642	Greenville	5
62546	Morrisonville	4
62613	Athens	10
62560	Raymond	2
62692	Waverly	7
62695	Woodson	1
62540	Kincaid	2
62082	Roodhouse	3
62677	Pleasant Plains	5
62305	Quincy	1
62627	Chandlerville	3
62378	Versailles	2
62056	Litchfield	4
62701	Springfield	3
62545	Mechanicsburg	4
62567	Stonington	2
62671	New Holland	1
62363	Pittsfield	4
62094	Witt	1
62621	Bluffs	5
62791	Springfield	1
62539	Illioopolis	2
62533	Farmersville	1
62690	Virden	8
62570	Tovey	1
62644	Havana	4
62515	Buffalo	5
62672	Nilwood	3
62681	Rushville	2
62520	Dawson	3
62023	Eagarville	1
62092	White Hall	9
62631	Concord	1
62624	Browning	2
62625	Cantrall	2
62667	Modesto	2
61723	Atlanta	2

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Orthopedic Rehab Patients		
ZIP Code	City	Patients
62689	Thayer	2
62512	Beason	6
62655	Kilbourne	1
62015	Butler	1
62016	Carrollton	1
62518	Chestnut	2
62319	Camden	1
62617	Bath	1
62643	Hartsburg	3
62312	Barry	1
62012	Brighton	1
62032	Fillmore	1
62361	Pearl	1
62054	Kane	2
62685	Shipman	1
62610	Alsey	1
Subtotal, HSA3		891
All Others		
61455	Macomb	3
61482	Table Grove	1
61475	Sciota	1
61615	Peoria	1
61501	Astoria	1
61422	Bushnell	1
61607	Peoria	1
62521	Decatur	20
62526	Decatur	18
62522	Decatur	4
61727	Clinton	2
62501	Argenta	1
61925	Dalton City	1
62550	Moweaqua	3
61756	Maroa	3
61701	Bloomington	1
62544	Macon	2
62549	Mt Zion	3
62535	Forsyth	2
62551	Niantic	1
62565	Shelbyville	4
62534	Findlay	1
61951	Sullivan	2
61856	Monticello	1

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Orthopedic Rehab Patients		
ZIP Code	City	Patients
62554	Oreana	1
61704	Bloomington	1
61911	Arthur	1
61853	Mahomet	1
61761	Normal	1
62420	Casey	1
61839	De Land	1
61914	Bethany	1
62573	Warrensburg	1
61850	Indianola	1
61777	Wapella	1
62443	Mason	1
62080	Ramsey	1
62401	Effingham	2
62284	Smithboro	1
62450	Olney	1
62899	Xenia	1
62246	Greenville	1
60506	Aurora	1
62040	Granite City	1
62231	Carlyle	1
Out of State/Unknown		8
Subtotal, All Others		108
Total Patients		999
Source: Memorial Health internal data for 12 months ending June 30, 2026.		

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand



Springfield Clinic Main Campus
1025 South 6th Street • P.O. Box 19248
Springfield, IL 62794-9248
217.528.7541 • 800.444.7541
www.SpringfieldClinic.com

Accredited by the Accreditation Association for Ambulatory HealthCare (AAAHC)

August 14, 2026

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

Re: Rehabilitation Institute of Springfield, LLC

Dear Mr. Knierly,

I am a Board-Certified Pulmonologist/Critical Care with the Springfield Clinic.

This letter contains referral documentation required per Ill. Admin. Code Section 1110.205(b)(3)(A)-(B). Over the past twelve months, we referred 373 patients for comprehensive rehabilitation care or treated patients who would have benefitted from comprehensive rehabilitation care. A list of these referrals by patient ZIP Code of residence is attached.

Based on our historical referrals, our group would anticipate referring 75 patients each year to the Rehabilitation Institute of Springfield as proposed by the applicant, if approved.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application and that a majority of the patients reside in the proposed geographic service area. The information provided in this letter is true and accurate to the best of my knowledge.

Physician's Signature

Date

8/28/26

(Please Print/Type Name): Gaurav Sangwan, MD

Notarization:

Subscribed and sworn to before me
this 28th day of August, 2026

Signature of Notary:

Seal:



Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Pulmonary Thoracic Rehab Patients		
ZIP Code	City	Patients
HSA3		
62531	Edinburg	1
62656	Lincoln	20
62712	Springfield	8
62049	Hillsboro	3
62650	Jacksonville	50
62684	Sherman	7
62558	Pawnee	7
62629	Chatham	8
62704	Springfield	30
62664	Mason City	2
62568	Taylorville	1
62640	Girard	3
62694	Winchester	5
62703	Springfield	36
62702	Springfield	46
62563	Rochester	8
62615	Auburn	8
62691	Virginia	4
62044	Greenfield	2
62635	Emden	1
62611	Arenzville	2
62707	Springfield	4
62711	Springfield	13
62665	Meredosia	2
62675	Petersburg	14
62668	Murrayville	2
62556	Palmer	1
62557	Pana	1
62661	Loami	1
62618	Beardstown	5
62670	New Berlin	5
62638	Franklin	6
62548	Mount Pulaski	2
62561	Riverton	5
62530	Divernon	4
62642	Greenview	2
62613	Athens	3
62353	Mount Sterling	2
62540	Kincaid	1
62082	Roodhouse	3
62677	Pleasant Plains	2
62627	Chandlerville	2

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(3) Service Demand

Springfield Clinic Pulmonary Thoracic Rehab Patients		
ZIP Code	City	Patients
62701	Springfield	1
62545	Mechanicsburg	3
62673	Oakford	1
62671	New Holland	1
62688	Tallula	2
62621	Bluffs	2
62690	Virden	3
62570	Tovey	1
62708	Springfield	6
62515	Buffalo	1
62092	White Hall	1
62624	Browning	1
62689	Thayer	4
62512	Beason	2
62323	Chambersburg	2
62572	Waggoner	1
Subtotal, HSA3		364
All Others		
61416	Bardolph	1
62521	Decatur	1
61727	Clinton	1
62422	Cowden	1
61702	Bloomington	1
62513	Blue Mound	1
Out of State/Unknown		3
Subtotal, All Others		9
Total Patients		373
Source: Memorial Health internal data for 12 months ending June 30, 2026.		

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(5) Service Accessibility

5) Service Accessibility

The number of beds being established or added for each category of service is necessary to improve access for planning area residents. The applicant shall document the following:

A) Service Restrictions

The applicant shall document that at least one of the following factors exists in the planning area:

- i) The absence of the proposed service within the planning area;
- ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;
- iii) Restrictive admission policies of existing providers;
- iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;
- v) For purposes of this subsection (b)(5) only, all services within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(5) Service Accessibility

B) Supporting Documentation

The applicant shall provide the following documentation, as applicable, concerning existing restrictions to service access:

- i) The location and utilization of other planning area service providers;
- ii) Patient location information by zip code;
- iii) Independent time-travel studies;
- iv) A certification of waiting times;
- v) Scheduling or admission restrictions that exist in area providers;
- vi) An assessment of area population characteristics that document that access problems exist; and
- vii) Most recently published IDPH Hospital Questionnaire.

Rehabilitation Institute of Springfield, LLC is being proposed to improve access to needed rehab services for planning area residents. HFSRB has not identified a numeric need for additional beds in HSA 3 based solely on the historically-low utilization of HSA 3 IRF providers. However, as discussed previously, the HFSRB methodology projects future need based solely on historical utilization of inpatient rehab beds in the state and/or health service area. Thus, the HFSRB bed need methodology understates actual demand for the service because there is no way for HFSRB to identify the 'gap in care' that exists in each planning region. Rather, HFSRB relies on providers, with knowledge of the individual market dynamics, to determine if there is a gap in care, and if so, to quantify that gap in care.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (b)(5) Service Accessibility

This application does just that. As documented in Attachment 12, HSA 3 residents face a significant and long-term gap in inpatient rehab care that is worsening as the population ages.

The response to Purpose of the Project (Attachment 12) provides much detail and supporting documentation regarding the area population's characteristics documenting that access problems exist for patients in need of rehab services. As previously shown:

- Utilization rates of inpatient rehab services for Medicare FFS beneficiaries in HSA 3, particularly Sangamon County, are significantly below state and national averages and are trending downward compared to state rates that have remained relatively flat while national rates have increased over the past decade. (See Table 6 and Figure 2, Attachment 12.)
- The population in HSA 3 ages 65 and older is increasing significantly in the service area, projected to increase by 7.8% from 2026 to 2031. (See Table 1, Attachment 12.) This trend will continue to increase the need for inpatient rehab services as Medicare recipients, consisting mainly of residents ages 65 and older, are the leading patient population requiring inpatient rehabilitation services
- All existing providers of inpatient rehab services that could be considered alternatives to Memorial's existing inpatient rehabilitation unit are located an hour or more away, far removed from the patient's medical hub and community providers, as well as the support network of family and friends.
- The above statistics and facts are supported by the physician letters attesting to the need for the proposed project, and their intention to refer patients to the new rehab hospital.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (c)(1) Unnecessary Duplication of Services

c) Unnecessary Duplication/Maldistribution – Review Criterion

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:

- A) A list of all zip code areas that are located, in total or in part, within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) of the project's site;**
- B) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and**
- C) The names and locations of all existing or approved health care facilities located within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) from the project site that provide the categories of bed service that are proposed by the project.**

The proposed project will not result in an unnecessary duplication of services as the Springfield Memorial Hospital inpatient rehab unit is the only provider of inpatient rehab services in the 17-mile radius. Upon opening, the proposed Rehab Institute will similarly be the sole provider in the 17-mile radius since Memorial Health will delicense the existing 30 IRF beds at Springfield Memorial Hospital upon opening of the proposed new rehab hospital.

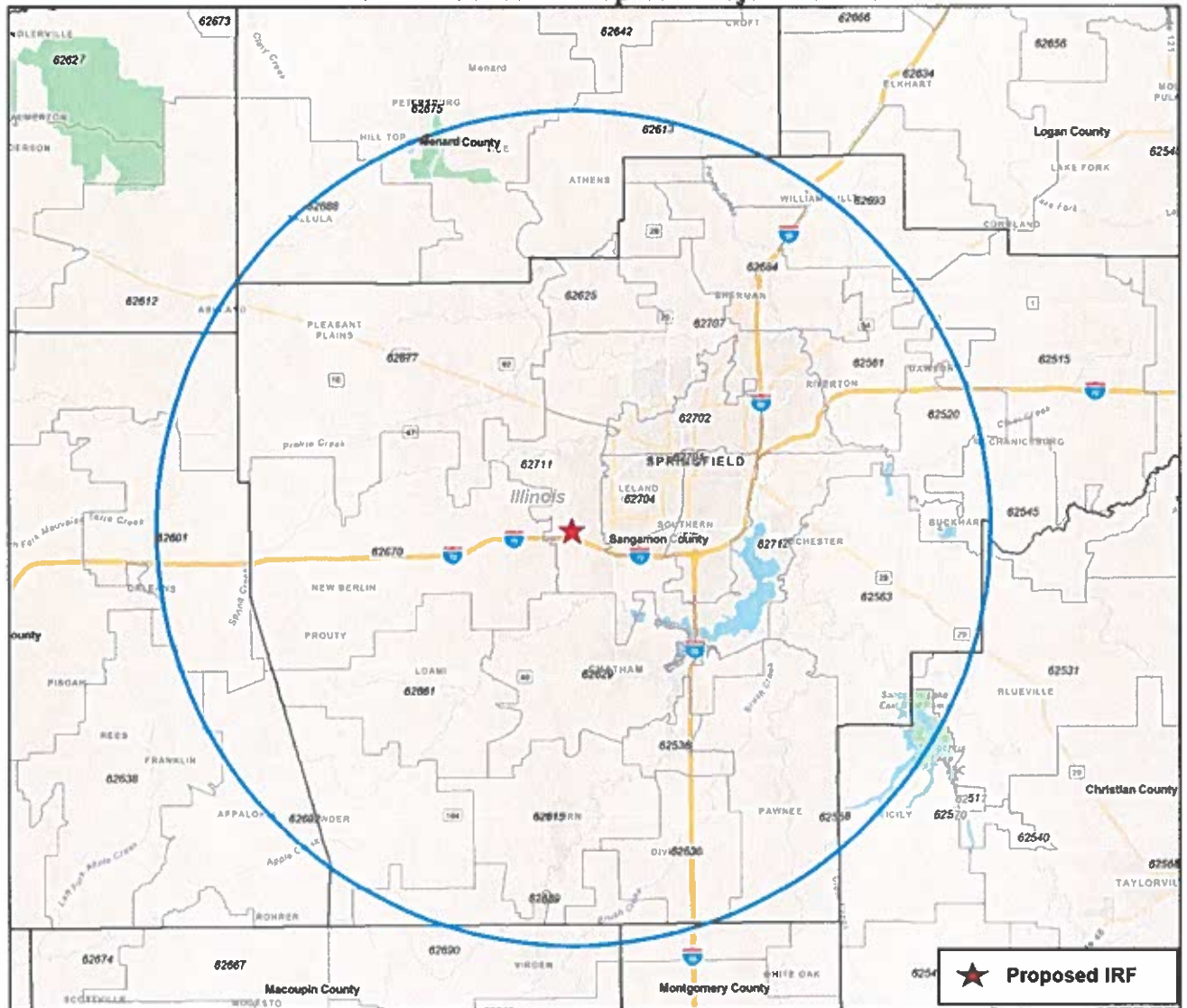
Memorial Health's proposed freestanding inpatient rehab hospital, in partnership with Encompass Health, will expand upon the foundation of Memorial's existing inpatient rehab service in order to provide locally accessible and available services for HSA 3 residents, as well as meeting the need for intensive inpatient rehab services for the patient population that Springfield Memorial currently serves from surrounding areas, including the Decatur area in contiguous Macon County.

The following ZIP Code map shows the proposed new Springfield Rehab Institute location. As shown, the proposed facility will be the only provider in the 17-mile radius.

Memorial Health will file at a later date a Certificate of Exemption for the discontinuation of its existing 30-bed inpatient rehabilitation service contingent upon the approval and opening of the proposed Rehabilitation Institute of Springfield project.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (c)(1) Unnecessary Duplication of Services

Figure 12
17-Mile Radius around Proposed Project Location



Source: ArcGIS.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (c)(1) Unnecessary Duplication of Services

Table 12			
ZIP Codes within 17-Mile Radius of Proposed Rehab Institute Site			
ZIP Code	City	2026 Total Population	2031 Total Population
62515	Buffalo	908	889
62520	Dawson	1,298	1,267
62530	Divernon	1,393	1,364
62536	Glenarm	924	906
62545	Mechanicsburg	1,362	1,344
62558	Pawnee	3,495	3,453
62561	Riverton	5,052	4,983
62563	Rochester	5,939	5,904
62601	Alexander	417	403
62612	Ashland	1,698	1,661
62615	Auburn	5,212	5,112
62625	Cantrall	937	917
62629	Chatham	16,025	16,456
62661	Loami	1,271	1,250
62670	New Berlin	3,073	3,027
62675	Petersburg	5,834	5,685
62677	Pleasant Plains	2,578	2,531
62684	Sherman	5,456	5,595
62688	Tallula	698	703
62689	Thayer	461	446
62690	Virden	3,625	3,515
62692	Waverly	1,907	1,848
62693	Williamsville	1,682	1,657
62701	Springfield	1,394	1,390
62702	Springfield	32,464	31,811
62703	Springfield	27,108	26,499
62704	Springfield	37,949	37,299
62707	Springfield	7,502	7,379
62711	Springfield	18,824	19,411
62712	Springfield	10,251	10,115

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (c)(1) Unnecessary Duplication of Services

Table 12 ZIP Codes within 17-Mile Radius of Proposed Rehab Institute Site			
ZIP Code	City	2026 Total Population	2031 Total Population
62638	Franklin	1,240	1,208
62613	Athens	3,628	3,537
62531	Edinburg	1,779	1,745
Total		213,384	211,310

Source: Claritas.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (c)(2) Maldistribution

- 2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:
- A) A ratio of beds to population that exceeds one and one-half times the State average;
 - B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or
 - C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.

The proposed project will not result in maldistribution of services. Rather, HSA 3 residents will have the appropriate number of inpatient rehab beds per population following opening of the 60-bed hospital.

As shown below, the HSA 3 beds per 1,000 population for ages 65 and older will approximate the statewide rate in 2031, with the statewide rate experiencing a decrease over time due to the aging of the population statewide and the addition of only the proposed 30 new beds associated with this project plus the recently-approved 20-bed expansion at Encompass' Rehabilitation Institute of Southern Illinois.

Table 13 Beds per 1,000 Population Ages 65+		
Geographic Region	2026 (Current Beds)	2031 (With 50 New Beds)*
HSA 3	0.39	0.59
Statewide	0.69	0.60
Sources: HFSRB State Summary Revised Bed Need Determinations 05/31/2026 Update and Illinois Department of Public Health Certificate of Need Population Projections, May 2024. *Note: includes proposed 30 beds in this application and 20 recently-approved beds to be added to The Rehabilitation Institute of Southern Illinois.		

The proposed Year 2 average annual 76.3% occupancy of Rehabilitation Institute of Springfield further demonstrates that the proposed project will not result in maldistribution of services, but instead will ensure that HSA 3 residents and residents in the greater Springfield area who currently rely on Memorial for their healthcare needs have needed inpatient rehab services locally available and accessible.

Attachment 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (c)(3) Impact of Project on Other Area Providers

- 3) The applicant shall document that, within 24 months after project completion, the proposed project:
- A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and
 - B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

The proposed 60-bed freestanding hospital will take the place of, and expand, the inpatient rehab services of Springfield Memorial Hospital's inpatient rehab unit in HSA 3. The only other provider in the entirety of the 18-county HSA is Blessing Hospital, located in the westernmost portion of the state in Quincy, Adams County, which is nearly two (2) hours and 115 miles distant from Springfield.

Notably, even if Blessing Hospital did serve patients from Sangamon and contiguous counties in the eastern portion of the HSA, all of Blessing Hospital's licensed IRF beds have been included in the quantified bed need calculations, demonstrating the severe shortage of beds in HSA 3.

IRF providers located outside the HSA, e.g., The Rehabilitation Institute of Southern Illinois in Shiloh, St. Clair County (HSA 11) and Carle BroMenn Medical Center in Normal, McLean County (HSA 4) are both similarly too far away from Springfield to be impacted by the proposed Springfield Rehab Institute.

Thus, the project will not and cannot lower the utilization of any other area provider in Illinois, because there is not one in close proximity serving the same patient population that the proposed project will primarily serve.

Absent the addition of beds, HSA 3 residents will continue to either forego needed rehab services altogether or, alternatively, choose less intensive (and therefore less optimal) post-acute rehabilitation services such as SNF or home health care, neither of which are viable options for patients in a community with an increasing population ages 65+.

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

e) Staffing

1) Availability – Review Criterion

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing a narrative explanation of how the proposed staffing will be achieved.

Memorial Health and Encompass Health both have in place numerous innovative approaches to recruit and retain staff members at their hospital facilities, thus Rehabilitation Institute of Springfield does not anticipate having difficulty hiring the necessary resources for the proposed project. In fact, a distinct advantage that the proposed project has in terms of recruitment is the level of professional engagement, challenge, and satisfaction employees have working with other professionals across disciplines. Additionally, existing Memorial Health inpatient rehab unit staff will also have the opportunity to transition over to the new Rehabilitation Institute of Springfield. Memorial Health has invested over thirty seven million dollars (\$37M+) in multi-year partnerships in support of clinical training programs as well as providing surgical skills and simulation labs.

The success of Encompass facilities, programs and services is due in large part to the highly-qualified and specially-trained **physicians and staff members** who comprise a **comprehensive, multidisciplinary team** including:

- **Medical Director:** A Physical Medicine and Rehabilitation (“PMR”) physician who frequently meets with the patient during the patient’s inpatient stay, and is ultimately responsible for implementing the patient’s care plan as the multidisciplinary team leader.
- **Rehabilitation nursing:** Implements each patient’s medical care program as directed by his or her physician.
- **Occupational therapy:** Designs and delivers activity-based therapy to promote independence in the areas of self-care, home management and community reintegration.
- **Physical therapy:** Evaluates and designs a treatment program to address limitations in physical function, mobility and safety.
- **Respiratory therapy:** Ensures proper respiratory function through services such as oxygen supplements and aerosol treatments.
- **Speech-language pathology:** Assesses and treats individuals with communication and comprehension disorders, cognitive difficulties and swallowing disorders.
- **Dietary and nutritional counseling:** Supervises all meals to ensure patients meet their required nutritional needs.
- **Case management:** Coordinates with the physician to ensure the patient’s needs are met and involves the family and other caregivers in the patient’s rehabilitation. The Case Manager is also responsible for:

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

- Working with the family prior to the patient's discharge to provide training to help family members care for patients after discharge.
- Visiting the patient's home prior discharge to identify and then address any special needs (such as equipment) the patient will have upon returning home.
- Coordination and collaboration of services between the patient and community service providers who will be responsible for providing care to the patient post-discharge.

Patients will benefit from the extensive array and number of staff members in place at Encompass Health hospitals, illustrated by the projected approximate 120 full-time equivalents ("FTEs") to be employed in Project Year 1 and the approximate 155 FTEs in Project Year 2.

Notably, because of the significant resources associated with Memorial's and Encompass' ability to recruit nationally, the proposed project will have no material impact on existing health care providers in the service area.

The following information details the ability of Encompass, as a rehab-centric organization, to recruit needed staff for the proposed project.

The three primary components of Encompass' employee recruitment and retention strategy are described below, and include:

- Competitive Compensation and Benefits
- National Recruitment Strategy
- Relationships with Local Universities and Colleges
-

Competitive Compensation and Benefits

Encompass Health offers competitive packages that include a range of benefits including medical and dental insurance coverage, generous paid time off (PTO) plans, health savings accounts (HSAs), 401K savings and investment programs, basic term life and optional group term life insurance, disability insurance, an employee stock benefit plan and tuition reimbursement as well as a scholarship program. Encompass Health also offers employee health nurse services and employee wellness activities focused on maintaining the health and wellness of the entire Encompass Health team.

To retain staff, Encompass Health provides benefits such as continuing education including in-person courses, live webinars as well as web-based education and online instruction modules. Encompass provides clinical career ladders for therapists, nurses, and staff. Continuing education funds are also allocated to support additional educational opportunities for clinical staff. Encompass Health also offers reimbursement for professional licenses and national professional association membership dues. For example, Encompass supports rehab nurses in attaining their Certified Rehabilitation Registered Nurse (CRRN) certification through additional training materials and financial incentives upon completion of the certification. It is Encompass' stated goal to increase the number of nurses with CRRN certification, which ultimately improves clinical outcomes, patient satisfaction, and employee engagement and satisfaction.

Employee recognition and development activities and opportunities include employee celebration activities, employee family social activities, employee of the quarter/year recognition, quarterly town hall meetings, departmental recognition programs, career ladders for select positions, employee activities committees, employee suggestion committees, management development programs and mentoring programs.

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

National Recruitment Strategy

Encompass Health has a dedicated recruitment team that utilizes various avenues to ensure job positions are marketed to the right individuals. One way that is achieved is through partnerships with national associations including, for example:

- American Physical Therapy Association Combined Sections Meeting (APTA CSM)
- Annual APTA events
- APTA National Student Conclave
- American Occupational Therapy Association (AOTA)
- AOTA National Student Conclave
- Association of Rehabilitation Nurses (ARN)
- American Speech-Language-Hearing Association (ASHA)
- American Academy of Physical Medicine and Rehabilitation (AAPM&R)
- National Black Nurses Association
- National Hispanic Nurses Association

Additionally, Encompass leverages automated software to purchase, place, and optimize job searches throughout top media sources including various websites such as Indeed, Glassdoor, LinkUp, ZipRecruiter, Monster, SimplyHired, CollegeRecruiter, StartWire, and Jobs2Careers. Positions are also posted on EncompassHealth.com (search engine optimized), as well as Nexxt.com, indeed.com, linkedin.com, APTA, AOTA and CareerBuilder. Job positions are also posted on social media, utilizing Facebook, Twitter and LinkedIn.

Relationships with Local Universities and Colleges

Encompass develops relationships/training programs with local universities and colleges, community colleges and other training agencies to create and support a nation-wide workforce. With over 600 affiliation agreements throughout the nation with universities and schools for allied health professionals, prospective employees become acquainted with Encompass Health and existing hospitals become familiar with the skills they possess (enabling future recruitment capabilities once operational).

In addition, Encompass continually invests in the future pipeline of top talent by investing in the relationships with local schools through lunch-n-learns, resume workshops and participation in career fair events.

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

f) Performance Requirements – Bed Capacity Minimums

- 1) The minimum freestanding facility size for comprehensive physical rehabilitation is a minimum facility capacity of 100 beds.**
- 2) The minimum hospital unit size for comprehensive physical rehabilitation is 16 beds.**

The Applicant proposes to construct a 60-bed freestanding rehab hospital in order to meet the planning area needs, as documented elsewhere in this application.

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (g) Assurances

g) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

Please see the following page for a letter from Rehabilitation Institute of Springfield's representative regarding the projected utilization of the proposed project. As shown, the new facility is expected to reach and maintain the occupancy standard in CON Project Year 2.

Comprehensive Physical Rehabilitation Service Specific Criteria
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 20
Comprehensive Physical Rehabilitation
Criterion 1110.205 (g) Assurances



Susan S. Lyerly
National Director, Certificate of Need Program
9001 Liberty Parkway
Birmingham, AL 35242
205.969-4528
susan.lyerly@encompasshealth.com

August 24, 2026

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

Re: Rehabilitation Institute of Springfield, LLC
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.205(g). Assurances

Dear Mr. Kniery,

As representative of the Rehabilitation Institute of Springfield, LLC, I, Susan S. Lyerly, Esq., attest to the Applicant's full anticipation to achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100.550(c) for comprehensive physical medicine services by the second year of operation after the project completion.

I hereby certify this is true and is based on my personal knowledge under penalty of perjury in accordance with 735 ILCS 5/1-109.

Sincerely,

A handwritten signature in blue ink that reads 'Susan S. Lyerly'.

Susan S. Lyerly, Esq.
National Director, Certificate of Need Program
Encompass Health Corporation

Notarization:

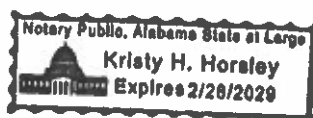
Subscribed and sworn to before me

this 24 day of August

Kristy H. Horeley

Signature of Notary

Seal



Availability of Funds

Rehabilitation Institute of Springfield, LLC

**ATTACHMENT 34
Availability of Funds**

The total estimated project cost is \$66,263,120. The Applicant/Licensee will fund the project costs with cash and cash equivalents obtained from Encompass Health, an Applicant. Encompass Health's existing internal resources are more than adequate funds for the proposed project as demonstrated in its letter of proof of funding and its most recent audited financial statements, which follow.

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

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

ATTACHMENT 34
Availability of Funds



Edmund M. Fay
Senior Vice President & Treasurer
9001 Liberty Parkway
Birmingham, AL 35242

205.970.7875
encompasshealth.com

August 20, 2026

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

Re: Rehabilitation Institute of Springfield, LLC
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.120(a) Available Funds Certification
Criterion 1120.140A. Reasonableness of Financing Arrangements

Dear Mr. Kniery,

In accordance with the verification requirements of 735 ILCS 5/1-109 of the Illinois Code of Civil Procedure, I hereby certify under the penalty of perjury the following:

1. Rehabilitation Institute of Springfield, LLC Project costs will be entirely funded by Encompass Health Corporation, an Applicant, from internal cash resources including cash and equivalents.
2. Encompass Health Corporation, an Applicant, will fund a portion of the necessary working capital and operating deficits through the first full fiscal year at which time the Project is expected to achieve the target utilization of 85% occupancy (*i.e.*, Project Year 2).
3. Encompass Health Corporation, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. In 2025, Encompass Health Corporation's operating activities generated \$1,175.6 Million and as of the end of 2025, the company had \$72.2 Million of unrestricted cash on its balance sheet. In addition, Encompass Health Corporation has at its discretion a \$1,000 Million Revolving Credit Facility, of which approximately \$746 Million was available as of June 30, 2026. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed Project. We have sufficient resources to fully fund these expenditures in addition to our other ongoing obligations.

ATTACHMENT 34
Availability of Funds



Edmund M. Fay
Senior Vice President & Treasurer
9001 Liberty Parkway
Birmingham, AL 35242

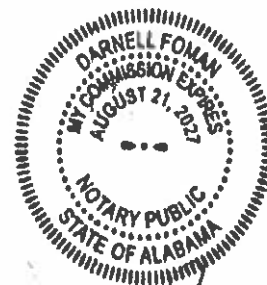
205.970.7875
encompasshealth.com

This letter shall also serve as a confirmation of our analysis of the funding options for this Project. Funding the Project through cash and securities is the lowest cost option. I hereby certify this is true and based upon my personal knowledge and under the penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely yours,

A handwritten signature in blue ink, appearing to read 'Edmund Fay', written over a light blue horizontal line.

Edmund Fay
Senior Vice President and Treasurer
Encompass Health Corporation



A handwritten signature in blue ink, appearing to read 'Darnell Foman', written below the notary seal.

ATTACHMENT 34
Availability of Funds



August 31, 2026

John Knieri
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street - Second Floor
Springfield, IL 62761-0001

Re: Rehabilitation Institute of Springfield, LLC
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.120(a) Available Funds Certification
Criterion 1120.140A. Reasonableness of Financing Arrangements

Dear Mr. Knieri,

In accordance with the verification requirements of 735 ILCS 5/1-109 of the Illinois Code of Civil Procedure, I hereby certify under the penalty of perjury the following:

1. Rehabilitation Institute of Springfield, LLC Project costs will be entirely funded by Encompass Health Corporation, an Applicant, from internal cash resources including cash and equivalents.
2. Memorial Health System, an Applicant, will fund a portion of the necessary working capital and operating deficits through the first full fiscal year at which time the Project is expected to achieve the target utilization of 85% occupancy (i.e., Project Year 2).
3. Memorial Health System, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed Project. We have sufficient resources to fully fund these expenditures in addition to our other ongoing obligations.

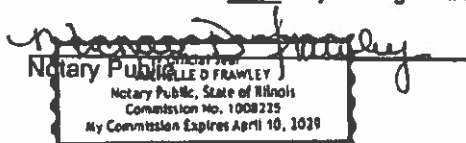
This letter shall also serve as a confirmation of our analysis of the funding options for this Project. Funding the Project through cash and securities is the lowest cost option.

I hereby certify this is true and based upon my personal knowledge and under the penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,


Mandy C. Eaton
President and Chief Executive Officer
Memorial Health

SUBSCRIBED AND SWORN
To before me this 27 day of August 2026



340 W. Miller St.
Springfield, IL 62702

217-788-3000

memorial health

Financial Viability*Rehabilitation Institute of Springfield, LLC***ATTACHMENT 36
Financial Viability**

The Income Statement for the Applicant entity, Rehabilitation Institute of Springfield follows.

	CON Year 1	CON Year 2
<u>Revenue</u>		
Gross Patient Revenue	\$ 39,270,500	\$ 58,244,700
Contractual Adjustments	17,391,300	25,944,100
Other Deductions from Revenue	995,800	1,477,300
Deductions from Revenue	18,387,100	27,421,400
Net Patient Revenue	\$ 20,883,400	\$ 30,823,300
Other Revenue	-	-
Total Revenue	\$ 20,883,400	\$ 30,823,300
<u>Operating Expenses</u>		
Salaries and Benefits	14,795,000	19,248,900
Supplies	952,000	1,398,300
Administrative Services	1,044,200	1,541,200
Depreciation and Amortization	2,884,900	2,897,400
Other Operating Expenses	3,536,400	4,377,900
Total Operating Expenses	23,212,500	29,463,700
Income from Project Operations	\$ (2,329,100)	\$ 1,359,600
Taxes	-	367,100
Net Income from Project Operations	\$ (2,329,100)	\$ 992,500

ATTACHMENT 36 Financial Viability

The Balance Statement for the Applicant entity, Rehabilitation Institute of Springfield follows.

	CON Year 1	CON Year 2
Cash	\$ 1,670,800	\$ 5,458,800
Accounts Receivable	4,806,000	6,502,400
Total Current Assets	6,476,800	11,961,200
PP&E	66,289,700	66,389,700
Accumulated Depreciation	(2,884,900)	(5,782,300)
PP&E, net	63,404,800	60,607,400
Other Assets	9,263,200	9,263,300
TOTAL ASSETS	\$ 79,144,900	\$ 81,831,900
CURRENT LIABILITIES		
Accounts Payable	436,000	573,500
Accrued Salaries	982,200	1,277,900
TOTAL CURRENT LIABILITIES	1,418,300	1,851,400
L/T LIABILITIES		
EQUITY		
Partners Equity	80,055,500	81,316,900
Retained Earnings	(2,328,900)	(1,336,400)
NET EQUITY	\$ 77,726,600	\$ 79,980,500
TOTAL LIAB AND EQUITY	\$ 79,144,900	\$ 81,831,900

Financial Viability
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 36
Financial Viability

The Financial Viability Ratios for the Applicant entity, Rehabilitation Institute of Springfield follows.

	CON Year 1	CON Year 2
Current Ratio:	4.6	6.5
Current Assets /	6,476,800	11,961,200
Current Liabilities	1,418,300	1,851,400
Net Margin Percentage	-11.2%	4.4%
Income b/f Tax /	(2,329,100)	1,359,600
Net Patient Revenue	20,883,400	30,823,300
Percent Debt to Capitalization	N/A	N/A
<i>Note: Licensee has no long-term debt</i>		
Projected Debt Service Coverage	N/A	N/A
<i>Note: Licensee has no long-term debt</i>		
Days Cash on Hand	30.0	75.0
Cash	1,670,800	5,458,800
Total Expenses excl Depreciation	20,327,600	26,566,300
Expenses per Day	55,700	72,700
Cushion Ratio	N/A	N/A
<i>Note: Licensee has no long-term debt</i>		

Financial Viability

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 36 Financial Viability

The assumptions supporting the income statement for Rehabilitation Institute of Springfield follow.

Patient Utilization

As explained and supported throughout this application, patient days are projected to reach 16,718 in CON Year 2, the first full fiscal year when the project achieves a target utilization of 85%.

Gross Patient Revenues

The Rehabilitation Institute's proposed charges are based upon the expected diagnostic and acuity levels of the patients treated and average charges per patient day experienced by Encompass Health and Memorial Health. Gross patient revenues include patient room, therapeutic, and ancillary service charges. Average charges per patient day are projected to be \$3,484 in CON Year 2.

Contractual Allowances

Contractual allowances are the difference between the gross patient charge and anticipated third-party payment rate. Projected contractual allowances are based upon anticipated payor mix and third-party payment rates for the anticipated diagnostic and acuity levels of the patients treated.

Proposed patient payor mix was developed from the service area payor mix and Encompass Health and Memorial Health experience, and is summarized below as follows:

Payor	Payor Mix
Medicare	36.0%
Medicare Advantage	30.7%
Medicaid	10.0%
Managed Care/Commercial	20.0%
Self-Pay/Other	3.0%
Charity	0.3%
Total	100.0%

Other Deductions from Revenue

Other Deductions are predominately comprised of self-pay discount, free care, bad debt, charity care, and indigent care write-offs. These deductions are based on the Rehab Institute's anticipated services and payor mix, as well as experiences in other Encompass and Memorial Health facilities.

Expenses

The Rehab Institute's projected expenses are based on historical expenses incurred at other Encompass hospitals and Encompass's vast operations knowledge and experience opening new hospitals in similar markets. Explanations of significant expense assumptions are provided below.

Salaries and Benefits

Clinical nursing staffing levels are based upon Encompass Health and Memorial Health's experience and standard hours of care, applied to anticipated patient volumes and patient acuity mix. Nursing staffing levels are sufficient to meet the medical and rehabilitation needs of the patients and to achieve service excellence.

Salaries and benefit expenses are based on projected patient census, staffing mix, area labor market conditions, and Encompass Health and Memorial Health experience in recruiting employees.

Financial Viability

Rehabilitation Institute of Springfield, LLC

ATTACHMENT 36 Financial Viability

Supplies and Drugs

Supplies and drugs expenses are based on the Rehab Institute's projected patient case mix and Encompass and Memorial Health's experience. Supplies and drug expenses for the proposed hospital will approximate \$84 per patient day in CON Year 2.

Administrative Services

These expenses, estimated to be 5% of net patient revenues, represent service fees that will be paid by the Rehab Institute to Encompass Health for administrative support and assistance in areas such as financial, accounting, payroll, management information systems, human resources, insurance, risk management, cash management and other related support services.

Depreciation and Amortization

Depreciation and amortization expenses are based upon the Rehab Institute's project costs depreciated over asset average useful lives using the straight-line method.

Other Operating Expenses

Other operating expenses are comprised of maintenance costs, utilities, contract and directorship fees, and other services. These expenses are based on projected patient utilization and Encompass Health and Memorial Health experience.

Taxes

Projected income taxes represent estimated federal and state taxes related to projected income. Although income taxes on an LLC are paid at the member level, taxes paid are estimated at an effective rate of 27%.

ATTACHMENT 36
Financial Viability

Table of Contents

Item 15. Financial Statements	
Report of Independent Registered Public Accounting Firm (PCAOB ID 238)	F-2
Consolidated Statements of Operations for each of the years in the three-year period ended December 31, 2025	F-5
Consolidated Statements of Comprehensive Income for each of the years in the three-year period ended December 31, 2025	F-6
Consolidated Balance Sheets as of December 31, 2025 and 2024	F-7
Consolidated Statements of Shareholders' Equity for each of the years in the three-year period ended December 31, 2025	F-8
Consolidated Statements of Cash Flows for each of the years in the three-year period ended December 31, 2025	F-9
Notes to Consolidated Financial Statements	F-11

ATTACHMENT 36

Financial Viability

Table of Contents

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of Encompass Health Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Encompass Health Corporation and its subsidiaries (the "Company") as of December 31, 2025 and 2024, and the related consolidated statements of comprehensive income, of shareholders' equity and of cash flows for each of the three years in the period ended December 31, 2025, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2025, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2025 and 2024, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2025 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2025, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

FORM 10-K

ATTACHMENT 36

Financial Viability

Table of Contents

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Patient Accounts Receivable - Contractual Allowances and Uncollectible Amounts

As described in Notes 1 and 4 to the consolidated financial statements, revenues are recognized (or measured) using the input method as therapy, nursing, and auxiliary services are provided based on management's estimate of the respective transaction price. Management's estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, potential adjustments that may arise from payment and other reviews, and uncollectible amounts. Revenues recognized are subject to a number of elements which may impact both the overall amount of revenue realized as well as the timing of the collection of the related patient accounts receivable. Factors considered by management in determining the estimated transaction price include the patient's total length of stay for in-house patients, each patient's discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Management assumes these factors will remain consistent with the experience for patients discharged in similar time periods for the same payor classes. The Company's consolidated accounts receivable balance is \$644.7 million as of December 31, 2025. Management estimates the allowance for uncollectible amounts based on the aging of accounts receivable, historical collection experience for each type of payor, and other relevant factors. As disclosed by management, changes in general economic conditions are also considered.

The principal considerations for our determination that performing procedures relating to valuation of patient accounts receivable – contractual allowances and uncollectible amounts is a critical audit matter are the significant judgment by management to estimate patient accounts receivable and the amount that will ultimately be collected under the terms of the third-party payor contracts, which in turn led to significant auditor judgment and effort to evaluate the audit evidence obtained related to the valuation of patient accounts receivable.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of patient accounts receivable related to contractual allowances and uncollectible amounts, which included controls over management's process, assumptions, and data used to estimate contractual allowances and uncollectible amounts and determine patient accounts receivable. These procedures also included, among others, i) evaluating management's process for developing the estimate for contractual allowances and uncollectible amounts, ii) testing the completeness and accuracy of underlying data used in the model, iii) evaluating the historical accuracy of management's process for developing the estimate of the amount which will ultimately be collected by comparing actual cash collections to the previously recorded patient accounts receivable, and iv) developing an independent expectation of the amount expected to be collected by management. Developing an independent expectation involved calculating the percentage of cash collections as compared to the recorded patient accounts receivable balance for prior years and comparing that percentage to management's collection expectation used to determine the current year estimate for contractual allowances and uncollectible amounts.

Valuation of Patient Accounts Receivable - Denied Claims

As described in Note 1 to the consolidated financial statements, the Company's Medicare claims have been subject to review by Medicare Administrative Contractors ("MACs") under programs known as "widespread probes." The MACs probes have resulted in denial of payment for claims billed under certain diagnosis codes. While the Company generally disputes or appeals most of the denials of payments resulting from the MACs probes, the Medicare appeals adjudication process, which is administered by the Office of Medicare Hearings and Appeals ("OMHA"), has been subject to significant delay resulting in a backlog of claims awaiting adjudication. As of December 31, 2025, there were approximately \$39.0 million in denied claims that were under review. As disclosed in Note 1, the Company's historical experience and success in the adjudication of these appeals is a component of management's estimate of transaction price.

F-3

ATTACHMENT 36 **Financial Viability**

Table of Contents

The principal considerations for our determination that performing procedures relating to valuation of patient accounts receivable – denied claims is a critical audit matter are the significant judgment by management to estimate the ultimate expected amount of collectible accounts receivable related to denied claims. This in turn led to a high degree of auditor judgment and effort to evaluate the audit evidence obtained related to the valuation of such denied claims

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of patient accounts receivable related to denied claims, which included controls around the identification of denied claims at period-end, as well as controls to assess the reasonableness of the success rate estimates. These procedures also included, among others, i) evaluating management's process for developing the estimates for collectible amounts related to denied claims, as well as the relevance and use of the historical billings and collection data as an input to the valuation analysis, ii) evaluating the reasonableness of management's analysis and success rate estimate for denied claims by comparing it to the Company's adjudicated denied claims results, iii) performing testing over a sample of denied revenue transactions by inspecting evidence that the claim was denied, and iv) performing testing over a sample of cash collections from the historical collection data used in management's estimation of collectability.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
February 26, 2026

We have served as the Company's auditor since 2003

FORM 10-K

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Consolidated Statements of Operations

	For the Year Ended December 31,		
	2025	2024	2023
	(In Millions, Except Per Share Data)		
Net operating revenues	\$ 5,935.2	\$ 5,373.2	\$ 4,801.2
Operating expenses:			
Salaries and benefits	3,115.9	2,901.0	2,600.1
Other operating expenses	888.7	802.6	719.1
Occupancy costs	59.0	57.3	56.3
Supplies	254.4	239.0	218.3
General and administrative expenses	236.2	209.2	201.7
Depreciation and amortization	327.9	299.6	273.9
Total operating expenses	4,882.1	4,508.7	4,069.4
Loss on early extinguishment of debt	—	0.6	—
Interest expense and amortization of debt discounts and fees	123.2	137.4	143.5
Other income	(18.8)	(20.1)	(15.7)
Equity in net income of nonconsolidated affiliates	(4.3)	(3.0)	(3.2)
Income from continuing operations before income tax expense	953.0	749.6	607.2
Provision for income tax expense	192.9	150.2	132.2
Income from continuing operations	760.1	599.4	475.0
Loss from discontinued operations, net of tax	(1.0)	(2.8)	(12.0)
Net income	759.1	596.6	463.0
Less: Net income attributable to noncontrolling interests	(192.9)	(140.9)	(111.0)
Net income attributable to Encompass Health	\$ 566.2	\$ 455.7	\$ 352.0
Weighted average common shares outstanding:			
Basic	100.5	99.9	99.5
Diluted	102.2	102.2	101.3
Earnings per common share:			
Basic earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	\$ 5.63	\$ 4.56	\$ 3.63
Discontinued operations	(0.01)	(0.03)	(0.12)
Net income	\$ 5.62	\$ 4.53	\$ 3.51
Diluted earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	\$ 5.55	\$ 4.49	\$ 3.59
Discontinued operations	(0.01)	(0.03)	(0.12)
Net income	\$ 5.54	\$ 4.46	\$ 3.47
Amounts attributable to Encompass Health:			
Income from continuing operations	\$ 567.2	\$ 458.5	\$ 364.0
Loss from discontinued operations, net of tax	(1.0)	(2.8)	(12.0)
Net income attributable to Encompass Health	\$ 566.2	\$ 455.7	\$ 352.0

The accompanying notes to consolidated financial statements are an integral part of these statements.

F-5

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Consolidated Statements of Comprehensive Income

	For the Year Ended December 31,		
	2025	2024	2023
	(In Millions)		
COMPREHENSIVE INCOME			
Net income	\$ 759.1	\$ 596.6	\$ 463.0
Other comprehensive income, net of tax:			
Net change in unrealized gain on available-for-sale securities:			
Unrealized net holding gain arising during the period	0.7	—	—
Reclassifications to net income	(0.1)	—	—
Other comprehensive gain before income taxes	0.6	—	—
Provision for income tax expense related to other comprehensive loss items	(0.1)	—	—
Other comprehensive income, net of tax	0.5	—	—
Comprehensive income	759.6	596.6	463.0
Comprehensive income attributable to noncontrolling interests	(192.9)	(140.9)	(111.0)
Comprehensive income attributable to Encompass Health	\$ 566.7	\$ 455.7	\$ 352.0

FORM 10-K

The accompanying notes to consolidated financial statements are an integral part of these statements.

F-6

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Consolidated Balance Sheets

	As of December 31,	
	2025	2024
	(In Millions, Except Share Data)	
Assets		
Current assets:		
Cash and cash equivalents	\$ 72.2	\$ 85.4
Restricted cash	30.7	37.7
Accounts receivable	619.2	598.8
Prepaid expenses	53.9	42.3
Other current assets	129.9	122.7
Total current assets	905.9	886.9
Property and equipment, net	4,101.6	3,643.1
Operating lease right-of-use assets	212.6	203.7
Goodwill	1,317.6	1,284.0
Intangible assets, net	308.3	297.8
Other long-term assets	243.7	219.2
Total assets ⁽¹⁾	\$ 7,089.7	\$ 6,534.7
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	\$ 43.6	\$ 138.6
Current operating lease liabilities	26.5	26.3
Accounts payable	178.2	171.0
Accrued payroll	243.7	227.9
Accrued distributions	54.8	31.4
Other current liabilities	289.6	245.8
Total current liabilities	836.4	841.0
Long-term debt, net of current portion	2,447.2	2,359.2
Long-term operating lease liabilities	196.6	189.7
Self-insured risks	153.1	138.6
Deferred income tax liabilities	126.8	105.2
Other long-term liabilities	53.8	51.8
Total liabilities ⁽¹⁾	3,813.9	3,685.5
Commitments and contingencies		
Redeemable noncontrolling interests	58.3	56.5
Shareholders' equity:		
Encompass Health shareholders' equity:		
Common stock, \$.01 par value; 200,000,000 shares authorized; issued: 116,036,500 in 2025; 116,036,500 in 2024	1.2	1.2
Capital in excess of par value	1,869.6	1,847.0
Accumulated income	1,289.4	796.7
Accumulated other comprehensive income	0.5	—
Treasury stock, at cost (16,039,648 shares in 2025 and 15,261,136 shares in 2024)	(722.5)	(577.9)
Total Encompass Health shareholders' equity	2,438.2	2,067.0
Noncontrolling interests	779.3	725.7
Total shareholders' equity	3,217.5	2,792.7
Total liabilities ⁽¹⁾ and shareholders' equity	\$ 7,089.7	\$ 6,534.7

⁽¹⁾ Our consolidated assets as of December 31, 2025 and December 31, 2024 include total assets of variable interest entities of \$203.8 million and \$208.1 million, respectively, which cannot be used by us to settle the obligations of other entities. Our consolidated liabilities as of December 31, 2025 and December 31, 2024 include total liabilities of the variable interest entities of \$50.5 million and \$45.0 million, respectively. See Note 2, *Variable Interest Entities*.

The accompanying notes to consolidated financial statements are an integral part of these statements.

F-7

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Consolidated Statements of Shareholders' Equity

Encompass Health Common Shareholders								
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated Income	Accumulated Other Comprehensive Income	Treasury Stock	Noncontrolling Interests	Total
(In Millions)								
December 31, 2022	99.8	\$ 1.1	\$ 1,730.2	\$ 115.7	\$ —	\$ (536.7)	\$ 516.0	\$1,826.3
Net income	—	—	—	352.0	—	—	102.7	454.7
Receipt of treasury stock	(0.1)	—	—	—	—	(8.2)	—	(8.2)
Dividends declared (\$0.60 per share)	—	—	0.5	(61.2)	—	—	—	(60.7)
Stock-based compensation	—	—	50.6	—	—	—	—	50.6
Distributions declared	—	—	—	—	—	—	(110.0)	(110.0)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	100.5	100.5
Other	0.6	0.1	5.7	—	—	(2.3)	(1.5)	2.0
December 31, 2023	100.3	1.2	1,787.0	406.5	—	(547.2)	607.7	2,255.2
Net income	—	—	—	455.7	—	—	135.8	591.5
Receipt of treasury stock	(0.2)	—	—	—	—	(12.1)	—	(12.1)
Dividends declared (\$0.64 per share)	—	—	0.4	(65.5)	—	—	—	(65.1)
Stock-based compensation	—	—	48.3	—	—	—	—	48.3
Distributions declared	—	—	—	—	—	—	(121.3)	(121.3)
Repurchases of common stock in open market	(0.4)	—	—	—	—	(31.1)	—	(31.1)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	134.2	134.2
Contribution of our hospital to consolidated joint venture	—	—	23.2	—	—	—	(30.8)	(7.6)
Other	1.1	—	(11.9)	—	—	12.5	0.1	0.7
December 31, 2024	100.8	1.2	1,847.0	796.7	—	(577.9)	725.7	2,792.7
Net income	—	—	—	566.2	—	—	183.5	749.7
Issuance of restricted stock	0.7	—	(28.8)	—	—	28.8	—	—
Receipt of treasury stock	(0.2)	—	—	—	—	(20.0)	—	(20.0)
Dividends declared (\$0.72 per share)	—	—	0.2	(73.5)	—	—	—	(73.3)
Stock-based compensation	—	—	56.5	—	—	—	—	56.5
Distributions declared	—	—	—	—	—	—	(164.1)	(164.1)
Repurchases of common stock in open market	(1.5)	—	—	—	—	(158.6)	—	(158.6)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	36.6	36.6
Other	0.2	—	(5.3)	—	0.5	5.2	(2.4)	(2.0)
December 31, 2025	100.0	\$ 1.2	\$ 1,869.6	\$ 1,289.4	\$ 0.5	\$ (722.5)	\$ 779.3	\$3,217.5

FORM 10-K

The accompanying notes to consolidated financial statements are an integral part of these statements

F-8

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	For the Year Ended December 31,		
	2025	2024	2023
	(In Millions)		
Cash flows from operating activities:			
Net income	\$ 759.1	\$ 596.6	\$ 463.0
Loss from discontinued operations, net of tax	1.0	2.8	12.0
Adjustments to reconcile net income to net cash provided by operating activities —			
Depreciation and amortization	327.9	299.6	273.9
Amortization of debt-related items	9.6	9.7	9.5
Equity in net income of nonconsolidated affiliates	(4.3)	(3.0)	(3.2)
Distributions from nonconsolidated affiliates	4.1	4.0	1.6
Stock-based compensation	56.5	48.3	50.6
Deferred tax expense	22.3	10.7	3.9
Other, net	(3.5)	15.3	5.2
Changes in assets and liabilities, net of acquisitions —			
Accounts receivable	(15.2)	3.0	(22.4)
Prepaid expenses and other assets	(31.2)	(57.3)	6.1
Accounts payable	(22.6)	3.0	11.8
Accrued payroll	15.9	20.4	39.2
Other liabilities	57.4	52.8	15.6
Net cash used in operating activities of discontinued operations	(1.4)	(3.1)	(16.0)
Total adjustments	415.5	403.4	375.8
Net cash provided by operating activities	1,175.6	1,002.8	850.8
Cash flows from investing activities:			
Purchases of property, equipment, and intangible assets	(736.4)	(642.5)	(583.1)
Proceeds from sale of restricted investments	172.8	18.9	7.4
Purchases of restricted investments	(184.4)	(22.5)	(23.0)
Other, net	(16.6)	(7.2)	(4.1)
Net cash used in investing activities	(764.6)	(653.3)	(602.8)

(Continued)

F-9

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Consolidated Statements of Cash Flows (Continued)

	For the Year Ended December 31,		
	2025	2024	2023
	(In Millions)		
Cash flows from financing activities:			
Principal payments on debt, including pre-payments	(115.1)	(255.2)	(7.2)
Principal borrowings on notes	—	15.0	20.0
Borrowings on revolving credit facility	210.0	80.0	60.0
Payments on revolving credit facility	(100.0)	(60.0)	(115.0)
Principal payments under finance lease obligations	(23.9)	(21.8)	(41.1)
Repurchases of common stock, including fees and expenses	(158.0)	(31.1)	—
Dividends paid on common stock	(71.1)	(62.8)	(60.4)
Distributions paid to noncontrolling interests of consolidated affiliates	(152.1)	(125.0)	(114.7)
Taxes paid on behalf of employees for shares withheld	(20.0)	(12.1)	(8.2)
Contributions from noncontrolling interests of consolidated affiliates	1.8	140.4	68.3
Other, net	(2.8)	2.0	1.1
Net cash used in financing activities	(431.2)	(330.6)	(197.2)
(Decrease) increase in cash, cash equivalents, and restricted cash	(20.2)	18.9	50.8
Cash, cash equivalents, and restricted cash at beginning of year	123.1	104.2	53.4
Cash, cash equivalents, and restricted cash at end of year	\$ 102.9	\$ 123.1	\$ 104.2
Reconciliation of Cash, Cash Equivalents, and Restricted Cash			
Cash and cash equivalents at beginning of period	\$ 85.4	\$ 69.1	\$ 21.8
Restricted cash at beginning of period	37.7	35.1	31.6
Cash, cash equivalents, and restricted cash at beginning of period	\$ 123.1	\$ 104.2	\$ 53.4
Cash and cash equivalents at end of period	\$ 72.2	\$ 85.4	\$ 69.1
Restricted cash at end of period	30.7	37.7	35.1
Cash, cash equivalents, and restricted cash at end of period	\$ 102.9	\$ 123.1	\$ 104.2
Supplemental cash flow information:			
Cash paid during the year for —			
Interest	\$ (133.1)	\$ (146.8)	\$ (147.7)
Supplemental schedule of noncash investing and financing activities:			
Accrued purchases of property, equipment, and intangible assets	\$ 29.7	\$ 1.9	\$ 26.7
Joint venture contributions	34.8	11.8	32.2

FORM 10-K

The accompanying notes to consolidated financial statements are an integral part of these statements.

F-10

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries Notes to Consolidated Financial Statements

1. Summary of Significant Accounting Policies:

Organization and Description of Business—

Encompass Health Corporation, incorporated in Delaware in 1984, including its subsidiaries, is a provider of inpatient rehabilitation services. We operate hospitals in 39 states and Puerto Rico, with concentrations in Florida and Texas. As of December 31, 2025, we operated 173 inpatient rehabilitation hospitals. We are the sole owner of 106 of these hospitals. We retain 50.0% to 97.5% ownership in the remaining 67 jointly owned hospitals.

Basis of Presentation and Consolidation—

The accompanying consolidated financial statements of Encompass Health and its subsidiaries were prepared in accordance with generally accepted accounting principles in the United States of America and include the assets, liabilities, revenues, and expenses of all wholly-owned subsidiaries, majority-owned subsidiaries over which we exercise control, and, when applicable, entities in which we have a controlling financial interest. Certain prior year amounts may have been reclassified for comparative purposes to conform to the current-year financial statement presentation.

We use the equity method to account for our investments in entities we do not control, but where we have the ability to exercise significant influence over operating and financial policies. Consolidated *Net income attributable to Encompass Health* includes our share of the net earnings of these entities. The difference between consolidation and the equity method impacts certain of our financial ratios because of the presentation of the detailed line items reported in the consolidated financial statements for consolidated entities compared to a one line presentation of equity method investments.

On December 31, 2025, we entered into an agreement to sell our 50% membership interest in Gamma Knife Center at Barnes-Jewish Hospital, LLC ("Gamma Knife") to our existing joint venture partner, Barnes-Jewish Hospital, LLC, for \$17.9 million effective January 1, 2026. We account for Gamma Knife as an equity method investment. As a result of this transaction, we expect to record an approximate \$13 million post-tax gain in *Other income* on our condensed consolidated statement of operations during the three months ended March 31, 2026 and expect the \$17.9 million proceeds to be classified as an investing activity within our condensed consolidated statement of cash flows during the three months ended March 31, 2026.

We eliminate all significant intercompany accounts and transactions from our financial results.

Variable Interest Entities—

Any entity considered a variable interest entity ("VIE") is evaluated to determine which party is the primary beneficiary and thus should consolidate the VIE. This analysis is complex, involves uncertainties, and requires significant judgment on various matters. In order to determine if we are the primary beneficiary of a VIE, we must determine what activities most significantly impact the economic performance of the entity, whether we have the power to direct those activities, and if our obligation to absorb losses or receive benefits from the VIE could potentially be significant to the VIE.

Use of Estimates and Assumptions—

The preparation of our consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) revenue reserves for contractual adjustments and uncollectible amounts; (2) fair value of acquired assets and assumed liabilities in business combinations; (3) asset impairments, including goodwill; (4) depreciable lives of assets; (5) useful lives of intangible assets; (6) economic lives and fair value of leased assets; (7) income tax valuation allowances; (8) uncertain tax positions; (9) fair value of stock options and restricted stock containing a market condition; (10) fair value of redeemable noncontrolling interests; (11) reserves for self-insured healthcare plans; (12) reserves for professional, workers' compensation, and comprehensive general insurance liability risks; and (13) contingency and litigation reserves. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Risks and Uncertainties

As a healthcare provider, we are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things:

- licensure, certification, and accreditation;
- policies, either at the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements);
- coding and billing for services;
- requirements of the 60% compliance threshold under The Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of patient information and medical records;
- minimum staffing;
- acquisition and dispensing of pharmaceuticals and controlled substances;
- pricing transparency and similar consumer protection rules; and
- disposal of medical and hazardous waste.

In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our hospitals, equipment, personnel, services, capital expenditure programs, operating procedures, and contractual arrangements. Those changes could also affect reimbursement as well as future compliance, training, and staffing costs.

If we fail to comply with applicable laws and regulations, we could be required to return portions of reimbursements deemed after the fact to have not been appropriate. We could also be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement. Because Medicare comprises a significant portion of our *Net operating revenues*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. Specifically, reductions in reimbursements, substantial damages, and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operation, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation and could cost us significant time and expense to defend.

Historically, the United States Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on the increases in and, in some cases, significant roll-backs or reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. There can be no assurance that future governmental initiatives will not result in reimbursement freezes and reductions, or reimbursement increases that are less than the increases we experience in our costs of

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

operation. Because we receive a significant percentage of our revenues from federal and state payors, such changes in legislation might have a material adverse effect on our financial position, results of operations, and cash flows.

In addition, there are increasing pressures from many third-party payors to control healthcare costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and nongovernmental third-party payors are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services. We could be adversely affected in some of the markets where we operate if we are unable to negotiate and maintain favorable agreements with third-party payors.

Our third-party payors may also, from time to time, request audits of the amounts paid, or to be paid, to us. We could be adversely affected in some of the markets where we operate if the auditing payor alleges substantial overpayments were made to us due to coding errors or lack of documentation to support medical necessity determinations.

Net Operating Revenues—

Our *Net operating revenues* disaggregated by payor source are as follows (in millions):

	Year Ended December 31,		
	2025	2024	2023
Medicare	\$ 3,886.9	\$ 3,495.3	\$ 3,126.1
Medicare Advantage	974.4	903.7	776.1
Managed care	634.0	579.2	531.4
Medicaid	184.2	179.4	190.7
Other third-party payors	39.7	41.7	41.8
Workers' compensation	29.6	27.8	25.8
Patients	17.2	15.9	14.9
Other income	169.2	130.2	94.4
Total	\$ 5,935.2	\$ 5,373.2	\$ 4,801.2

We record *Net operating revenues* on an accrual basis using our best estimate of the transaction price for the type of service provided to the patient. Our estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, potential adjustments that may arise from payment and other reviews, and uncollectible amounts. Our accounting systems calculate contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Adjustments related to payment reviews by third-party payors or their agents are based on our historical experience and success rates in the claims adjudication process. Estimates for uncollectible amounts are based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors.

Management continually reviews the revenue transaction price estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms that result from contract renegotiations and renewals. Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation, we may receive reimbursement for healthcare services authorized and provided that is different from our estimates, and such differences could be material. In addition, laws and regulations governing the Medicare and Medicaid programs, are complex, subject to interpretation, and are routinely modified for provider reimbursement. All healthcare providers participating in the Medicare and Medicaid programs are required to meet certain financial reporting requirements. Federal regulations require submission of annual cost reports covering medical costs and expenses associated with the services provided under each hospital provider number to program beneficiaries. Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to Encompass Health under these reimbursement programs. These audits often require several years to reach the final determination of amounts earned under the programs. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

The Centers for Medicare & Medicaid Services ("CMS") has been granted authority to suspend payments, in whole or in part, to Medicare providers if CMS possesses reliable information an overpayment, fraud, or willful misrepresentation exists. If CMS suspects payments are being made as the result of fraud or misrepresentation, CMS may suspend payment at any time without providing prior notice to us. The initial suspension period is limited to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the United States Department of Health and Human Services Office of Inspector General (the "HHS-OIG") or the United States Department of Justice (the "DOJ"). Therefore, we are unable to predict if or when we may be subject to a suspension of payments by the Medicare and/or Medicaid programs, the possible length of the suspension period, or the potential cash flow impact of a payment suspension. Any such suspension would adversely impact our financial position, results of operations, and cash flows.

Pursuant to legislative directives and authorizations from Congress, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. As a matter of course, we undertake significant efforts through training and education to ensure compliance with Medicare requirements. However, past audits have led, and future audits may lead, to assertions we have been underpaid or overpaid by Medicare or submitted improper claims in some instances. Ultimately, audits may require us to refund any amounts determined to have been overpaid. Audits also require us to incur additional costs to respond to requests for records and defend the validity of payments and claims. In some circumstances auditors assert the authority to extrapolate denial rationales to large pools of claims not actually audited, which could increase the impact of the audit. We cannot predict when or how these audit programs will affect us.

Medicare Administrative Contractors ("MACs"), under programs known as "widespread probes," have conducted pre-payment claim reviews of our Medicare billings and in some cases denied payment for certain diagnosis codes. We dispute, or "appeal," most of these denials. As discussed above, our historical experience and success in the adjudication of these appeals is a component of our estimate of transaction price. The Medicare appeals adjudication process is administered by the Office of Medicare Hearings and Appeals ("OMHA") and has been subject to significant delay resulting in a backlog of claims awaiting adjudication. Beginning in March 2020, OMHA increased the frequency of hearings and the number of claims set at each hearing, which we believe adds to the substantive and procedural deficiencies in the appeals process. During 2022, the backlog of "widespread probe" claims adjudicated by the administrative law judge ("ALJ") continued and were substantially resolved. This OMHA practice resulted in a reduction in our success in the adjudication of these appeals, but have increased the pace of recovery of these claims. We have appealed certain adverse ALJ rulings to the Department Appeals Board ("DAB"), the final level of administrative review. As of December 31, 2025, approximately \$12 million and \$21 million in denied claims are awaiting review at the ALJ and DAB levels, respectively. In addition, we have appealed approximately \$6 million in claims denied by the DAB pending review by the United States district courts as of December 31, 2025. Reserves against appeals pending before the ALJ, DAB, and the United States district courts totaled \$7.0 million, \$12.3 million, and \$4.6 million, respectively, as of December 31, 2025.

During the fourth quarter of 2023, we recorded an additional reserve totaling \$21.9 million related to appeals pending before the DAB and several federal district courts. The increase in reserve was driven primarily by an increase in unfavorable adjudication outcomes experienced at the DAB during the second half of 2023 and largely offsets the remaining net carrying value of these claims. These appeals related primarily to claims denied prior to 2018. This adjustment did not impact our reserve methodology for ongoing claims audit programs, including TPE and RCD (defined and discussed below). We will continue to pursue ongoing appeals before the DAB and federal district courts where economically beneficial.

Under CMS's Targeted Probe and Educate ("TPE") program, MACs use data analysis to identify healthcare providers with unusual billing practices, high claim error rates, and items and services that have high national error rates. Once a MAC selects a provider for claims review, the initial volume of claims review is limited to 20 to 40 claims. The TPE program includes up to three rounds of claims review if necessary with corresponding provider education and a subsequent period to allow for improvement. If results do not improve sufficiently after three rounds, the MAC may refer the provider to CMS for further action, which may include extrapolation of error rates to a broader universe of claims or referral to a UPIC or RAC (defined below). We cannot predict the impact of the TPE program on our ability to collect claims on a timely basis.

On December 14, 2020, CMS announced a five-year review choice demonstration for inpatient rehabilitation services (the "RCD"), under which Medicare reimbursement claims are assessed for compliance with applicable coverage and clinical documentation requirements. In August 2023, inpatient rehabilitation facilities ("IRFs") located in Alabama began participation in RCD. On June 17, 2024, CMS expanded RCD to include IRFs located in Pennsylvania and billing to a certain MAC. We do

FORM 10-K

ATTACHMENT 36 **Financial Viability**

Table of Contents

Encompass Health Corporation and Subsidiaries
Notes to Consolidated Financial Statements

not bill to that MAC, so we are not subject to the program in Pennsylvania at this time. In December 2025, CMS announced the expansion of RCD to Texas and California, effective March 2, 2026 and May 1, 2026, respectively. With the expansion to those two states, we expect 33 of our current inpatient rehabilitation hospitals (representing approximately 11.9% of our IRF Medicare claims) to be subject to RCD. After the initial four states, CMS intends to expand the demonstration to include additional IRFs based on the MAC to which those IRFs submit claims. There are no details of that expansion at this time.

Under the RCD, participating IRFs have an initial choice between pre-claim or post-payment review of 100% of Medicare claims submitted to demonstrate compliance with applicable requirements. We elected the pre-claim review option for our IRFs in Alabama for the first cycle. Under the pre-claim review choice, services can begin prior to the submission of the review request and continue while the decision is being made. The pre-claim review request with required documentation must be submitted, reviewed, and approved before the final claim is paid. If a certain percentage of the claims reviewed are found to be valid, the IRF may then opt out of the 100% review. The opt-out validation percentages for the first, second, and third cycles were 80% or greater, 85% or greater and 90% or greater, respectively. In opting out, the IRF may elect spot prepayment reviews of samples consisting of 5% of total claims or selective post-payment review of a statistically valid random sample. Our claim validation rate for the first cycle ending in February 2024 exceeded the 80% threshold at all participating hospitals. For the second cycle, which began on May 1, 2024, we elected not to opt out, so our hospitals in Alabama remained subject to the 100% pre-claim review. None of our hospitals in Alabama achieved the opt-out claim validation rate for the second or third cycles ending in October 2024 and June 2025, respectively. In the third cycle, we again submitted 100% of review requests pre-claim. None of our IRFs in Alabama achieved the 90% claim validation rate for the third cycle ending in June 2025. We believe many of the non-affirmations in these cycles were based on application of improper standards or requirements that directly conflict with the Medicare coverage criteria for IRFs. We have engaged, and will continue to engage, with the MAC and CMS to ensure the review process is consistent with existing rules, regulations and statutes. In the fourth cycle which began September 1, 2025, the affirmation rate required to opt-out remains 90% or greater. Given the inconsistent review process applied by the MAC across the previous cycles, we cannot predict the impact, if any, RCD may have on the collectability of our Medicare claims over the program's term and ultimately on our financial position, results of operations, and cash flows.

In connection with CMS approved and announced Recovery Audit Contractors ("RACs") audits related to IRFs, we received requests from 2013 to 2025 to review certain patient files for discharges occurring from 2010 to 2025. These RAC audits are focused on identifying Medicare claims that may contain improper payments. RAC contractors must have CMS approval before conducting these focused reviews which cover issues ranging from billing documentation to medical necessity. Medical necessity is an assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting.

CMS has also established other types of contractors, including the Unified Program Integrity Contractors ("UPICs") and the Supplemental Medical Review Contractor ("SMRC"). The UPICs conduct audits with a focus on potential fraud and abuse issues. Like the RACs, the UPICs conduct audits and have the ability to refer matters to the HHS-OIG or the DOJ. Unlike RACs, UPICs do not receive a specific financial incentive based on the amount of the error as a result of UPIC audits. We have, from time to time, received UPIC record requests which have resulted in claim denials on paid claims. We have appealed substantially all UPIC denials arising from these audits using the same process we follow for appealing other denials by contractors. As of December 31, 2025, we have appealed \$18.0 million of overpayment determination related to one UPIC audit to the DAB, challenging both the denials and the improper use of extrapolation. It is not possible to predict when this matter will be resolved or the ultimate outcome. The SMRC conducts nationwide medical reviews of Medicare claims to determine compliance with coverage, coding, payment, and billing requirements.

To date, the Medicare claims that are subject to these post-payment audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2025. Because we have confidence in the medical judgment of both the referring and admitting physicians who assess the treatment needs of their patients, we have appealed substantially all claim denials arising from these audits using the same process we follow for appealing denials by MACs. Due to the delays announced by CMS in the related adjudication process discussed above, we believe the resolution of any claims that are subsequently denied as a result of these claim audits could take several years. In addition, because we have limited experience with UPICs and RACs in the context of claims reviews of this nature, we cannot provide assurance as to the timing or outcomes of these disputes. As such, we make estimates for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for denials by MACs. During 2025, 2024, and 2023, our adjustment to *Net operating revenues* for claims that are part of these post-payment claims review process was not material.

ATTACHMENT 36 **Financial Viability**

Table of Contents

Encompass Health Corporation and Subsidiaries
Notes to Consolidated Financial Statements

Our performance obligations relate to contracts with a duration of less than one year. Therefore, we elected to apply the optional exemption to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. These unsatisfied or partially unsatisfied performance obligations primarily relate to services provided at the end of the reporting period.

We are subject to changes in government legislation that could impact Medicare payment levels and changes in payor patterns that may impact the level and timing of payments for services rendered.

Net operating revenues are recognized over time as the services are provided to the patient. The performance obligation is the rendering of services to the patient during the term of their inpatient stay. Revenues are recognized (or measured) using the input method as therapy, nursing, and auxiliary services are provided based on our estimate of the respective transaction price. Revenues recognized are subject to a number of elements which impact both the overall amount of revenue realized as well as the timing of the collection of the related accounts receivable. Factors considered in determining the estimated transaction price include the patient's total length of stay for in-house patients, each patient's discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Such additional factors are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes.

Cash and Cash Equivalents—

Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. Carrying values of *Cash and cash equivalents* approximate fair value due to the short-term nature of these instruments.

We maintain amounts on deposit with various financial institutions, which may, at times, exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and we have not experienced any losses on such deposits.

Marketable Securities—

We record all equity securities with readily determinable fair values and for which we do not exercise significant influence at fair value and record the change in fair value for the reporting period in our consolidated statements of operations.

We record debt securities with readily determinable fair values and for which we do not exercise significant influence as available-for-sale securities. We carry the available-for-sale securities at fair value and report unrealized holding gains or losses, net of income taxes, in *Accumulated other comprehensive income*, which is a separate component of shareholders' equity. We recognize realized gains and losses in our consolidated statements of operations using the specific identification method. Unrealized losses are charged against earnings when a decline in fair value was determined to be other than temporary. Management reviews several factors to determine whether a loss is other than temporary, such as the length of time a security is in an unrealized loss position, the extent to which fair value is less than cost, the financial condition and near term prospects of the issuer, industry, or geographic area and our ability and intent to hold the security for a period of time sufficient to allow for any anticipated recovery in fair value.

FORM 10-K

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Accounts Receivable

We report accounts receivable from services rendered at their estimated transaction price which takes into account price concessions from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, workers' compensation programs, employers, and patients. Our accounts receivable are concentrated by type of payor. The concentration of patient service accounts receivable by payor class, as a percentage of total patient service accounts receivable, is as follows:

	As of December 31,	
	2025	2024
Medicare	54.9 %	55.5 %
Managed care and other discount plans, including Medicare Advantage	35.6 %	34.3 %
Medicaid	3.6 %	4.0 %
Other third-party payors	2.8 %	2.8 %
Workers' compensation	2.5 %	2.6 %
Patients	0.6 %	0.8 %
Total	100.0 %	100.0 %

While revenues and accounts receivable from the Medicare program are significant to our operations, we do not believe there are significant credit risks associated with this government agency. We do not believe there are any other significant concentrations of revenues from any particular payor that would subject us to any significant credit risks in the collection of our accounts receivable.

Accounts requiring collection efforts are reviewed via system-generated work queues that automatically stage (based on age and size of outstanding balance) accounts requiring collection efforts for patient account representatives. Collection efforts include contacting the applicable party (both in writing and by telephone), providing information (both financial and clinical) to allow for payment or to overturn payor decisions to deny payment, and arranging payment plans with self-pay patients, among other techniques. When we determine all in-house efforts have been exhausted or it is a more prudent use of resources, accounts may be turned over to a collection agency.

The collection of outstanding receivables from Medicare, managed care payors, other third-party payors, and patients is our primary source of cash and is critical to our operating performance. While it is our policy to verify insurance prior to a patient being admitted, there are various exceptions that can occur. Such exceptions include instances where we are (1) unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid, and it takes several days, weeks, or months before qualification for such benefits is confirmed or denied, and (3) the patient is transferred to our hospital from an acute care hospital without having access to a credit card, cash, or check to pay the applicable patient responsibility amounts (i.e., deductibles and co-payments).

Our primary collection risks relate to patient responsibility amounts and claims reviews conducted by MACs or other contractors. Patient responsibility amounts include accounts for which the patient was the primary payor or the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient co-payment amounts remain outstanding. Changes in the economy, such as increased unemployment rates or periods of recession, can further exacerbate our ability to collect patient responsibility amounts.

If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. Changes in general economic conditions, business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable, financial position, results of operations, and cash flows.

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries Notes to Consolidated Financial Statements

Property and Equipment—

We report land, buildings, improvements, vehicles, and equipment at cost, net of accumulated depreciation and amortization and any asset impairments. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the underlying leases. Useful lives are generally as follows:

	Years
Buildings	10 to 30
Leasehold improvements	2 to 15
Vehicles	5
Furniture, fixtures, and equipment	3 to 10

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and betterments that increase the estimated useful life of an asset. We capitalize pre-acquisition costs when they are directly identifiable with a specific property, the costs would be capitalizable if the property were already acquired, and acquisition of the property is probable. We capitalize interest expense on major construction and development projects while in progress.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balances are removed from the respective accounts, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of operations. However, if the sale, retirement, or disposal involves a discontinued operation, the resulting net amount, less any proceeds, is included in the results of discontinued operations.

Leases—

We determine if an arrangement is a lease or contains a lease at inception and perform an analysis to determine whether the lease is an operating lease or a finance lease. We measure right-of-use assets and lease liabilities at the lease commencement date based on the present value of the remaining lease payments. As most of our leases do not provide a readily determinable implicit rate, we estimate an incremental borrowing rate based on the credit quality of the Company and by comparing interest rates available in the market for similar borrowings, and adjusting this amount based on the impact of collateral over the term of each lease. We use this rate to discount the remaining lease payments in measuring the right-of-use asset and lease liability. We use the implicit rate when readily determinable. We recognize lease expense for operating leases on a straight-line basis over the lease term. For our finance leases, we recognize amortization expense from the amortization of the right-of-use asset and interest expense on the related lease liability. Certain of our lease agreements contain annual escalation clauses based on changes in the Consumer Price Index. The changes to the Consumer Price Index, as compared to our initial estimate at the lease commencement date, are treated as variable lease payments and recognized in the period in which the obligation for those payments was incurred. In general, we do not account for lease and non-lease components separately for purposes of establishing right-of-use assets and lease liabilities.

Leases with an initial term of twelve months or less are not recorded on the consolidated balance sheets. We recognize lease expense for these leases on a straight-line basis over the lease term.

Goodwill and Other Intangible Assets—

We are required to test our goodwill and indefinite-lived intangible asset for impairment at least annually, absent some triggering event that would accelerate an impairment assessment. Absent any impairment indicators, we perform this impairment testing as of October 1st of each year. We recognize an impairment charge for any amount by which the carrying amount of the asset exceeds its implied fair value. We present an impairment charge as a separate line item within income from continuing operations in the consolidated statements of operations, unless the impairment is associated with a discontinued operation. In that case, we include the impairment charge, on a net-of-tax basis, within the results of discontinued operations.

We assess qualitative factors in our single reporting unit to determine whether it is necessary to perform the quantitative impairment test. If, based on this qualitative assessment, we were to believe we must perform the quantitative impairment test, we would determine the fair value of our reporting unit using generally accepted valuation techniques.

FORM 10-K

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

including the income approach and the market approach. The income approach includes the use of our reporting unit's discounted projected operating results and cash flows. This approach includes many assumptions related to pricing and volume, operating expenses, capital expenditures, discount factors, tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. We reconcile the estimated fair value of our reporting unit to our market capitalization. When we dispose of a hospital, goodwill is allocated to the gain or loss on disposition using the relative fair value methodology.

We assess qualitative factors related to our indefinite-lived intangible asset to determine whether it is necessary to perform the quantitative impairment test. If, based on this qualitative assessment, we were to believe we must perform the quantitative impairment test, we would determine the fair value of our indefinite-lived intangible asset using generally accepted valuation techniques including the relief-from-royalty method. This method is a form of the income approach in which value is equated to a series of cash flows and discounted at a risk-adjusted rate. It is based on a hypothetical royalty, calculated as a percentage of forecasted revenue, that we would otherwise be willing to pay to use the asset, assuming it were not already owned. This approach includes assumptions related to pricing and volume, as well as a royalty rate a hypothetical third party would be willing to pay for use of the asset. When making our royalty rate assumption, we consider rates paid in arms-length licensing transactions for assets comparable to our asset.

We amortize the cost of intangible assets with finite useful lives over their respective estimated useful lives to their estimated residual value. As of December 31, 2025, none of our finite useful lived intangible assets has an estimated residual value. We also review these assets for impairment whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount.

The range of estimated useful lives and the amortization basis for our intangible assets, excluding goodwill, are generally as follows:

	Estimated Useful Life and Amortization Basis
Certificates of need	10 to 30 years using straight-line basis
Licenses	10 to 20 years using straight-line basis
Noncompete agreements	1 to 18 years using straight-line basis
Trade names:	
Encompass	indefinite-lived asset
All other	10 to 20 years using straight-line basis
Internal-use software	3 to 7 years using straight-line basis
Market access assets	20 years using accelerated basis

We capitalize the costs of obtaining or developing internal-use software, including external direct costs of material and services and certain directly related payroll costs. Amortization begins when the internal-use software is ready for its intended use. Costs incurred during the preliminary project and post-implementation stages, as well as maintenance and training costs, are expensed as incurred.

Impairment of Long-Lived Assets and Other Intangible Assets

We assess the recoverability of long-lived assets (excluding goodwill and our indefinite-lived asset) and identifiable acquired intangible assets with finite useful lives, whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount. We measure the recoverability of assets to be held and used by a comparison of the carrying amount of the asset to the expected net future cash flows to be generated by that asset, or, for identifiable intangibles with finite useful lives, by determining whether the amortization of the intangible asset balance over its remaining life can be recovered through undiscounted future cash flows. The amount of impairment of identifiable intangible assets with finite useful lives, if any, to be recognized is measured based on projected discounted future cash flows. We measure the amount of impairment of other long-lived assets (excluding goodwill) as the amount by which the carrying value of the asset exceeds the fair market value of the asset, which is generally determined based on projected discounted future cash flows or appraised

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

values. We classify long-lived assets to be disposed of other than by sale as held and used until they are disposed. We report long-lived assets to be disposed of by sale as held for sale and recognize those assets in the balance sheet at the lower of carrying amount or fair value less cost to sell, and we cease depreciation.

Financing Costs—

We amortize financing costs using the effective interest method over the expected life of the related debt. Excluding financing costs related to our revolving line of credit (which are included in *Other long-term assets*), financing costs are presented as a direct deduction from the face amount of the financings. The related expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

We accrete discounts and amortize premiums using the effective interest method over the expected life of the related debt, and we report discounts or premiums as a direct deduction from, or addition to, the face amount of the financing. The related income or expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

Fair Value Measurements—

Fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions market participants would use in pricing an asset or liability.

The basis for these assumptions establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- *Level 1* – Observable inputs such as quoted prices in active markets,
- *Level 2* – Inputs, other than quoted prices in active markets, that are observable either directly or indirectly; and
- *Level 3* – Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future cash flows to a single present amount based on market expectations (including present value techniques, option-pricing models, and lattice models).

Our financial instruments consist mainly of cash and cash equivalents, restricted cash, restricted marketable securities, accounts receivable, accounts payable, letters of credit, and long-term debt. The carrying amounts of cash and cash equivalents, restricted cash, accounts receivable, and accounts payable approximate fair value because of the short-term maturity of these instruments. The fair value of our letters of credit is deemed to be the amount of payment guaranteed on our behalf by third-party financial institutions. We determine the fair value of our long-term debt using quoted market prices, when available, or discounted cash flows based on various factors, including maturity schedules, call features, and current market rates.

On a recurring basis, we are required to report our restricted marketable securities at fair value. The fair values of our restricted marketable securities are determined based on quoted market prices in active markets or quoted prices, dealer quotations, or alternative pricing sources supported by observable inputs in markets that are not considered to be active.

FORM 10-K

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

In addition, there are assets and liabilities that are not required to be reported at fair value on a recurring basis. However, these assets may be recorded at fair value as a result of impairment charges or other adjustments made to the carrying value of the applicable assets. The fair value of our property and equipment is determined using discounted cash flows and significant unobservable inputs, unless there is an offer to purchase such assets, which could be the basis for determining fair value. The fair value of our intangible assets, excluding goodwill, is determined using discounted cash flows and significant unobservable inputs. The fair value of our goodwill is determined using discounted projected operating results and cash flows, which involve significant unobservable inputs.

See also the “Redeemable Noncontrolling Interests” section of this note.

Noncontrolling Interests in Consolidated Affiliates—

The consolidated financial statements include all assets, liabilities, revenues, and expenses of less-than-100%-owned affiliates we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities. We record adjustments to noncontrolling interests for the allocable portion of income or loss to which the noncontrolling interests holders are entitled based upon their portion of the subsidiaries they own. Distributions to holders of noncontrolling interests are adjusted to the respective noncontrolling interests holders' balance.

Effective July 1, 2024, we expanded our existing joint venture with Piedmont Healthcare (“Piedmont”), which we control, by contributing the assets and operations of our previously wholly-owned 70-bed hospital in Augusta, Georgia. Piedmont contributed approximately \$90 million on July 1, 2024, which indirectly resulted in Piedmont obtaining a 50% ownership interest in the hospital. As a result of this transaction, we recorded a post-tax gain of \$23.2 million increasing *Capital in excess of par value* on the consolidated statement of shareholders' equity for the year ended December 31, 2024. The contribution from Piedmont is included in *Contributions from noncontrolling interests of consolidated affiliates* on the consolidated statement of cash flows for the year ended December 31, 2024.

Redeemable Noncontrolling Interests—

Certain of our joint venture agreements contain provisions that allow our partners to require us to purchase their interests in the joint venture at fair value at certain points in the future. Because these noncontrolling interests provide for redemption features that are not solely within our control, we classify them as *Redeemable noncontrolling interests* outside of permanent equity in our consolidated balance sheets. At the end of each reporting period, we compare the carrying value of the *Redeemable noncontrolling interests* to their estimated redemption value. If the estimated redemption value is greater than the current carrying value, the carrying value is adjusted to the estimated redemption value, with the adjustments recorded through equity in the line item *Capital in excess of par value*.

The fair value of our *Redeemable noncontrolling interests* in our joint venture entities is determined primarily using the income approach. The income approach includes the use of the joint venture entities' projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the applicable joint venture entity, or *Level 3* inputs. The projected operating results use management's best estimates of economic and market conditions over the forecasted periods including assumptions for pricing and volume, operating expenses, and capital expenditures.

Share-Based Payments—

Encompass Health has shareholder-approved stock-based compensation plans that provide for the granting of stock-based compensation to certain employees and directors. All share-based payments to employees are recognized in the financial statements based on their estimated grant-date fair value and amortized on a straight-line basis over the applicable requisite service period.

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Litigation Reserves—

We accrue for loss contingencies associated with outstanding litigation for which management has determined it is probable a loss contingency exists and the amount of loss can be reasonably estimated. If the accrued amount associated with a loss contingency is greater than \$5.0 million, we also accrue estimated future legal fees associated with the loss contingency. This requires management to estimate the amount of legal fees that will be incurred in the defense of the litigation. These estimates are based on our expectations of the scope, length to complete, and complexity of the claims. In the future, additional adjustments may be recorded as the scope, length to complete, or complexity of outstanding litigation changes.

Advertising Costs—

We expense costs of print, radio, television, and other advertisements as incurred. Advertising expenses, primarily included in *Other operating expenses* within the accompanying consolidated statements of operations, were \$5.3 million, \$5.8 million, and \$6.1 million in each of the years ended December 31, 2025, 2024, and 2023, respectively.

Income Taxes—

We provide for income taxes using the asset and liability method. This approach recognizes the amount of income taxes payable or refundable for the current year, as well as deferred tax assets and liabilities for the future tax consequence of events recognized in the consolidated financial statements and income tax returns. Deferred income tax assets and liabilities are adjusted to recognize the effects of changes in tax laws or enacted tax rates.

A valuation allowance is required when it is more likely than not some portion of the deferred tax assets will not be realized. Realization is dependent on generating sufficient future taxable income in the applicable tax jurisdiction. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences, our forecast of taxable income in future periods by jurisdiction, our ability to sustain a core level of earnings, and the availability of prudent tax planning strategies are important considerations in our assessment.

We evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. We review these tax uncertainties in light of changing facts and circumstances, such as the progress of tax audits, and adjust them accordingly. We have used the with-and-without method to determine when we will recognize excess tax benefits from stock-based compensation.

Encompass Health and its corporate subsidiaries file a consolidated federal income tax return. Some subsidiaries consolidated for financial reporting purposes are not part of the consolidated group for federal income tax purposes and file separate federal income tax returns. State income tax returns are filed on a separate, combined, or consolidated basis in accordance with relevant state laws and regulations. Partnerships, limited liability companies, and other pass-through entities we consolidate or account for using the equity method of accounting may file separate federal, state, and local income tax returns. We include the allocable portion of each pass-through entity's income or loss in our federal income tax return. We allocate the remaining income or loss of each pass-through entity to the other partners or members who are responsible for their portion of the taxes.

Assets and Liabilities in and Results of Discontinued Operations—

We report the disposal of the component, or group of components, as discontinued operations only when it represents a strategic shift that has, or will have, a major effect on our operations and financial results. In the period a component of an entity has been disposed of or classified as held for sale, we reclassify the results of operations for current and prior periods into a single caption titled *Loss from discontinued operations, net of tax*. In addition, we classify the assets and liabilities of those components as current and noncurrent assets and liabilities within *Other current assets*, *Other long-term assets*, *Other current liabilities*, and *Other long-term liabilities* in our consolidated balance sheets. We also classify cash flows related to discontinued operations as one line item within each category of cash flows in our consolidated statements of cash flows.

FORM 10-K

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

During 2025, 2024 and 2023, we incurred legal costs of \$1.2 million, \$2.9 million, and \$15.8 million, respectively, related to ongoing litigation against former executive officers of our home health and hospice business, which was spun off on July 1, 2022. These costs are included in *Loss from discontinued operations, net of tax*, in the consolidated statements of operations. In January 2026, we reached an agreement with certain defendants of this litigation on our claims for attorneys' fees and mitigation damages previously awarded to us. In February 2026, we collected approximately \$22 million in full satisfaction of our claims. As a result, we expect to record an approximate \$16 million after tax gain in *Income (loss) from discontinued operations, net of tax*, in the condensed consolidated statements of operations during the three months ended March 31, 2026.

Earnings per Common Share—

The calculation of earnings per common share is based on the weighted-average number of our common shares outstanding during the applicable period. The calculation for diluted earnings per common share recognizes the effect of all potential dilutive common shares that were outstanding during the respective periods, unless their impact would be antidilutive. The calculation of earnings per common share also considers the effect of participating securities. Stock-based compensation awards that contain nonforfeitable rights to dividends and dividend equivalents, such as our restricted stock units, are considered participating securities and are included in the computation of earnings per common share pursuant to the two-class method. In applying the two-class method, earnings are allocated to both common stock shares and participating securities based on their respective weighted-average shares outstanding for the period.

Treasury Stock—

Shares of common stock repurchased by us are recorded at cost, including direct incremental costs, as treasury stock. When shares are reissued, we use an average cost method to determine cost. The difference between the cost of the shares and the re-issuance price is added to or deducted from *Capital in excess of par value*. We account for the retirement of treasury stock as a reduction of retained earnings.

Comprehensive Income—

Comprehensive income is comprised of *Net income* and changes in unrealized gains or losses on available-for-sale securities and is included in the consolidated statements of comprehensive income.

Recently Adopted Accounting Pronouncements—

In December 2023, the FASB issued ASU 2023-09, "Income Taxes (Topic 740): Improvements to Income Tax Disclosures," which intends to improve the transparency of income tax disclosures by requiring companies to (1) disclose consistent categories and greater disaggregation of information in the effective rate reconciliation and (2) provide information on income taxes paid disaggregated by jurisdiction. We adopted ASU 2023-09 prospectively with an effective date as of January 1, 2025. The disclosures required are presented in Note 14, *Income Taxes*.

Recent Accounting Pronouncements Not Yet Adopted—

In November 2024, the FASB issued ASU 2024-03, "Income Statement—Reporting Comprehensive Income—Expense Disaggregation Disclosures (Subtopic 220-40): Disaggregation of Income Statement Expenses," which requires disaggregation of certain expense captions into specified categories within the notes to the financial statements for both interim and annual reporting periods. ASU 2024-03 is effective for our annual periods beginning January 1, 2027 and interim periods beginning January 1, 2028. Early adoption is permitted. We are currently evaluating the requirements of this standard and any potential impact it may have on our consolidated financial statements.

In September 2025, the FASB issued ASU 2025-06, "Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Targeted Improvements to the Accounting for Internal-Use Software," which intends to modernize the guidance related to internal-use software costs to reflect current software development methods. ASU 2025-06 requires entities to begin capitalizing software costs when management authorizes and commits to funding the software project, and it is probable the project will be completed and the software will be used for its intended purpose. ASU 2025-06 is effective for our annual and interim periods beginning January 1, 2028. Early adoption is permitted. The guidance can be applied on a prospective basis, a modified basis for in-process projects, or on a retrospective basis. We are currently evaluating the requirements of this standard and any potential impact it may have on our consolidated financial statements.

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

We do not believe any other recently issued, but not yet effective, accounting standards will have a material effect on our consolidated financial position, results of operations, or cash flows.

2. Variable Interest Entities:

As of December 31, 2025 and December 31, 2024, we consolidated eight limited partnership-like entities that are VIEs and of which we are the primary beneficiary. Our ownership percentages in these entities range from 50.0% to 75.0% as of December 31, 2025. Through partnership and management agreements with or governing each of these entities, we manage all of these entities and handle all day-to-day operating decisions. Accordingly, we have the decision-making power over the activities that most significantly impact the economic performance of our VIEs and an obligation to absorb losses or receive benefits from the VIE that could potentially be significant to the VIE. These decisions and significant activities include, but are not limited to, marketing efforts, oversight of patient admissions, medical training, nurse and therapist scheduling, provision of healthcare services, billing, collections and creation and maintenance of medical records. The terms of the agreements governing each of our VIEs prohibit us from using the assets of each VIE to satisfy the obligations of other entities.

The carrying amounts and classifications of the consolidated VIEs' assets and liabilities, which are included in our consolidated balance sheets, are as follows (in millions):

	As of December 31,	
	2025	2024
Assets		
Current assets:		
Cash and cash equivalents	\$ 1.6	\$ 0.4
Accounts receivable	34.9	34.5
Other current assets	4.7	9.6
Total current assets	41.2	44.5
Property and equipment, net	135.0	135.7
Operating lease right-of-use assets	1.3	1.3
Goodwill	15.9	15.9
Intangible assets, net	0.8	1.0
Other long-term assets	9.6	9.7
Total assets	\$ 203.8	\$ 208.1
Liabilities		
Current liabilities:		
Current portion of long-term debt	\$ 1.0	\$ 1.0
Accounts payable	6.6	6.2
Accrued payroll	10.9	11.0
Other current liabilities	19.0	12.7
Total current liabilities	37.5	30.9
Long-term debt, net of current portion	11.6	12.7
Long-term operating lease liabilities	1.4	1.4
Total liabilities	\$ 50.5	\$ 45.0

FORM 10-K

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

3. Cash and Marketable Securities:

The components of our investments as of December 31, 2025 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	\$ 72.2	\$ 30.7	\$ —	\$ 102.9
Equity securities	—	—	36.3	36.3
Available-for-sale debt securities:				
U.S. government and agency securities	—	—	40.4	40.4
Corporate bonds and notes	—	—	69.1	69.1
Total	\$ 72.2	\$ 30.7	\$ 145.8	\$ 248.7

The components of our investments as of December 31, 2024 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	\$ 85.4	\$ 37.7	\$ —	\$ 123.1
Equity securities	—	—	130.9	130.9
Total	\$ 85.4	\$ 37.7	\$ 130.9	\$ 254.0

Restricted Cash—

Restricted cash consisted of the following (in millions):

	As of December 31,	
	2025	2024
Current:		
Affiliate cash	\$ 12.1	\$ 17.9
Self-insured captive funds	18.6	19.8
Total restricted cash	\$ 30.7	\$ 37.7

Affiliate cash represents cash accounts maintained by joint ventures in which we participate where one or more of our external partners requested, and we agreed, that the joint venture's cash not be commingled with other corporate cash accounts and be used only to fund the operations of those joint ventures. Self-insured captive funds represent cash held at our wholly owned insurance captive, HCS, Ltd., as discussed in Note 9, *Self-Insured Risks*. These funds are committed to pay third-party administrators for claims incurred and are restricted by insurance regulations and requirements. These funds cannot be used for purposes outside HCS without the permission of the Cayman Islands Monetary Authority.

The classification of restricted cash held by HCS as current or noncurrent depends on the classification of the corresponding claims liability.

Marketable Securities—

Restricted marketable securities at both balance sheet dates represent restricted assets held at HCS. HCS insures a substantial portion of Encompass Health's professional liability, workers' compensation, and other insurance claims. These funds are committed for payment of claims incurred, and the classification of these marketable securities as current or noncurrent depends on the classification of the corresponding claims liability. As of December 31, 2025, \$42.2 million of restricted marketable securities are included in *Other current assets* and \$103.6 million are included in *Other long-term assets*.

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

in the consolidated balance sheet. As of December 31, 2024, \$39.0 million of restricted marketable securities are included in *Other current assets* and \$91.9 million are included in *Other long-term assets* in the consolidated balance sheet. During the years ended December 31, 2025, December 31, 2024, and December 31, 2023, \$2.1 million, \$1.0 million, and \$1.3 million, respectively, of unrealized net gains were recognized in our consolidated statements of operations on marketable securities still held at the reporting date.

A summary of our debt securities as of December 31, 2025 is as follows (in millions):

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Available-for-sale debt securities:				
U.S. government and agency securities	\$ 40.2	\$ 0.2	\$ —	\$ 40.4
Corporate bonds and notes	68.7	0.5	(0.1)	69.1

During the year ended December 31, 2025, we did not record any impairment charges related to our debt securities. We did not have any debt securities during the years ended December 31, 2024 and December 31, 2023.

Investing information related to our available-for-sale debt securities is as follows (in millions):

	For the Year Ended December 31,		
	2025	2024	2023
Proceeds from sales and maturities	\$ 32.3	\$ —	\$ —

The contractual maturities of our available-for-sale debt securities as of December 31, 2025 are as follows (in millions):

	Amortized Cost	Fair Value
Due in one year or less	\$ 24.3	\$ 24.4
Due after one year through five years	74.2	74.6
Due after five years through ten years	4.9	4.9
Due after ten years	5.5	5.6
Total	\$ 108.9	\$ 109.5

4. Accounts Receivable:

Accounts receivable consists of the following (in millions):

	As of December 31,	
	2025	2024
Current:		
Patient accounts receivable	\$ 613.4	\$ 593.0
Other accounts receivable	5.8	5.8
	619.2	598.8
Noncurrent patient accounts receivable	25.5	30.6
Accounts receivable	\$ 644.7	\$ 629.4

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Because the resolution of claims that are part of Medicare audit programs can take several years, we review the patient receivables that are part of this adjudication process to determine their appropriate classification as either current or noncurrent. Amounts considered noncurrent are included in *Other long-term assets* in our consolidated balance sheets. See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues," for additional information.

5. Property and Equipment:

Property and equipment consists of the following (in millions):

	As of December 31,	
	2025	2024
Land	\$ 339.7	\$ 302.6
Buildings	4,325.7	3,859.3
Leasehold improvements	388.3	372.8
Vehicles	6.1	5.6
Furniture, fixtures, and equipment	897.0	808.8
	5,956.8	5,349.1
Less: Accumulated depreciation and amortization	(2,372.8)	(2,111.9)
	3,584.0	3,237.2
Construction in progress	517.6	405.9
Property and equipment, net	<u>\$ 4,101.6</u>	<u>\$ 3,643.1</u>

As of December 31, 2025, approximately 68% of our consolidated *Property and equipment, net* held by Encompass Health Corporation and its guarantor subsidiaries was pledged to the lenders under our credit agreement. See Note 8, *Long-term Debt*, for additional information on our credit agreement.

Depreciation expense was \$273.9 million, \$245.1 million, and \$215.7 million for the years ended December 31, 2025, December 31, 2024 and December 31, 2023, respectively. Interest capitalized was \$17.6 million, \$15.2 million, and \$13.5 million for the years ended December 31, 2025, December 31, 2024 and December 31, 2023, respectively.

6. Leases:

We lease real estate, vehicles, and equipment under operating and finance leases with non-cancelable terms generally expiring at various dates through 2039. Our operating and finance leases generally have 1- to 25-year terms, with one or more renewal options, primarily relating to our real estate leases, with terms to be determined at the time of renewal. The exercise of such lease renewal options is at our sole discretion, and to the extent we are reasonably certain we will exercise a renewal option, the years related to that option are included in our determination of the lease term for purposes of classifying and measuring a given lease. Certain leases also include options to purchase the leased property.

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

The components of lease costs are as follows (in millions):

	For the Year Ended December 31,		
	2025	2024	2023
Operating lease cost	\$ 43.4	\$ 41.7	\$ 40.9
Finance lease cost:			
Amortization of right-of-use assets	25.7	25.7	25.7
Interest on lease liabilities	23.0	24.7	26.2
Total finance lease cost	48.7	50.4	51.9
Short-term and variable lease cost	1.7	2.3	2.9
Sublease income	(3.2)	(3.1)	(3.3)
Total lease cost	<u>\$ 90.6</u>	<u>\$ 91.3</u>	<u>\$ 92.4</u>

Supplemental consolidated balance sheet information related to leases is as follows (in millions):

		As of December 31,	
		2025	2024
Assets			
Operating lease	Operating lease right-of-use assets	\$ 212.6	\$ 203.7
Finance lease ⁽¹⁾	Property and equipment, net	195.9	221.5
Total leased assets		<u>\$ 408.5</u>	<u>\$ 425.2</u>
Liabilities			
Current liabilities:			
Operating lease	Current operating lease liabilities	\$ 26.5	\$ 26.3
Finance lease	Current portion of long-term debt	26.5	23.7
Noncurrent liabilities:			
Operating lease	Long-term operating lease liabilities	196.6	189.7
Finance lease	Long-term debt, net of current portion	268.1	294.7
Total leased liabilities		<u>\$ 517.7</u>	<u>\$ 534.4</u>

⁽¹⁾ Finance lease assets are recorded net of accumulated amortization of \$222.9 million and \$197.3 million as of December 31, 2025 and December 31, 2024, respectively.

	As of December 31,	
	2025	2024
Weighted Average Remaining Lease Term		
Operating lease	9.7 years	9.7 years
Finance lease	8.9 years	9.8 years
Weighted Average Discount Rate		
Operating lease	6.3 %	6.4 %
Finance lease	7.7 %	7.7 %

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Notes to Consolidated Financial Statements

Maturities of lease liabilities as of December 31, 2025 are as follows (in millions):

<u>Year Ending December 31,</u>	<u>Operating Leases</u>	<u>Finance Leases</u>
2026	\$ 39.5	\$ 47.6
2027	42.9	47.4
2028	41.9	46.4
2029	27.5	47.3
2030	21.0	47.4
2031 and thereafter	132.4	175.3
Total lease payments	305.2	411.4
Less: Interest portion	(82.1)	(116.8)
Total lease liabilities	<u>\$ 223.1</u>	<u>\$ 294.6</u>

Supplemental cash flow information related to our leases is as follows (in millions):

	<u>For the Year Ended December 31,</u>		
	<u>2025</u>	<u>2024</u>	<u>2023</u>
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows from operating leases	\$ 42.6	\$ 40.7	\$ 39.0
Operating cash flows from finance leases	23.6	25.5	27.1
Financing cash flows from finance leases	23.9	21.8	41.1
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	\$ 38.2	\$ 26.7	\$ 26.2
Finance leases	0.2	—	21.4

7. Goodwill and Other Intangible Assets:

The following table shows changes in the carrying amount of *Goodwill* (in millions):

	<u>Amount</u>
Goodwill as of December 31, 2022	\$ 1,263.2
Acquisitions	18.1
Goodwill as of December 31, 2023	1,281.3
Acquisitions	2.7
Goodwill as of December 31, 2024	1,284.0
Acquisitions	33.6
Goodwill as of December 31, 2025	<u>\$ 1,317.6</u>

Goodwill increased in 2023, 2024, and 2025 as a result of our acquisitions of inpatient rehabilitation operations.

We performed impairment reviews as of October 1, 2025, 2024, and 2023 and concluded no *Goodwill* impairment existed. As of December 31, 2025, we had no accumulated impairment losses related to *Goodwill*.

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

The following table provides information regarding our other intangible assets (in millions):

	Gross Carrying Amount	Accumulated Amortization	Net
Certificates of need:			
2025	\$ 137.0	\$ (54.9)	\$ 82.1
2024	131.4	(49.0)	82.4
Licenses:			
2025	\$ 65.6	\$ (57.5)	\$ 8.1
2024	65.7	(56.4)	9.3
Noncompete agreements:			
2025	\$ 64.9	\$ (61.7)	\$ 3.2
2024	66.5	(63.4)	3.1
Trade name - Encompass:			
2025	\$ 135.2	\$ —	\$ 135.2
2024	135.2	—	135.2
Trade names - all other:			
2025	\$ 38.9	\$ (24.5)	\$ 14.4
2024	39.6	(23.6)	16.0
Internal-use software:			
2025	\$ 245.7	\$ (180.9)	\$ 64.8
2024	214.4	(163.3)	51.1
Market access assets:			
2025	\$ 13.2	\$ (12.7)	\$ 0.5
2024	13.2	(12.5)	0.7
Total intangible assets:			
2025	\$ 700.5	\$ (392.2)	\$ 308.3
2024	666.0	(368.2)	297.8

Amortization expense for other intangible assets is as follows (in millions):

	For the Year Ended December 31,		
	2025	2024	2023
Amortization expense	\$ 28.3	\$ 28.8	\$ 32.5

Total estimated amortization expense for our other intangible assets for the next five years is as follows (in millions):

Year Ending December 31,	Estimated Amortization Expense
2026	\$ 27.4
2027	20.2
2028	13.6
2029	11.6
2030	10.6

FORM 10-K

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Notes to Consolidated Financial Statements

8. Long-term Debt:

Our long-term debt outstanding consists of the following (in millions):

	As of December 31,	
	2025	2024
Credit Agreement—		
Advances under revolving credit facility	\$ 130.0	\$ 20.0
Bonds payable—		
5.75% Senior Notes due 2025	—	99.8
4.50% Senior Notes due 2028	792.0	788.4
4.75% Senior Notes due 2030	787.0	784.2
4.625% Senior Notes due 2031	393.6	392.5
Other notes payable	93.6	94.5
Finance lease obligations	294.6	318.4
	2,490.8	2,497.8
Less: Current portion	(43.6)	(138.6)
Long-term debt, net of current portion	\$ 2,447.2	\$ 2,359.2

The following chart shows scheduled principal payments due on long-term debt for the next five years and thereafter (in millions):

Year Ending December 31,	Face Amount	Net Amount
2026	\$ 43.6	\$ 43.6
2027	177.2	177.2
2028	835.9	827.8
2029	44.7	44.6
2030	850.2	837.1
Thereafter	566.9	560.5
Total	\$ 2,518.5	\$ 2,490.8

Senior Secured Credit Agreement—

The credit agreement provides for a \$1 billion revolving credit facility, with a \$260 million letter of credit subfacility and a swingline loan subfacility, all of which mature in October 2027.

Amounts drawn on the revolving credit facility bear interest at a rate per annum of, at our option, (1) secured overnight financing rate ("SOFR") or (2) the higher of (a) Barclays Bank PLC's prime rate and (b) the federal funds rate plus 0.5%, in each case, plus, in each case, an applicable margin that varies depending upon our leverage ratio. We are also subject to a commitment fee of 0.25% or 0.30%, depending on our leverage ratio, per annum on the daily amount of the unutilized commitments under the revolving credit facility. The current interest rate on SOFR borrowings under the credit agreement includes a credit spread of 1.25%.

The credit agreement contains affirmative and negative covenants and default and acceleration provisions, including a minimum interest coverage ratio and a maximum leverage ratio. Under one such negative covenant, we are restricted from paying common stock dividends, prepaying certain senior notes, making certain investments, and repurchasing preferred and common equity unless (1) we are not in default under the terms of the credit agreement and (2) our senior secured leverage ratio, as defined in the credit agreement, does not exceed 2x. In the event the senior secured leverage ratio exceeds 2x, these payments are subject to a limit of \$200 million plus the Available Amount, as defined in the credit agreement. Our obligations

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

under the credit agreement are secured by the current and future personal property of the Company and its subsidiary guarantors. The maximum leverage ratio in the financial covenants is 4.50x as of December 31, 2025.

As of December 31, 2025, \$130 million was drawn under the revolving credit facility with an interest rate of 5.9%. As of December 31, 2024, \$20 million was drawn under the revolving credit facility with an interest rate of 7.8%. As of December 31, 2025 and 2024, \$46.3 million and \$36.3 million, respectively, was being utilized under the letter of credit subfacility, which were being used in the ordinary course of business to secure workers' compensation and other insurance coverages and for general corporate purposes.

Bonds Payable—

Senior Notes

The Company's 5.75% Senior Notes due 2025 (the "2025 Notes"), 4.50% Senior Notes due 2028 (the "2028 Notes"), 4.75% Senior Notes due 2030 (the "2030 Notes"), and 4.625% Senior Notes due 2031 (the "2031 Notes" and collectively the "Senior Notes") were issued pursuant to an indenture (the "Base Indenture") dated as of December 1, 2009, as supplemented by each Senior Notes' respective supplemental indenture (together with the Base Indenture, the "Indenture"). Pursuant to the terms of the Indenture, the Senior Notes are jointly and severally guaranteed on a senior, unsecured basis by all of our existing and future subsidiaries that guarantee borrowings under our credit agreement and other capital markets debt. The Senior Notes are senior, unsecured obligations of Encompass Health and rank equally with our other senior indebtedness, senior to any of our subordinated indebtedness, and effectively junior to our secured indebtedness to the extent of the value of the collateral securing such indebtedness.

Upon the occurrence of a change in control (as defined in the Indenture), each holder of the Senior Notes may require us to repurchase all or a portion of the notes in cash at a price equal to 101% of the principal amount of the Senior Notes to be repurchased, plus accrued and unpaid interest.

The Senior Notes contain covenants and default and acceleration provisions, that, among other things, limit our and certain of our subsidiaries' ability to (1) incur additional debt, (2) make certain restricted payments, (3) consummate specified asset sales, (4) incur liens, and (5) merge or consolidate with another person.

2025 Notes

In September 2015, we issued \$350 million of the 2025 Notes at par. In August and November 2024, we redeemed \$150 million and \$100 million, respectively, of the outstanding principal balance of our 2025 Notes using cash on hand. Pursuant to the terms of the 2025 Notes, these optional redemptions were made at a price of par. In September 2025, we redeemed the remaining \$100 million of the outstanding principal balance of our 2025 Notes at maturity using cash on hand and capacity under our revolving credit facility. Inclusive of financing costs, the effective interest rate on the 2025 Notes was 6.0%. Interest on the 2025 Notes was payable semiannually in arrears on March 15 and September 15.

2028 and 2030 Notes

In September 2019, we issued \$500 million of the 2028 Notes at par and \$500 million of the 2030 Notes at par. Certain of the proceeds from this offering were used to fund the purchase of equity rights from management investors of our former home health and hospice business.

In May 2020, we issued an additional \$300 million of the 2028 Notes at a price of 99.0% of the principal amount and an additional \$300 million of the 2030 Notes at a price of 98.5% of the principal amount, which resulted in approximately \$583 million in net proceeds. We used a portion of the net proceeds from this borrowing, together with cash on hand, to repay borrowings under our revolving credit facility.

FORM 10-K

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

The 2028 Notes mature on February 1, 2028 and bear interest at a per annum rate of 4.50%. Inclusive of financing costs, the effective interest rate on the 2028 Notes is 5.0%. Interest on the 2028 Notes is payable semiannually in arrears on February 1 and August 1. We may redeem the 2028 Notes at par, in whole or in part, at any time on or after February 1, 2025.

The 2030 Notes mature on February 1, 2030 and bear interest at a per annum rate of 4.75%. Inclusive of financing costs, the effective interest rate on the 2030 Notes is 5.2%. Interest on the 2030 Notes is payable semiannually in arrears on February 1 and August 1. We may redeem the 2030 Notes, in whole or in part, at any time on or after February 1, 2025 at the redemption prices set forth below:

<u>Period</u>	<u>Redemption Price*</u>
2025	102.375 %
2026	101.583 %
2027	100.792 %
2028 and thereafter	100.000 %

* Expressed in percentage of principal amount

2031 Notes

In October 2020, we issued \$400 million of the 2031 Notes at par. The 2031 Notes mature on April 1, 2031 and bear interest at a per annum rate of 4.625%. Inclusive of financing costs, the effective interest rate on the 2031 Notes is 5.0%. Interest is payable semiannually in arrears on April 1 and October 1 of each year. We may redeem the 2031 Notes, in whole or in part, at any time on or after April 1, 2026 at the redemption prices set forth below:

<u>Period</u>	<u>Redemption Price*</u>
2026	102.313 %
2027	101.542 %
2028	100.771 %
2029 and thereafter	100.000 %

* Expressed in percentage of principal amount

Other Notes Payable—

Our notes payable consist of the following (in millions)

	<u>As of December 31,</u>		<u>Current Interest Rates</u>
	<u>2025</u>	<u>2024</u>	
Sale/leaseback transactions involving real estate accounted for as financings	\$ 28.0	\$ 28.0	9.2% to 13.4%
Construction of new hospitals	41.0	47.6	5.0% to 6.3%
Software contracts	24.6	18.9	4.7% to 6.5%
Other notes payable	<u>\$ 93.6</u>	<u>\$ 94.5</u>	

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

9. Self-Insured Risks:

We insure a substantial portion of our professional liability, general liability, and workers' compensation risks through a self-insured retention program ("SIR") underwritten by our consolidated wholly owned offshore captive insurance subsidiary, HCS, Ltd., which we fund via regularly scheduled premium payments. HCS is an insurance company licensed by the Cayman Island Monetary Authority. For 2025, 2024, and 2023, HCS insured the first \$6 million per claim and \$45 million of annual aggregate losses associated with general and professional liability risks. Workers' compensation exposures are capped on a per claim basis. Risks in excess of specified limits per claim and in excess of our aggregate SIR amount are covered by unrelated commercial carriers.

The following table presents the changes in our self-insurance reserves (in millions):

	2025	2024	2023
Balance at beginning of period, gross	\$ 194.8	\$ 184.5	\$ 175.1
Less: Reinsurance receivables	(37.6)	(36.4)	(32.3)
Balance at beginning of period, net	157.2	148.1	142.8
Increase for the provision of current year claims	67.5	59.1	54.7
Decrease for the provision of prior year claims	(6.2)	(10.9)	(10.5)
Payments related to current year claims	(8.9)	(6.9)	(8.1)
Payments related to prior year claims	(31.7)	(32.2)	(30.8)
Balance at end of period, net	177.9	157.2	148.1
Add: Reinsurance receivables	33.1	37.6	36.4
Balance at end of period, gross	\$ 211.0	\$ 194.8	\$ 184.5

As of December 31, 2025 and 2024, \$57.9 million and \$56.2 million, respectively, of these reserves are included in *Other current liabilities* in our consolidated balance sheets.

Provisions for these risks are based primarily upon actuarially determined estimates. These reserves represent the unpaid portion of the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. The changes to the estimated ultimate loss amounts are included in current operating results.

The reserves for these self-insured risks cover approximately 1,100 individual claims at December 31, 2025 and 2024, and estimates for potential unreported claims. The time period required to resolve these claims can vary depending upon the jurisdiction, the nature, and the form of resolution of the claims. The estimation of the timing of payments beyond a year can vary significantly. Although considerable variability is inherent in reserve estimates, management believes the reserves for losses and loss expenses are adequate; however, there can be no assurance the ultimate liability will not exceed management's estimates.

FORM 10-K

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

10. Redeemable Noncontrolling Interests:

The following is a summary of the activity related to our *Redeemable noncontrolling interests* (in millions):

	For the Year Ended December 31,		
	2025	2024	2023
Balance at beginning of period	\$ 56.5	\$ 42.0	\$ 35.6
Net income attributable to noncontrolling interests	9.4	5.1	8.3
Distributions declared	(11.2)	(10.2)	(1.1)
Contribution to joint ventures	—	18.0	—
Change in fair value	3.6	1.6	(0.8)
Balance at end of period	\$ 58.3	\$ 56.5	\$ 42.0

The following table reconciles the net income attributable to nonredeemable *Noncontrolling interests*, as recorded in the shareholders' equity section of the consolidated balance sheets, and the net income attributable to *Redeemable noncontrolling interests*, as recorded in the mezzanine section of the consolidated balance sheets, to the *Net income attributable to noncontrolling interests* presented in the consolidated statements of operations (in millions):

	For the Year Ended December 31,		
	2025	2024	2023
Net income attributable to nonredeemable noncontrolling interests	\$ 183.5	\$ 135.8	\$ 102.7
Net income attributable to redeemable noncontrolling interests	9.4	5.1	8.3
Net income attributable to noncontrolling interests	\$ 192.9	\$ 140.9	\$ 111.0

11. Fair Value Measurements:

Our financial assets and liabilities that are measured at fair value on a recurring basis are as follows (in millions):

	Fair Value	Fair Value Measurements at Reporting Date Using			
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Valuation Technique ⁽¹⁾
As of December 31, 2025					
Equity securities	\$ 36.3	\$ 20.3	\$ 16.0	\$ —	M
Available for sale debt securities:					
U.S. government and agency securities	40.4	40.4	—	—	M
Corporate bonds and notes	69.1	—	69.1	—	M
Redeemable noncontrolling interests	58.3	—	—	58.3	I
As of December 31, 2024					
Equity securities	\$ 130.9	\$ 4.2	\$ 126.7	\$ —	M
Redeemable noncontrolling interests	56.5	—	—	56.5	I

⁽¹⁾ The two valuation techniques are: market approach (M) and income approach (I).

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

There are assets and liabilities that are not required to be measured at fair value on a recurring basis. However, these assets may be recorded at fair value as a result of impairment charges or other adjustments made to the carrying value of the applicable assets. During the years ended December 31, 2025, 2024, and 2023, we did not record any material gains or losses related to these assets.

As discussed in Note 1, *Summary of Significant Accounting Policies*, "Fair Value Measurements," the carrying value equals fair value for our financial instruments that are not included in the table below and are classified as current in our consolidated balance sheets. The carrying amounts and estimated fair values for our other financial instruments are presented in the following table (in millions):

	As of December 31, 2025		As of December 31, 2024	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Long-term debt:				
Advances under revolving credit facility	\$ 130.0	\$ 130.0	\$ 20.0	\$ 20.0
5.75% Senior Notes due 2025	—	—	99.8	99.7
4.50% Senior Notes due 2028	792.0	799.6	788.4	772.3
4.75% Senior Notes due 2030	787.0	796.6	784.2	759.0
4.625% Senior Notes due 2031	393.6	392.7	392.5	369.9
Other notes payable	93.6	93.6	94.5	94.5
Financial commitments:				
Letters of credit	—	46.3	—	36.3

Fair values for our long-term debt and financial commitments are determined using inputs, including quoted prices in nonactive markets, that are observable either directly or indirectly, or *Level 2* inputs within the fair value hierarchy. See Note 1, *Summary of Significant Accounting Policies*, "Fair Value Measurements" and "Redeemable Noncontrolling Interests."

12. Share-Based Payments:

The Company has awarded employee stock-based compensation in the form of stock options and restricted stock awards ("RSAs") under the terms of share-based incentive plans designed to align employee and executive interests to those of its stockholders. All employee stock-based compensation awarded between January 1, 2023 and May 1, 2025 was issued under the 2016 Omnibus Performance Incentive Plan (the "2016 Plan"), a stockholder-approved plan that reserved and provided for the grant of up to 16,860,765 shares of common stock after adjustment for the effect of the spin off of our home health and hospice business in 2022. This plan allowed for the grants of nonqualified stock options, incentive stock options, restricted stock, stock appreciation rights, performance shares, performance share units, dividend equivalents, restricted stock units ("RSUs"), and/or other stock-based awards. No additional stock-based compensation will be awarded from the 2016 Plan.

On May 1, 2025, our stockholders approved the 2025 Omnibus Performance Incentive Plan, which reserves and provides for the grant of up to 12,000,000 shares of common stock. All employee stock-based compensation awarded after May 1, 2025 was issued under this plan. This plan allows for the same types of equity grants as the 2016 Plan.

Stock-based compensation expense recognized in continuing operations was \$56.5 million, \$48.3 million, and \$50.6 million during the years ended December 31, 2025, 2024, and 2023, respectively.

Stock Options—

Under our share-based incentive plans, officers and employees are given the right to purchase shares of Encompass Health common stock at a fixed grant price determined on the day the options are granted. The terms and conditions of the options, including exercise prices and the periods in which options are exercisable, are generally at the discretion of the compensation and human capital committee of our board of directors. However, no options are exercisable beyond ten years from the date of grant. Granted options vest over the awards' requisite service periods, which are generally three years.

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

The fair values of the options granted during the years ended December 31, 2025, 2024, and 2023 have been estimated at the grant date using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	For the Year Ended December 31,		
	2025	2024	2023
Expected volatility	28.0 %	27.9 %	28.5 %
Risk-free interest rate	4.1 %	4.2 %	4.2 %
Expected life (years)	7.3	7.2	6.9
Dividend yield	0.9 %	1.0 %	1.1 %

The Black-Scholes option-pricing model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, the Black-Scholes option-pricing model requires the input of highly subjective assumptions, including the expected stock price volatility. We estimate our expected term through an analysis of actual, historical post-vesting exercise, cancellation, and expiration behavior by our officers and projected post-vesting activity of outstanding options. We calculate volatility based on the historical volatility of our common stock over the period commensurate with the expected term of the options. The risk-free interest rate is the implied daily yield currently available on U.S. Treasury issues with a remaining term closely approximating the expected term used as the input to the Black-Scholes option-pricing model. We estimated our dividend yield based on our annual dividend rate and our stock price on the dividend payment dates. Under the Black-Scholes option-pricing model, the weighted-average grant date fair value per share of employee stock options granted during the years ended December 31, 2025, 2024, and 2023 was \$35.22, \$26.14, and \$19.23, respectively.

A summary of our stock option activity and related information is as follows:

	Shares (In Thousands)	Weighted- Average Exercise Price per Share	Weighted- Average Remaining Life (Years)	Aggregate Intrinsic Value (In Millions)
Outstanding, December 31, 2024	840	\$ 53.05		
Granted	51	98.45		
Exercised	(180)	37.55		
Outstanding, December 31, 2025	711	60.27	5.2	\$ 32.6
Exercisable, December 31, 2025	591	56.11	4.5	29.6

We recognized approximately \$1.8 million, \$1.9 million, and \$2.5 million of compensation expense related to our stock options for the years ended December 31, 2025, 2024, and 2023, respectively. As of December 31, 2025, there was \$0.2 million of unrecognized compensation cost related to unvested stock options. This cost is expected to be recognized over a weighted-average period of 21 months. The total intrinsic value of options exercised during the years ended December 31, 2025, 2024, and 2023 was \$14.6 million, \$4.0 million, and \$2.5 million, respectively.

Restricted Stock—

The RSAs granted in 2025, 2024, and 2023 included service-based awards and performance-based awards (that also included a service requirement). These awards generally vest over a three-year requisite service period. For RSAs with a service and/or performance requirement, the fair value of the RSA is determined by the closing price of our common stock on the grant date. A portion of the RSAs granted also includes a market condition for certain members of management. For awards with a market condition, the fair value of the market condition component of the RSAs is determined using a lattice model. Inputs into the model include the historical price volatility of our common stock, the historical volatility of the common stock of the companies in the defined peer group, and the risk-free interest rate. Utilizing these inputs and potential future changes in stock prices, multiple trials are run to determine the fair value.

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

A summary of our issued restricted stock awards is as follows (share information in thousands):

	Shares	Weighted-Average Grant Date Fair Value
Nonvested shares at December 31, 2024	804	\$ 61.14
Granted	467	73.92
Vested	(587)	58.15
Forfeited	(16)	74.85
Nonvested shares at December 31, 2025	668	72.38

The weighted-average grant-date fair value of restricted stock granted during the years ended December 31, 2024 and 2023 was \$61.67 and \$65.20 per share, respectively. We recognized approximately \$53.2 million, \$44.9 million, and \$46.6 million of compensation expense related to our restricted stock awards for the years ended December 31, 2025, 2024, and 2023, respectively. As of December 31, 2025, there was \$40.2 million of unrecognized compensation expense related to unvested restricted stock. This cost is expected to be recognized over a weighted-average period of 21 months. The remaining unrecognized compensation expense for the performance-based awards may vary each reporting period based on changes in the expected achievement of performance measures. The total fair value of shares vested during the years ended December 31, 2025, 2024, and 2023 was \$55.7 million, \$33.7 million, and \$24.3 million, respectively. We accrue dividends on outstanding RSAs, which are paid upon vesting.

Nonemployee Stock-Based Compensation Plans

During the years ended December 31, 2025, 2024, and 2023, we provided incentives to the nonemployee members of our board of directors through the issuance of RSUs out of our share-based incentive plans. RSUs are fully vested when awarded and receive dividend equivalents in the form of additional RSUs upon the payment of a cash dividend on our common stock. We issued 15,060, 23,509, and 32,365 RSUs, inclusive of dividend equivalents, during the years ended December 31, 2025, 2024, and 2023, respectively. The non-dividend equivalent RSUs had a fair value of \$115.94, \$83.42, and \$63.00 per unit during the years ended December 31, 2025, 2024, and 2023, respectively, and we recognized approximately \$1.5 million of compensation expense upon their issuance in 2025, 2024, and 2023. There was no unrecognized compensation related to unvested shares as of December 31, 2025. We issued 3,569, 5,707, and 7,518 of RSUs as dividend equivalents during the years ended December 31, 2025, 2024, and 2023, respectively. During the years ended December 31, 2025 and 2024, 269,020 and 314,988 RSUs, respectively, were released following the retirement of certain former members of our board of directors. The total fair value of shares released during the years ended December 31, 2025 and 2024 was \$26.2 million and \$29.1 million, respectively. As of December 31, 2025, 262,238 RSUs were outstanding.

13. Employee Benefit Plans:

Substantially all Encompass Health employees are eligible to enroll in Encompass Health-sponsored healthcare plans, including coverage for medical and dental benefits. Our primary healthcare plans are national plans administered by third-party administrators. We are self-insured for these plans. During 2025, 2024, and 2023, costs associated with these plans, net of amounts paid by employees, approximated \$252.2 million, \$227.4 million, and \$186.2 million, respectively.

The Encompass Health Corporation 401(k) Retirement Plan (the "401(k) Plan") is a qualified 401(k) savings plan. The 401(k) Plan allows eligible employees to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. Encompass Health employees who are at least 21 years of age are eligible to participate in the 401(k) Plan and all contributions to the plan are in the form of cash. Encompass Health's employer matching contribution under the 401(k) Plan is 50% of the first 6% of each participant's elective deferrals, which vest 100% after three years of service. Participants are always fully vested in their own contributions.

Employer contributions to the 401(k) Plan approximated \$35.6 million, \$32.1 million, and \$31.3 million in 2025, 2024, and 2023, respectively. In 2025, 2024, and 2023, approximately \$2.7 million, \$2.9 million, and \$1.1 million, respectively, from forfeited accounts were used to fund the matching contributions in accordance with the terms of the 401(k) Plan.

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Notes to Consolidated Financial Statements

Senior Management Bonus Program—

We maintain a Senior Management Bonus Program to reward senior management for performance based on a combination of corporate or regional goals for all periods presented. The corporate and regional goals are approved on an annual basis by our board of directors as part of our routine budgeting and financial planning process. The program applies to persons who join the Company in, or are promoted to, senior management positions. In 2026, we expect to pay approximately \$30.6 million under the program for the year ended December 31, 2025. In February 2025 and March 2024, we paid \$28.3 million and \$27.9 million, respectively, under the program for the years ended December 31, 2024 and 2023.

14. Income Taxes:

The domestic and foreign components of *Income from continuing operations before income tax expense* are as follows (in millions):

	For the Year Ended December 31, 2025
United States	\$ 944.8
Foreign	8.2
Income from continuing operations before income tax expense	<u>\$ 953.0</u>

The significant components of the *Provision for income tax expense* related to continuing operations are as follows (in millions):

	For the Year Ended December 31, 2025
Current:	
Federal	\$ 132.3
State and local	35.7
Foreign	2.6
Total current expense	<u>170.6</u>
Deferred:	
Federal	20.0
State and local	2.3
Foreign	—
Total deferred expense	<u>22.3</u>
Total income tax expense related to continuing operations	<u>\$ 192.9</u>

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

A reconciliation of differences between the federal income tax at statutory rates and our actual income tax expense on our income from continuing operations, is presented below (in millions, except for percentages):

	For the Year Ended December 31, 2025	
	Amount	%
Tax expense at statutory rate	\$ 200.1	21.0 %
State and other income taxes, net of federal tax effect ⁽¹⁾	31.6	3.3 %
Changes in valuation allowance	2.9	0.3 %
Noncontrolling interests	(40.5)	(4.2)%
Nontaxable or nondeductible items:		
Share-based windfall tax benefits	(12.5)	(1.3)%
Nondeductible executive compensation	10.1	1.0 %
Other	1.9	0.2 %
Tax credits	(2.5)	(0.3)%
Foreign tax effects	2.6	0.3 %
Other, net	(0.8)	(0.1)%
Income tax expense	<u>\$ 192.9</u>	<u>20.2 %</u>

⁽¹⁾ In 2025, state taxes in Florida, Tennessee, Pennsylvania, Massachusetts, California, and Virginia made up the majority (greater than 50 percent) of the tax effect of this category.

The *Provision for income tax expense* in 2025 was less than the federal statutory rate primarily due to the impact of noncontrolling interests offset by state and other income tax expense. See Note 1, Summary of Significant Accounting Policies, "Income Taxes," for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in this discussion.

FORM 10-K

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Deferred income taxes recognize the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and amounts used for income tax purposes and the impact of available NOLs. The significant components of our deferred tax assets and liabilities are presented in the following table (in millions):

	As of December 31,	
	2025	2024
Deferred income tax assets:		
Net operating loss	\$ 5.5	\$ 8.8
Insurance reserve	21.2	20.9
Stock-based compensation	22.2	24.0
Revenue reserves	8.5	8.0
Operating lease liabilities	21.3	22.5
Other accruals	28.8	29.4
Tax credits	19.5	17.0
Total deferred income tax assets	127.0	130.6
Less: Valuation allowance	(21.4)	(21.0)
Net deferred income tax assets	105.6	109.6
Deferred income tax liabilities:		
Intangibles	(66.4)	(63.4)
Operating lease right-of-use assets	(20.5)	(21.1)
Property, net	(27.1)	(18.8)
Carrying value of partnerships	(117.9)	(111.2)
Other	(0.5)	(0.3)
Total deferred income tax liabilities	(232.4)	(214.8)
Net deferred income tax liabilities	\$ (126.8)	\$ (105.2)

We have state NOLs of \$4.2 million that expire in various amounts at varying times through 2036. For the years ended December 31, 2025 and 2024, the net increase (decrease) in our valuation allowance was \$0.4 million and \$(7.4) million, respectively. The net increase in our valuation allowance in 2025 related primarily to utilization and expiration of state net operating losses, primarily offset by increases to foreign tax credits that we do not anticipate we will be able to utilize. The decrease in our valuation allowance in 2024 related primarily to the utilization and expiration of state NOLs.

As of December 31, 2025, we have a remaining valuation allowance of \$21.4 million. This valuation allowance remains recorded primarily due to foreign tax credits generated by our operations in Puerto Rico. We determined it was necessary to maintain a valuation allowance on our foreign tax credits due to uncertainties related to our ability to utilize a portion of these credits before they expire. The amount of the valuation allowance has been determined based on the weight of all available evidence, as described above, including management's estimates of taxable income over the periods in which the related deferred tax assets will be recoverable.

Our continuing practice is to recognize interest and penalties related to income tax matters in income tax expense. Interest recorded as part of our income tax provision during 2025, 2024, and 2023 was not material. Accrued interest income related to income taxes as of December 31, 2025 and 2024 was not material.

In December 2016, we signed an agreement with the IRS to participate in their Compliance Assurance Process ("CAP") for the 2017 tax year and have renewed this agreement each year since. CAP is a program in which we and the IRS endeavor to agree on the treatment of significant tax positions prior to the filing of our federal income tax returns. In April 2025, the IRS issued a no change letter effectively closing our 2023 tax year audit. Thus, the statute of limitations has expired, or we have settled, federal income tax examinations with the IRS for all tax years through 2023.

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

The IRS offered, and we accepted, admission into the IRS Bridge Plus Pilot program ("CAP Bridge") for the years 2024, 2025, and 2026. Under this program, we are required to provide additional documentation (including a draft return) to the IRS prior to filing our return. The IRS performs a risk assessment review of this documentation and provides recommendations to us. We then file our return and submit a post-filing representation that our return was filed consistent with the documentation provided and any IRS recommendations. After further review, the IRS then issues either a full or partial acceptance letter. We are currently under audit by the IRS under the CAP Bridge program for tax years 2024, 2025, and 2026. Our state income tax returns are also periodically examined by various regulatory taxing authorities; however, there are no current state audits at this time.

For the tax years that remain open under the applicable statutes of limitations, management considered potential unrecognized tax benefits and determined there are no material unrecognized tax benefits that would impact prior years' income taxes.

Income taxes paid (net of refunds) consisted of the following (in millions):

	For the Year Ended December 31, 2025
Federal	\$ 91.8
State and local	29.1
Foreign	3.1
Income taxes paid (net of refunds)	<u>\$ 124.0</u>

On July 4, 2025, President Trump signed into law the One Big Beautiful Bill Act ("OBBBA"). The OBBBA contained a broad range of tax reform provisions affecting businesses. While tax changes in the OBBBA did not have a material impact on our effective tax rate, certain tax provisions in the OBBBA, namely the provision that permanently extended bonus depreciation for assets placed in service after January 19, 2025 and the provision allowing for immediate expensing of certain research and development costs, resulted in current deductions that yielded lower cash income tax for 2025. We currently estimate these provisions produced an additional approximately \$84 million in current deductions resulting in approximately \$22 million in cash tax savings in 2025. We continue to evaluate the tax and other provisions of the OBBBA and the potential effects on our financial position, results of operations, and cash flows.

Information prior to the adoption of ASU 2023-09—

As described in Note 1, *Summary of Significant Accounting Policies*, "Recent Accounting Pronouncements," we elected to prospectively adopt the guidance in ASU 2023-09, "Income Taxes (Topic 740): Improvements to Income Tax Disclosures." The information below is in accordance with the guidance prior to the adoption of ASU 2023-09.

The significant components of the *Provision for income tax expense* related to continuing operations are as follows (in millions):

	For the Year Ended December 31,	
	2024	2023
Current:		
Federal	\$ 111.0	\$ 101.7
State and other	28.5	26.6
Total current expense	<u>139.5</u>	<u>128.3</u>
Deferred:		
Federal	8.6	(0.7)
State and other	2.1	4.6
Total deferred expense	<u>10.7</u>	<u>3.9</u>
Total income tax expense related to continuing operations	<u>\$ 150.2</u>	<u>\$ 132.2</u>

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

A reconciliation of differences between the federal income tax at statutory rates and our actual income tax expense on our income from continuing operations, which include federal, state, and other income taxes, is presented below:

	For the Year Ended December 31,	
	2024	2023
Tax expense at statutory rate	21.0 %	21.0 %
Increase (decrease) in tax rate resulting from:		
State and other income taxes, net of federal tax benefit	3.9 %	4.1 %
Increase in valuation allowance	— %	0.3 %
Noncontrolling interests	(3.8)%	(4.0)%
Share-based windfall tax benefits	(1.0)%	— %
Other, net	(0.1)%	0.4 %
Income tax expense	20.0 %	21.8 %

The *Provision for income tax expense* in 2024 was less than the federal statutory rate primarily due to the impact of noncontrolling interests and share-based windfall tax benefits, offset by state and other income tax expense. The *Provision for income tax expense* in 2023 was greater than the federal statutory rate primarily due to state and other income tax expense and a gross increase in valuation allowance, offset by the impact of noncontrolling interests. See Note 1, *Summary of Significant Accounting Policies*, "Income Taxes," for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in this discussion.

The amount of income tax payments and refunds are as follows (in millions):

	For the Year Ended December 31,	
	2024	2023
Income tax payments	\$ 164.5	\$ 109.3
Income tax refunds	0.7	2.7

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

15. Earnings per Common Share:

The following table sets forth the computation of basic and diluted earnings per common share (in millions, except per share amounts):

	For the Year Ended December 31,		
	2025	2024	2023
Basic:			
<i>Numerator:</i>			
Income from continuing operations	\$ 760.1	\$ 599.4	\$ 475.0
Less: Net income attributable to noncontrolling interests included in continuing operations	(192.9)	(140.9)	(111.0)
Less: Income from continuing operations allocated to participating securities	(1.5)	(2.8)	(2.4)
Income from continuing operations attributable to Encompass Health common shareholders	565.7	455.7	361.6
Loss from discontinued operations, net of tax, attributable to Encompass Health common shareholders	(1.0)	(2.8)	(12.0)
Net income attributable to Encompass Health common shareholders	\$ 564.7	\$ 452.9	\$ 349.6
<i>Denominator:</i>			
Basic weighted average common shares outstanding	100.5	99.9	99.5
<i>Basic earnings per share attributable to Encompass Health common shareholders:</i>			
Continuing operations	\$ 5.63	\$ 4.56	\$ 3.63
Discontinued operations	(0.01)	(0.03)	(0.12)
Net income	\$ 5.62	\$ 4.53	\$ 3.51
Diluted:			
<i>Numerator:</i>			
Income from continuing operations	\$ 760.1	\$ 599.4	\$ 475.0
Less: Net income attributable to noncontrolling interests included in continuing operations	(192.9)	(140.9)	(111.0)
Income from continuing operations attributable to Encompass Health common shareholders	567.2	458.5	364.0
Loss from discontinued operations, net of tax, attributable to Encompass Health common shareholders	(1.0)	(2.8)	(12.0)
Net income attributable to Encompass Health common shareholders	\$ 566.2	\$ 455.7	\$ 352.0
<i>Denominator:</i>			
Diluted weighted average common shares outstanding	102.2	102.2	101.3
<i>Diluted earnings per share attributable to Encompass Health common shareholders:</i>			
Continuing operations	\$ 5.55	\$ 4.49	\$ 3.59
Discontinued operations	(0.01)	(0.03)	(0.12)
Net income	\$ 5.54	\$ 4.46	\$ 3.47

FORM 10-K

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

The following table sets forth the reconciliation between basic weighted average common shares outstanding and diluted weighted average common shares outstanding (in millions)

	For the Year Ended December 31,		
	2025	2024	2023
Basic weighted average common shares outstanding	100.5	99.9	99.5
Restricted stock awards, dilutive stock options, and restricted stock units	1.7	2.3	1.8
Diluted weighted average common shares outstanding	102.2	102.2	101.3

Options to purchase shares of common stock outstanding during 2025 and 2024 were immaterial. Options to purchase approximately 0.3 million shares of common stock were outstanding during 2023 but were not included in the computation of diluted weighted-average shares because to do so would have been antidilutive.

On October 28, 2013, we announced our board of directors authorized the repurchase of up to \$200 million of our common stock, which has been amended from time to time. Most recently, on July 24, 2024, our board of directors approved resetting the aggregate common stock repurchase authorization to \$500 million. As of December 31, 2025, approximately \$332 million remained under this authorization. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. During 2025 and 2024, we repurchased 1.5 million and 0.4 million shares of our common stock in the open market for \$158.0 million and \$31.1 million, respectively. There were no repurchases of our common stock during 2023.

In July 2022, our board of directors declared a cash dividend of \$0.15 per share. The cash dividend of \$0.15 per common share was declared and paid in each quarter through July 2024. In July 2024, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of \$0.17 per share. The cash dividend of \$0.17 per common share was declared and paid in each quarter through July 2025. In July 2025, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of \$0.19 per share. Subsequent to July 2025, the cash dividend of \$0.19 per common share was declared and paid in each quarter through January 2026. Future dividend payments are subject to declaration by our board of directors.

16. Contingencies and Other Commitments:

We provide services in the highly regulated healthcare industry. Furthermore, operating inpatient rehabilitation hospitals requires significant staffing and involves intensive therapy for individuals suffering from significant physical or cognitive disabilities or injuries. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. The resolution of any such lawsuits, claims, or legal and regulatory proceedings could materially and adversely affect our financial position, results of operations, and cash flows in a given period.

The False Claims Act allows private citizens, called “relators,” to institute civil proceedings on behalf of the United States alleging violations of the False Claims Act. These lawsuits, also known as “whistleblower” or “*qui tam*” actions, can involve significant monetary damages, fines, attorneys’ fees and the award of bounties to the relators who successfully prosecute or bring these suits to the government. *Qui tam* cases are sealed at the time of filing, which means knowledge of the information contained in the complaint typically is limited to the relator, the federal government, and the presiding court. The defendant in a *qui tam* action may remain unaware of the existence of a sealed complaint for years. While the complaint is under seal, the government reviews the merits of the case and may conduct a broad investigation and seek discovery from the defendant and other parties before deciding whether to intervene in the case and take the lead on litigating the claims. The court lifts the seal when the government makes its decision on whether to intervene. If the government decides not to intervene, the relator may elect to continue to pursue the lawsuit individually on behalf of the government. It is possible that *qui tam* lawsuits have been filed against us, which suits remain under seal, or that we are unaware of such filings or precluded by existing law or court order from discussing or disclosing the filing of such suits. We may be subject to liability under one or more undisclosed *qui tam* cases brought pursuant to the False Claims Act.

It is our obligation as a participant in Medicare and other federal healthcare programs to routinely conduct audits and reviews of the accuracy of our billing systems and other regulatory compliance matters. As a result of these reviews, we have made, and will continue to make, disclosures to the HHS-OIG and CMS relating to amounts we suspect represent over-

ATTACHMENT 36 Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

payments from these programs, whether due to inaccurate billing or otherwise. Some of these disclosures have resulted in, or may result in, Encompass Health refunding amounts to Medicare or other federal healthcare programs.

Other Commitments—

We are a party to service and other contracts in connection with conducting our business. Minimum amounts due under these agreements are \$62.9 million in 2026, \$38.9 million in 2027, \$35.8 million in 2028, \$30.3 million in 2029, \$27.4 million in 2030, and \$37.3 million thereafter. These contracts primarily relate to software licensing and support and medical equipment.

17. Segment Reporting:

We manage our operations using one operating segment which is also our reportable segment: inpatient rehabilitation. Our national network of inpatient rehabilitation hospitals provide specialized rehabilitative treatment on an inpatient basis. Our inpatient rehabilitation hospitals provide a higher level of rehabilitative care to patients who are recovering from conditions such as stroke and other neurological disorders, cardiac and pulmonary conditions, brain and spinal cord injuries, complex orthopedic conditions, and amputations.

The accounting policies of our reportable segment are the same as those described in Note 1, *Summary of Significant Accounting Policies*. All revenues for our services are generated through external customers. See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues," for the disaggregation of our revenues. Our chief operating decision maker ("CODM") is the chief executive officer. Our CODM evaluates the performance and allocates resources based on adjusted earnings before interest, taxes, depreciation, and amortization ("Adjusted EBITDA"). Our CODM primarily considers forecast-to-budget variances and current year actuals to prior year actuals variances to assess performance and to help inform operating decisions, including allocating resources.

Selected financial information, including significant segment expenses, for our reportable segment is as follows (in millions):

	For the Year Ended December 31,		
	2025	2024	2023
Net operating revenues	\$ 5,935.2	\$ 5,373.2	\$ 4,801.2
Less:			
Salaries and benefits	3,115.9	2,901.0	2,600.1
Other operating expenses	886.0	785.2	709.3
Supplies	254.4	239.0	218.3
Occupancy costs	59.0	57.3	56.3
General and administrative expenses	173.8	156.1	146.5
Net income attributable to noncontrolling interests	192.9	148.2	113.2
Other segment items ⁽¹⁾	(14.7)	(17.3)	(13.6)
Adjusted EBITDA	\$ 1,267.9	\$ 1,103.7	\$ 971.1

⁽¹⁾ Includes interest income, investment gain or loss, and equity in net income of nonconsolidated affiliates.

FORM 10-K

ATTACHMENT 36

Financial Viability

Table of Contents

Encompass Health Corporation and Subsidiaries
Notes to Consolidated Financial Statements

Segment reconciliation (in millions):

	For the Year Ended December 31,		
	2025	2024	2023
Adjusted EBITDA	\$ 1,267.9	\$ 1,103.7	\$ 971.1
Stock-based compensation	(56.5)	(48.3)	(50.6)
Depreciation and amortization	(327.9)	(299.6)	(273.9)
Loss on disposal or impairment of assets	(2.7)	(17.4)	(9.8)
Loss on early extinguishment of debt	—	(0.6)	—
Interest expense and amortization of debt discounts and fees	(123.2)	(137.4)	(143.5)
Net income attributable to noncontrolling interests	192.9	140.9	111.0
Change in fair market value of marketable securities	2.5	1.0	0.7
Asset impairment impact on noncontrolling interests	—	7.3	—
State regulatory change impact on noncontrolling interests	—	—	2.2
Income from continuing operations before income tax expense	\$ 953.0	\$ 749.6	\$ 607.2

Additional detail regarding the revenues of our operating segment by service line follows (in millions):

	For the Year Ended December 31,		
	2025	2024	2023
Net operating revenues			
Inpatient	\$ 5,756.3	\$ 5,230.5	\$ 4,693.8
Other	178.9	142.7	107.4
Net operating revenues	\$ 5,935.2	\$ 5,373.2	\$ 4,801.2

Equity in net income of nonconsolidated affiliates and the *Provision for income tax expense* are reported on our consolidated statements of operations. Segment assets are reported on our consolidated balance sheets as *Total assets*. Segment capital expenditures are reported on our consolidated statements of cash flows as *Purchases of property, equipment, and intangible assets*.

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Consolidated Financial Statements
and Supplementary Information

Years Ended September 30, 2025 and 2024

Contents

Report of Independent Auditors.....	1
Consolidated Financial Statements	
Consolidated Balance Sheets	4
Consolidated Statements of Operations and Changes in Net Assets	6
Consolidated Statements of Cash Flows.....	8
Notes to Consolidated Financial Statements.....	10
Supplementary Information	
Consolidating Balance Sheets 2025.....	44
Consolidating Statements of Operations and Changes in Net Assets 2025.....	45
Consolidating Statements of Cash Flows 2025	47
Consolidating Balance Sheets 2024.....	48
Consolidating Statements of Operations and Changes in Net Assets 2024.....	49
Consolidating Statements of Cash Flows 2024	51
Obligated Group Balance Sheet 2025.....	52
Obligated Group Statements of Operations and Changes in Net Assets 2025	53
Obligated Group Statements of Cash Flows 2025	55

ATTACHMENT 36 **Financial Viability**



Ernst & Young LLP
Suite 2600
7676 Forsyth Boulevard
St. Louis, MO 63105

Tel: +1 314 290 1000
ey.com

Report of Independent Auditors

The Board of Directors
Memorial Health

Opinion

We have audited the consolidated financial statements of Memorial Health and Subsidiaries (Memorial Health), which comprise the consolidated balance sheets as of September 30, 2025 and 2024, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes (collectively referred to as the “financial statements”).

In our opinion, the accompanying financial statements present fairly, in all material respects, the consolidated financial position of Memorial Health at September 30, 2025 and 2024, and the consolidated results of its operations, changes in its net assets, and its cash flows for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor’s Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Memorial Health, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

ATTACHMENT 36 **Financial Viability**



In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Memorial Health's ability to continue as a going concern for one year after the date that the financial statements are issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Memorial Health's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Memorial Health's ability to continue as a going concern for a reasonable period of time.

ATTACHMENT 36
Financial Viability



**Shape the future
with confidence**

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal-control-related matters that we identified during the audit.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating balance sheets, consolidating statement of operations and changes in net assets, consolidating statements of cash flows, obligated group balance sheet, obligated group statement of operations and changes in net assets, and obligated group statement of cash flows are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Ernst & Young LLP

December 17, 2025

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Consolidated Balance Sheets *(Dollars in Thousands)*

	September 30	
	2025	2024
Assets		
Current assets:		
Cash and cash equivalents	\$ 76,697	\$ 14,758
Short-term investments	39,928	57,722
Assets whose use is limited	11,416	11,491
Receivables:		
Patient accounts receivable	224,431	240,096
Receivables from third-party payors	59,309	13,138
Other receivables	54,042	43,418
Inventories	26,752	24,250
Prepaid expenses	30,113	28,878
Total current assets	<u>522,688</u>	<u>433,751</u>
Long-term investments:		
Unrestricted investments	728,524	744,744
Assets whose use is limited	<u>101,312</u>	<u>91,831</u>
Total long-term investments	829,836	836,575
Property, plant, and equipment, net	709,837	736,483
Right-of-use asset – operating leases	23,650	21,788
Other assets:		
Investments in partnerships	7,741	7,098
Beneficial interest in trusts and retained life estates	108,638	110,509
Other	<u>39,121</u>	<u>31,620</u>
Total other assets	<u>155,500</u>	<u>149,227</u>
Total assets	<u><u>\$ 2,241,511</u></u>	<u><u>\$ 2,177,824</u></u>

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Consolidated Balance Sheets (continued) *(Dollars in Thousands)*

	September 30	
	2025	2024
Liabilities and net assets		
Current liabilities:		
Long-term debt	\$ 54,647	\$ 18,230
Short-term borrowings	49,493	49,666
Operating lease liability – current portion	4,026	2,627
Accounts payable	138,774	115,684
Accrued payroll	85,535	82,439
Interest payable	3,187	3,204
Payables to third-party payors	53,430	56,843
Other	47,933	24,819
Total current liabilities	437,025	353,512
Noncurrent liabilities:		
Long-term debt obligations, net	252,415	310,178
Operating lease liability – noncurrent portion	20,324	19,761
Deferred compensation and benefits	29,453	26,194
Self-insurance accrued expenses	44,030	49,088
Accrued employee benefits	14,535	15,036
Other	697	1,015
Total noncurrent liabilities	361,454	421,272
Total liabilities	798,479	774,784
Net assets:		
Without donor restrictions	1,291,080	1,252,087
With donor restrictions	151,952	150,953
Total net assets	1,443,032	1,403,040
Total liabilities and net assets	<u>\$ 2,241,511</u>	<u>\$ 2,177,824</u>

See accompanying notes.

Financial Viability*Rehabilitation Institute of Springfield, LLC***ATTACHMENT 36
Financial Viability****Memorial Health and Subsidiaries****Consolidated Statements of Operations and Changes in Net Assets**
(Dollars in Thousands)

	Year Ended September 30	
	2025	2024
Revenues:		
Net patient service revenues	\$ 1,565,009	\$ 1,444,494
Capitation revenues	94,726	123,830
Other revenues	90,171	66,327
Total revenues	1,749,906	1,634,651
Expenses:		
Salaries and wages	723,475	680,828
Employee benefits	174,423	153,145
Physician fees	142,684	119,183
Pharmaceutical supplies	66,531	61,310
Patient service supplies	191,790	175,225
Purchased services and other	228,012	209,615
Hospital provider assessment	80,228	51,968
Purchased medical services	53,565	71,407
Depreciation and amortization	76,996	69,523
Interest expense and other financing costs	11,779	12,963
Total expenses	1,749,483	1,605,167
Income (loss) from operations	423	29,484
Nonoperating gains (losses):		
Interest and dividends	14,334	18,772
Realized gain (loss) on investments, net	27,178	13,296
Unrealized gain (loss) on investments, net	10,020	60,959
Gain (loss) on derivatives	—	(112)
Net periodic benefit cost	(456)	(616)
Other revenue (expense), net	(12,402)	(14,152)
Total nonoperating gains (losses), net	38,674	78,147
Excess (deficit) of revenues over expenses	39,097	107,631

Financial Viability*Rehabilitation Institute of Springfield, LLC***ATTACHMENT 36
Financial Viability****Memorial Health and Subsidiaries****Consolidated Statements of Operations and Changes in Net Assets (continued)**
(Dollars in Thousands)

	Year Ended September 30	
	2025	2024
Net assets without donor restrictions:		
Excess (deficit) of revenues over expenses	\$ 39,097	\$ 107,631
Pension and other postretirement liability adjustments	(104)	(674)
Increase (decrease) in net assets without donor restrictions	38,993	106,957
Net assets with donor restrictions:		
Contributions	3,041	1,761
Net investment gain (loss)	1,252	4,012
Net assets released from restrictions	(3,656)	(3,296)
Change in fair value of split interest agreements	362	(1,036)
Increase (decrease) in net assets with donor restrictions	999	1,441
Increase (decrease) in net assets	39,992	108,398
Net assets, beginning of fiscal year	1,403,040	1,294,642
Net assets, end of fiscal year	<u>\$ 1,443,032</u>	<u>\$ 1,403,040</u>

See accompanying notes.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Consolidated Statements of Cash Flows *(Dollars in Thousands)*

	Year Ended September 30	
	2025	2024
Operating activities		
Change in net assets	\$ 39,992	\$ 108,398
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:		
(Gain) loss on derivatives	—	112
Interest and dividends	(14,821)	(19,399)
Realized (gain) loss on investments, net	(28,072)	(13,547)
Unrealized (gain) loss on investments, net	(10,856)	(63,631)
Restricted contributions and other	(3,041)	(1,761)
Unrealized (gain) loss on beneficial interest in trusts	327	(84)
Depreciation and amortization	76,996	69,523
Amortization of debt issuance premiums	(1,022)	(1,070)
(Gain) loss on disposal of assets	(26,203)	2,911
Deferred tax asset	(285)	279
Pension and other postretirement liability adjustments	104	674
Changes in assets and liabilities:		
Accounts receivable	16,048	(34,783)
Inventory and other assets	(7,892)	(18,114)
Estimated third-party payor settlements	(49,584)	5,224
Accounts payable and other current liabilities	51,182	30,186
Self-insurance and other long-term liabilities	(1,469)	13,250
Net cash provided by (used in) operating activities	<u>41,404</u>	<u>78,168</u>
Investing activities		
Acquisition of property and equipment	(92,759)	(55,987)
Proceeds on sale of property	49,298	484
Investments classified as trading, net	78,851	(8,354)
Change in investment in partnerships	(643)	(645)
Net change in other assets	(485)	(129)
Net cash provided by (used in) investing activities	<u>34,262</u>	<u>(64,631)</u>

Financial Viability*Rehabilitation Institute of Springfield, LLC***ATTACHMENT 36
Financial Viability****Memorial Health and Subsidiaries****Consolidated Statements of Cash Flows (continued)**
(Dollars in Thousands)

	Year Ended September 30	
	2025	2024
Financing activities		
Restricted contributions and other	\$ 3,041	\$ 1,761
Repayment of long-term debt	(18,254)	(19,289)
Issuance of long-term debt	10,645	—
Proceeds from short-term borrowings	119,356	408
Repayment of short-term borrowings	(119,529)	(427)
Extinguishment of long-term debt, net of debt issuance cost payments	(10,816)	—
Distributions from beneficial interest in trusts	1,622	1,615
Net cash provided by (used in) financing activities	<u>(13,935)</u>	<u>(15,932)</u>
Net increase (decrease) in cash, cash equivalents, and restricted cash	61,731	(2,395)
Cash, cash equivalents, and restricted cash, beginning of fiscal year	16,854	19,249
Cash, cash equivalents, and restricted cash, end of fiscal year	<u>\$ 78,585</u>	<u>\$ 16,854</u>
Supplemental disclosure of cash flow information		
Cash paid for interest	<u>\$ 10,742</u>	<u>\$ 11,799</u>
Reconciliation of cash, cash equivalents, and restricted cash to the consolidated balance sheets		
Cash and cash equivalents	\$ 76,697	\$ 14,758
Restricted cash, included in assets whose use is limited	1,888	2,096
	<u>\$ 78,585</u>	<u>\$ 16,854</u>

See accompanying notes.

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements
(Dollars in Thousands)

September 30, 2025

1. Organization

Memorial Health System, doing business as (d/b/a) Memorial Health (Corporate), is incorporated as a not-for-profit corporation under the laws of the state of Illinois and is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (the Code). Memorial Health and Subsidiaries (collectively, MH) comprise the following corporations and their subsidiaries:

Corporate, sole corporate member of:

- Memorial Medical Center d/b/a Springfield Memorial Hospital (SMH):
 - Memorial Medical Center Foundation d/b/a Springfield Memorial Foundation (SMF)
- Decatur Memorial Hospital (DMH):
 - Decatur Memorial Health Foundation d/b/a Decatur Memorial Foundation (DMF)
- The Passavant Memorial Area Hospital Association d/b/a Jacksonville Memorial Hospital (JMH):
 - Jacksonville CRNAs, Inc. (CRNA)
 - Passavant Area Hospital Foundation d/b/a Jacksonville Memorial Foundation (JMF)
- The Abraham Lincoln Memorial Hospital d/b/a Lincoln Memorial Hospital (LMH)
- Taylorville Memorial Hospital (TMH):
 - Taylorville Memorial Hospital Foundation, Inc. d/b/a Taylorville Memorial Foundation (TMF)
- Memorial Physician Services d/b/a Memorial Medical Group (MMG)
- Mental Health Centers of Central Illinois d/b/a Memorial Behavioral Health (MBH):
 - Springfield Residential Services (SRS)
- Memorial Home Services NFP d/b/a Memorial Home Care (MHC):
 - Memorial Home Services of Central Illinois, Inc. (MHSCI)
- Memorial Health Ventures (MHV)
- Memorial Health Partners, LLC (MHP)
- Abraham Lincoln Healthcare Foundation d/b/a Lincoln Memorial Foundation (LMF)

All significant intercompany transactions and balances have been eliminated in the consolidated financial statements.

ATTACHMENT 36 **Financial Viability**

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

2. Summary of Significant Accounting Policies

Cash, Cash Equivalents, and Restricted Cash

Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of 90 days or less when purchased. Highly liquid debt instruments with original short-term maturities of more than 90 days or money market mutual funds that are commingled within MH short-term and long-term investment portfolios are not considered cash equivalents. Amounts included in assets whose use is limited on the consolidated balance sheets may include restricted cash, which may be held within short-term or long-term investments. This restricted cash held in assets whose use is limited represents cash set aside within investment portfolios based on management's policy or contractual arrangements.

Short-Term Investments

Short-term investments primarily include money market mutual funds, highly liquid debt instruments, corporate obligations, government obligations, mutual funds, and corporate equity securities that are classified as current assets because such amounts are available to meet MH's operating cash requirements.

Inventories

Inventories, consisting primarily of medical supplies and drugs, are stated at the lower of cost or net realizable value. Cost is determined using the weighted average cost method.

Long-Term Investments

Long-term investments primarily include unrestricted investments and assets whose use is limited. Assets whose use is limited include amounts set aside under revocable self-insurance trust agreements, assets held by trustees under indenture agreements, assets restricted as to use by donors, cash restricted as to withdrawal or use, and deferred compensation investments. Amounts designated to help meet the current liabilities of MH have been classified as the current portion of assets whose use is limited on the consolidated balance sheets.

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

2. Summary of Significant Accounting Policies (continued)

Investment securities are recorded at fair value, based on the valuation methodologies used in the fair value measurement and disclosures topic of the Financial Accounting Standards Board Accounting Standards Codification (ASC). The cost of securities sold is based on the specific identification method. MH classifies its investment portfolio as trading, with unrealized gains and losses included in excess of revenues over expenses.

MH invests in alternative investments (primarily private equity and credit funds) generally through limited partnerships (LPs) and perpetual funds, which are reported based on the net asset value of the investments, as a practical expedient for fair value. The calculated net asset values are provided by the respective organizations and based on historical cost, appraisals, or other estimates that require varying degrees of judgment. Management has utilized the best available information for reported values, which, in some instances, are valuations as of an interim date not more than 90 days before year-end. Generally, the net asset value of MH's holdings reflects net contributions to the organization and an allocated share of realized and unrealized investment income and expenses. Returns from investments based on the net asset value, whether realized or unrealized, are included in investment earnings in excess of revenues over expenses.

Realized and unrealized gains and losses on investments, interest, and dividends from all other investments are reported as nonoperating gains (losses) unless the income is restricted by donor or law.

MH has elected the fair value option in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP) when valuing investments in farmland, which are included in unrestricted investments on the consolidated balance sheets.

Available Resources and Liquidity

MH considers all cash and cash equivalents, short-term investments, and unrestricted investments to be financial assets available and free from restriction to meet cash needs for operating activities of MH within one year of September 30, 2025.

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

2. Summary of Significant Accounting Policies (continued)

Property, Plant, and Equipment

Property, plant, and equipment are recorded at cost or, if donated, at fair value at the date of receipt. Depreciation is calculated using the straight-line method over the estimated useful lives of the assets as follows:

Land improvements	5–50 years
Buildings and improvements	5–80 years
Equipment	3–20 years

Leasehold improvements and equipment under finance leases are depreciated or amortized over the corresponding lease term and included in depreciation and amortization expense.

Beneficial Interest in Trusts and Retained Life Estates

SMH, DMH, and JMH are the beneficiaries of several irrevocable trusts held and administered by third-party trustees. The income from these trusts is distributed annually. The proceeds from the trusts are classified as net assets without donor restrictions or net assets with donor restrictions, based on the terms of the applicable trust agreement. SMF and LMF are owners of retained life estates held as farmland. The estate assets are classified as net assets with donor restrictions due to timing. Beneficial interest in the trusts and retained life estates totaled \$108,638 and \$110,509 as of September 30, 2025 and 2024, respectively, and is equal to the estimated fair value of the underlying trust assets and estates (primarily Illinois farmland). Trust distributions were \$1,622 and \$1,615 in 2025 and 2024, respectively, and are included in other revenue in the nonoperating gains (losses) section of the consolidated statements of operations and changes in net assets.

Other Assets

Other assets primarily consist of cash surrender value of life insurance policies, noncompete agreement clauses in physician acquisition contracts, employee retention loan agreements, notes receivable, and reinsurance recoveries. Under the terms of the physician employment agreements, vesting to the physicians in the cash surrender values occurs over various terms.

ATTACHMENT 36

Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

2. Summary of Significant Accounting Policies (continued)

Deferred Compensation Investments

MH has nonqualified deferred compensation plans available to select employees. Contributions to the plans are invested in mutual funds and are payable to the employees upon vesting, retirement, or resignation. Deferred compensation investments, which are recorded at fair value, have been reported in assets whose use is limited, and deferred compensation liabilities are reported in noncurrent liabilities on the accompanying consolidated balance sheets.

Accrued Employee Benefits

Accrued employee benefits consist of the accrual for the paid sick time program, supplemental retirement defined benefit plans, and the accrual for post-employment benefits, which consists of two liabilities: the continuation of medical benefits to employees on long-term disability and the postretirement health care benefits for certain employee groups that meet special qualifications. MH accrues these benefits based on actuarial estimates.

Net Assets

MH's net assets are classified as with donor restrictions and without donor restrictions based on the existence or absence of donor-imposed restrictions. Net assets with donor restrictions consist of net assets whose use by MH has been limited by donors to a specific time period or for a particular purpose or which must be maintained by MH in perpetuity with the related investment income expendable to support the donor-designated purpose. The general nature of the donor restrictions is to support MH's mission and health education programs and to assist in capital purchasing.

As of September 30, 2025 and 2024, MH's endowments consist of 80 and 85, respectively, individual donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds, including funds designated by the Board of Directors, to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) (Dollars in Thousands)

2. Summary of Significant Accounting Policies (continued)

The endowment net asset composition by type of fund consisted of the following:

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total
September 30, 2025			
Donor-restricted endowment funds	\$ —	\$ 33,387	\$ 33,387
Board-designated endowment funds	6,737	—	6,737
Total endowment funds	<u>\$ 6,737</u>	<u>\$ 33,387</u>	<u>\$ 40,124</u>
September 30, 2024			
Donor-restricted endowment funds	\$ —	\$ 31,532	\$ 31,532
Board-designated endowment funds	6,289	—	6,289
Total endowment funds	<u>\$ 6,289</u>	<u>\$ 31,532</u>	<u>\$ 37,821</u>

Of all of MH's foundations, only SMF has a policy of appropriating for distribution each year 5% of its endowment funds' average fair value of investments over the prior 36 months as of September 30 of the preceding fiscal year in which the distribution is planned. In establishing this policy, SMF considers the long-term expected return on its endowments. Accordingly, over the long term, SMF expects the current spending policy to allow its endowment to grow at the average long-term rate of inflation. This is consistent with SMF's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specific term, as well as to provide additional real growth through new gifts and investment return.

Net Patient Service Revenues and Accounts Receivable Valuation

MH provides health care services through inpatient and outpatient care facilities located in central Illinois and grants credit to patients, substantially all of whom are local residents. MH generally does not require collateral or other security in extending credit to patients; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies, including, but not limited to, Medicare, Medicaid, health maintenance organizations, and commercial insurance policies.

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

2. Summary of Significant Accounting Policies (continued)

MH recognizes revenues in the period in which performance obligations are satisfied. Generally, MH bills patients and third-party payors several days after services are performed or the patient is discharged. Accounts receivable primarily consist of amounts due from third-party payors and patients. MH's ability to collect outstanding receivables is critical to its operations and cash flows. Amounts MH receives for treatment of patients covered by governmental programs and third-party payors, as well as directly from patients, are subject to explicit and implicit price concessions. Accordingly, the revenue and accounts receivable reported in MH's consolidated financial statements are recorded at the net consideration to which MH expects to be entitled in exchange for providing patient care.

MH has agreements with third-party payors that provide for payments at amounts different from its established charges. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and these amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, or investigations. MH's patient service revenue increased by \$266 and \$1,938 in 2025 and 2024, respectively, as the result of these retroactive adjustments.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Noncompliance with Medicare and Medicaid laws and regulations can make MH subject to significant regulatory action, including substantial fines and penalties, as well as exclusion from the Medicare and Medicaid programs. MH's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs consistent with the constraints that are required by ASC 606, *Revenue from Contracts with Customers*.

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

2. Summary of Significant Accounting Policies (continued)

The majority of MH's performance obligations are satisfied over time for the delivery of patient care in both inpatient and outpatient settings. Revenue for performance obligations satisfied over time is recognized based on estimated expected payment at that point in time. MH believes this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the remaining services needed to satisfy the obligation. Generally, unsatisfied or partially unsatisfied performance obligations at the end of the reporting period are related to patients admitted to MH's hospitals who have not yet been discharged. MH measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. As substantially all of MH's performance obligations are part of a contract that is expected to have a duration of one year or less, MH has elected to apply the exemption provided by ASC 606-10 not to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied as of the period-end.

MH has elected to apply the practical expedient permitted under ASC 606 and does not adjust the estimated amount of consideration from patients or third-party payors for the effects of a significant financing component, due to MH's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less.

MH uses a portfolio approach to account for categories of patient contracts as a collective group, rather than recognizing revenue on an individual contract basis. The portfolios primarily consist of major payor classes for inpatient, outpatient, and other patient revenue. Based on historical collection trends and other analysis, MH believes that revenue recognized by using the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)

(Dollars in Thousands)

2. Summary of Significant Accounting Policies (continued)

MH's initial estimate of the transaction price is determined by reducing the total standard charges related to the patient services provided by various elements of variable consideration, including contractual adjustments, discounts, implicit price concessions, and other reductions to MH's standard charges. MH determines the transaction price associated with services provided to patients who have third-party payor coverage based on reimbursement terms per contractual agreements, MH's discount policies, and historical experience. Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. For patients with deductibles and coinsurance, or uninsured and underinsured patients who do not apply or do not meet the qualifications for charity care, MH determines the transaction price associated with services on the basis of charges reduced by implicit price concessions. Implicit price concessions are based upon management's judgmental assessment of historical and expected net collections considering business and general economic conditions in its service area, trends in health care coverage, and other collection indicators. Throughout the year, management assesses the adequacy of the allowance for implicit price concessions, taking into consideration recent write-off experience by payor category, including those not covered by insurance. Subsequent changes to the estimate of the transaction price (determined on a portfolio basis when applicable) are generally recorded as adjustments to patient service revenue in the period of change. For the fiscal years ended September 30, 2025 and 2024, changes in estimates of implicit price concessions, discounts, contractual adjustments, or other reductions were not significant.

Capitation Revenues

MH has entered into risk-based contracts to provide medical services. Under these arrangements, MH receives capitation payments based on the demographic characteristics of covered members for agreeing to provide health care services to enrolled members, regardless of the actual services provided. MH has engaged in stop-loss insurance contracts to protect against future significant losses for catastrophic cases.

Purchased medical services represent payments made to non-MH and out-of-network providers for covered medical claims. MH estimates its liability for covered medical claims, including claims incurred but not reported as of the consolidated balance sheet dates, based upon historical costs incurred and payment-processing experience. The liability for covered medical claims is included in other current liabilities on the accompanying consolidated balance sheets.

ATTACHMENT 36 **Financial Viability**

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

2. Summary of Significant Accounting Policies (continued)

Charity Care

In support of its mission, MH provides care to patients who lack financial resources and are deemed to be financially indigent. Traditional charity care includes cost of services provided to persons who MH determines cannot afford health care because of inadequate resources. The charges for services provided to charity patients are not reported as net patient service revenue. The unpaid cost of traditional charity care was \$13,397 and \$7,965 for the fiscal years ended September 30, 2025 and 2024, respectively. MH calculates the unpaid cost of services by payor using an activity-based costing methodology.

Asset Impairment

MH considers whether indicators of impairment are present and, if present, performs the necessary tests to determine whether the carrying values of an asset are recoverable. Impairment write-downs are recognized in depreciation expense at the time the impairment is identified. MH had no material asset impairment for the fiscal years ended September 30, 2025 or 2024.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets to MH are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received or the condition is met. Gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. A donor restriction expires when a stipulated time restriction ends or the purpose restriction is accomplished. At that time, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported on the consolidated statements of operations and changes in net assets as net assets released from restrictions.

Donor-restricted contributions whose restrictions are met within the same year as they are received are reported in other revenue (expense), net in the nonoperating gains (losses) section of the consolidated statements of operations and changes in net assets.

ATTACHMENT 36

Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

2. Summary of Significant Accounting Policies (continued)

Performance Indicator

MH's performance indicator, excess of revenues over expenses, includes all changes in net assets without donor restrictions other than net assets released from restrictions for property acquisitions and pension and other postretirement liability adjustments.

Operating and Nonoperating Gains (Losses)

MH's primary mission is to improve lives and build stronger communities through better health through a broad range of general and specialized health care services, including inpatient acute care, outpatient services, physician services, and other health care services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to MH's primary mission are considered to be nonoperating. Nonoperating activities include interest, dividends, realized and unrealized gains and losses on investments, gains and losses on derivatives, net periodic benefit cost, and other revenues and expenses not related to patient care, such as the provision for income taxes and contribution expense.

Functional Classification of Expenses

MH's accounting policies conform to U.S. GAAP applicable to health care organizations. Substantially all expenses are related to providing health care services to the community. However, there are certain costs not directly attributable to health care services, including certain salaries and benefits, depreciation, and other costs. These costs are allocated to management, general, and administrative on a reasonable basis that is consistently applied.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

2. Summary of Significant Accounting Policies (continued)

Expenses by functional classification consist of the following:

	Health Care Services	Management, General, and Administrative	Total
Year ended September 30, 2025			
Expenses:			
Salaries and wages	\$ 617,383	\$ 106,092	\$ 723,475
Employee benefits	149,804	24,619	174,423
Physician fees	142,684	-	142,684
Pharmaceutical supplies	66,531	-	66,531
Patient services supplies	191,790	-	191,790
Purchased services and other	139,759	88,253	228,012
Hospital provider assessment	80,228	-	80,228
Purchased medical services	53,565	-	53,565
Depreciation	68,527	8,469	76,996
Interest expense and other financing costs	11,779	-	11,779
Total	\$ 1,522,050	\$ 227,433	\$ 1,749,483
 Year ended September 30, 2024			
Expenses:			
Salaries and wages	\$ 569,880	\$ 110,948	\$ 680,828
Employee benefits	126,645	26,500	153,145
Physician fees	119,064	119	119,183
Pharmaceutical supplies	61,310	-	61,310
Patient services supplies	175,225	-	175,225
Purchased services and other	130,485	79,130	209,615
Hospital provider assessment	51,968	-	51,968
Purchased medical services	71,407	-	71,407
Depreciation	61,502	8,021	69,523
Interest expense and other financing costs	12,958	5	12,963
Total	\$ 1,380,444	\$ 224,723	\$ 1,605,167

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

2. Summary of Significant Accounting Policies (continued)

Income Taxes

Each of MH's subsidiaries, excluding those described in the following paragraph, is a separately incorporated not-for-profit corporation, as described under Section 501(c)(3) of the Code, and is tax-exempt from federal and state income taxes on related income pursuant to Section 501(a) of the Code. They do, however, operate certain programs that may result in unrelated business income. Upon review as required by ASC 740, *Income Taxes*, no tax provision was recorded for the fiscal years ended September 30, 2025 or 2024.

MH is no longer subject to income tax examinations for years prior to 2021.

MHP is considered a disregarded entity for tax purposes and is exempt from income tax. MHSCI is a taxable for-profit corporation subject to federal and state income taxes.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Reclassifications

Certain balances in the 2024 consolidated financial statements and related notes have been reclassified to conform to the current year presentation. The effect of such reclassifications did not change total net assets, net assets without donor restrictions, operating income, or excess (deficit) of revenues over expenses.

ATTACHMENT 36 **Financial Viability**

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

3. Affiliation With Southern Illinois University School of Medicine

MH has entered an affiliation agreement with Southern Illinois University School of Medicine (SIU) in an effort to enhance the quality, sophistication, and access of health care in central and southern Illinois. The term of the agreement renewed on July 30, 2025, and automatically renews for successive five-year terms, until terminated by either party. The agreement requires advance notice of either party's intent to terminate the affiliation agreement to be no less than three years prior to the expiration of the current five-year term. The affiliation agreement allows SIU to conduct both graduate and undergraduate medical educational programs at MH facilities.

In addition, the affiliation allows for both parties (including all of SIU's and MH's subsidiaries) to execute separate agreements to provide the following: academic support, medical director and/or chairman contracts, administrative services, space leases, recruitment contracts, and/or clinical service contracts. MH also provides other support and funding in the form of grants to SIU through SMF.

The table below reports the extent to which MH and SIU have partnered to strengthen their affiliation:

	Year Ended September 30	
	2025	2024
Agreement type		
Academic support provided	\$ 55,146	\$ 38,864
Grants and contributions provided	5,232	4,506
Medical director/chairman contracts provided	8,747	13,109
Administrative, clinical, recruitment, and other services provided	1,138	1,053
Lease revenues	10,476	10,458
Administrative and clinical service revenues	922	744

All agreement types listed above are included in income (loss) from operations on the consolidated statements of operations and changes in net assets, except for grants and contributions provided, which are included in nonoperating gains (losses).

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

4. Revenues

Net Patient Service Revenues

MH provides health care services through inpatient, outpatient, and ambulatory care facilities. Certain patients receive services that are covered by governmental and third-party payments, including Medicare and Medicaid (56.6% and 53.4% of net patient service revenues in 2025 and 2024, respectively), at contractual rates generally below MH's established rates.

The following is the mix of net patient service revenues by major payor source:

	Year Ended September 30	
	2025	2024
Medicare	\$ 571,949	\$ 516,514
Medicaid	313,240	254,416
Managed care	348,263	320,718
BlueCross BlueShield	258,569	260,150
Other commercial payors	68,858	81,232
Patients	4,130	11,464
Total	<u>\$ 1,565,009</u>	<u>\$ 1,444,494</u>

MH is paid for services rendered to Medicare program beneficiaries generally under prospectively determined rates. Those rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. SMH's and DMH's patients receive reimbursement under the prospective payment system. JMH, TMH, and LMH are designated as critical access hospitals and receive cost-based reimbursement for the majority of their Medicare services.

Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient and home health services rendered to Medicaid program beneficiaries are reimbursed upon a per visit, per diem rate or on a fee-for-service basis. MH recognizes that revenues and receivables from government agencies are significant to operations, but it does not believe that there are significant credit risks associated with these government agencies.

Financial Viability*Rehabilitation Institute of Springfield, LLC***ATTACHMENT 36
Financial Viability****Memorial Health and Subsidiaries****Notes to Consolidated Financial Statements (continued)**
*(Dollars in Thousands)***4. Revenues (continued)**

The following is the mix of net receivables by major payor source:

	September 30	
	2025	2024
Medicare	31.4%	33.8%
Medicaid	8.7	7.6
Managed care	27.6	25.2
BlueCross BlueShield	13.6	14.5
Other commercial payors	14.7	15.0
Patients	4.0	3.9
Total	100.0%	100.0%

Hospital Access Improvement Revenue

On January 1, 2025, the state of Illinois updated the Hospital Assessment Program which effectively increased the amount of funding eligible to match federal funds and extended the expiration of the program to December 31, 2028. The Center for Medicaid and Medicaid Services (CMS) approved the state of Illinois's plan in September 2025, which led MH to accrue \$51,651 in Medicaid assessment revenue in September 2025, which was retroactive to January 1, 2025, and is reported in receivables from third-party payors on the consolidated balance sheet at September 30, 2025.

The following is a breakdown of the Illinois Hospital Assessment Program:

	Year Ended September 30	
	2025	2024
Hospital access improvement payments included		
in net patient service revenue	\$ 200,046	\$ 151,505
Hospital provider assessment	80,228	51,968
Net impact of Illinois Hospital Assessment Program	<u>\$ 119,818</u>	<u>\$ 99,537</u>

ATTACHMENT 36

Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

4. Revenues (continued)

Capitation Revenues

Memorial Health Partners (MHP), Memorial Health's Clinically Integrated Network, had an agreement with Health Alliance Medical Plans (HAMP). This agreement, executed on July 1, 2022, affords MHP a per member per month global capitation payment for services provided to members attributed to a Memorial Health primary care physician.

In February 2025, HAMP notified MHP of its intent to close all commercial lines of business effective December 31, 2025, including the agreement MHP has with HAMP. MHP and HAMP executed an amendment in spring 2025 to terminate its global capitation agreement effective June 30, 2025. MHP and HAMP will engage in normal runout per terms of the agreement with an intent to fully settle outstanding receivables owed to MHP in spring 2026.

5. Investments

MH's investments are exposed to various kinds and levels of risk. Fixed-income securities expose MH to interest rate risk, credit risk, and liquidity risk. As interest rates change, the value of many fixed-income securities is affected. Credit risk is the risk that the obligor of the security will not fulfill its obligations. Liquidity risk is affected by the willingness of market participants to buy and sell given securities. Equity securities expose MH to market risk, performance risk, and liquidity risk. Market risk is the risk associated with major movements of the equity markets, both foreign and domestic. Performance risk is the risk associated with a company's operating performance. Liquidity risk, as previously defined, tends to be higher for foreign equities, equities related to small capitalization companies, and investments in farmland.

Alternative investments, which consist of private equity and private credit funds, have similar risks as income and equity securities, although there may be additional risks. These investments consist principally of noncontrolling interests in limited partnerships. Because these funds are invested through limited partnerships, the underlying net asset value of the investments is based on valuations provided by the managers. All of the fund manager valuations are independently priced or verified by qualified third parties.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

5. Investments (continued)

The limited partnership fund investments also have restrictions on the timing of withdrawals, which may reduce liquidity. Due to restrictions on the limited partnership fund investments, these funds are not considered redeemable.

However, the potential to sell interests in these limited partnership fund investments in the secondary market prior the end of the fund term does exist. While uncertainty exists regarding whether the contractual commitment will require funding during the contractual period, MH forecasts funding unfunded commitments of \$35,680 to private equity and private credit funds as of September 30, 2025. These committed amounts are expected to be primarily satisfied by distributions from existing investments.

The composition of short-term and long-term investments, all at fair market value, is set forth in the following table:

	September 30	
	2025	2024
Cash, cash equivalents, and restricted cash	\$ 1,888	\$ 2,096
Money market mutual funds	51,892	87,655
U.S. Treasury obligations	42,379	39,641
Government obligations	14,403	14,889
Corporate obligations	70,530	65,527
Foreign obligations	9,510	14,875
Domestic equities	70,781	74,271
International equities	6,528	5,325
Investment in farmland	100,608	105,356
Private equity and credit funds	137,137	117,796
Private equity perpetual fund	95,238	116,527
Mutual funds	29,538	26,273
Equity and fixed income – commingled funds	249,437	234,191
Accrued interest receivable and other	1,311	1,366
Assets whose use is limited, short-term and long-term investments	<u>\$ 881,180</u>	<u>\$ 905,788</u>

ATTACHMENT 36

Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

6. Fair Value Measurements

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC 820, *Fair Value Measurement*, establishes a fair value hierarchy that prioritizes the inputs used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to unobservable inputs (Level 3 measurement).

Certain of MH's financial assets and financial liabilities are measured at fair value on a recurring basis, including investments and beneficial interest in trusts and retained life estates. The three levels of the fair value hierarchy and a description of the valuation methodologies used for instruments measured at fair value are as follows:

- Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities as of the reporting date. Level 1 primarily consists of financial instruments such as money market securities and listed equities.
- Level 2 – Pricing inputs other than quoted prices included in Level 1, which are either directly observable or can be derived or supported from observable data as of the reporting date. Level 2 inputs may include quoted prices for similar assets and liabilities in non-active markets or pricing models whose inputs are observable for substantially the full term of the asset or liability.
- Level 3 – Pricing inputs include those that are significant to the fair value of the financial asset or financial liability and are not observable from objective sources. These inputs may be used with internally developed methodologies that result in management's best estimate of fair value.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

Financial instruments categorized as Level 3 consist of investments in farmland and beneficial interest in trusts. Investments in farmland have been valued based on market value appraisals of the corresponding real estate. Beneficial interest in trusts and retained life estates are recorded at fair value based on MH's interest in the value of the underlying trust assets. Real estate appraisals on land held within the trust are used as unobservable inputs to estimate MH's allocable portion of trust assets.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) (Dollars in Thousands)

6. Fair Value Measurements (continued)

The fair value of financial assets and financial liabilities measured at fair value on a recurring basis was determined using the following inputs at September 30, 2025:

	Level 1	Level 2	Level 3	Total
Assets				
Cash, cash equivalents, and restricted cash	\$ 1,888	\$ —	\$ —	\$ 1,888
Money market mutual funds	46,606	5,286	—	51,892
U.S. Treasury obligations	42,379	—	—	42,379
Government obligations	—	14,403	—	14,403
Corporate obligations	—	70,530	—	70,530
Foreign obligations	—	9,510	—	9,510
Domestic equities	70,781	—	—	70,781
International equities	6,528	—	—	6,528
Investments in farmland	—	—	100,608	100,608
Mutual funds equities	29,538	—	—	29,538
Subtotal	197,720	99,729	100,608	398,057
Assets not at fair value:				
Assets measured at net asset value: ^a				
Equity and fixed income – commingled funds	—	—	—	249,437
Private equity and credit funds	—	—	—	137,137
Private equity perpetual fund	—	—	—	95,238
Accrued interest and dividends receivable	—	—	—	1,311
Short-term and long-term investments	197,720	99,729	100,608	881,180
Beneficial interest in trusts and retained life estates	—	—	108,638	108,638
Total assets	\$ 197,720	\$ 99,729	\$ 209,246	\$ 989,818

^a In accordance with ASC 820, certain investments that are measured at the fair value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to amounts presented on the consolidated balance sheet.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

6. Fair Value Measurements (continued)

The following table presents the category, fair value, redemption frequency, and redemption notice period for assets, the fair values of which are estimated using net asset value per share as of September 30, 2025:

<u>Assets</u>	<u>Fair Value</u>	<u>Unfunded Commitment</u>	<u>Redemption Frequency</u>	<u>Redemption Notice Period</u>
Equity and fixed income – commingled funds ^a	\$ 160,770	\$ -	Monthly	7-10 days
Equity and fixed income – commingled funds ^b	\$ 88,667	\$ -	Daily	2-5 days
Private equity and credit funds ^c	\$ 137,137	\$ 35,680	N/A	N/A
Private equity perpetual fund ^d	\$ 95,238	\$ -	Quarterly	12 months

^a Includes investments in international and emerging market equity securities and bank loan fixed-income investments. The fair values of the investments in this class have been estimated using the net asset value per share of the investments.

^b Includes investments in domestic large cap equity securities and high-yield fixed-income investments. The fair values of the investments in this class have been estimated using the net asset value per share of the investments.

^c Includes investments in seven separate partnerships as a limited partner. The fair value of the investment in this class has been estimated using the net asset value per share of the investments.

^d Includes an investment in a perpetual LLC as an investor. The fair value of the investment in this fund has been estimated using the net asset value per share of the investments.

ATTACHMENT 36

Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

6. Fair Value Measurements (continued)

The fair value of financial assets and financial liabilities measured at fair value on a recurring basis was determined using the following inputs at September 30, 2024:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets				
Cash, cash equivalents, and restricted cash	\$ 2,096	\$ —	\$ —	\$ 2,096
Money market mutual funds	61,328	26,327	—	87,655
U.S. Treasury obligations	39,641	—	—	39,641
Government obligations	—	14,889	—	14,889
Corporate obligations	—	65,527	—	65,527
Foreign obligations	—	14,875	—	14,875
Domestic equities	74,271	—	—	74,271
International equities	5,325	—	—	5,325
Investments in farmland	—	—	105,356	105,356
Mutual funds equities	26,273	—	—	26,273
Subtotal	<u>208,934</u>	<u>121,618</u>	<u>105,356</u>	<u>435,908</u>
Assets not at fair value:				
Assets measured at net asset value: ^a				
Equity and fixed income – commingled funds	—	—	—	234,191
Private equity and credit funds	—	—	—	117,796
Private equity perpetual fund	—	—	—	116,527
Accrued interest and dividends receivable	—	—	—	1,366
Short-term and long-term investments	<u>208,934</u>	<u>121,618</u>	<u>105,356</u>	<u>905,788</u>
Beneficial interest in trusts and retained life estates	—	—	110,509	110,509
Total assets	<u>\$ 208,934</u>	<u>\$ 121,618</u>	<u>\$ 215,865</u>	<u>\$ 1,016,297</u>

^a In accordance with ASC 820, certain investments that are measured at the fair value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to amounts presented on the consolidated balance sheet.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

6. Fair Value Measurements (continued)

The following table presents the category, fair value, redemption frequency, and redemption notice period for assets, the fair values of which are estimated using net asset value per share as of September 30, 2024:

Assets	Fair Value	Unfunded Commitment	Redemption Frequency	Redemption Notice Period
Equity and fixed income – commingled funds ^a	\$ 141,880	\$ –	Monthly	7-10 days
Equity and fixed income – commingled funds ^b	\$ 92,311	\$ –	Daily	2-5 days
Private equity and credit funds ^c	\$ 117,796	\$ 55,024	N/A	N/A
Private equity perpetual fund ^d	\$ 116,527	\$ –	Quarterly	12 months

^a Includes investments in international and emerging market equity securities and bank loan fixed-income investments. The fair values of the investments in this class have been estimated using the net asset value per share of the investments.

^b Includes investments in domestic large cap equity securities and high-yield fixed-income investments. The fair values of the investments in this class have been estimated using the net asset value per share of the investments.

^c Includes investments in seven separate partnerships as a limited partner. The fair value of the investment in this class has been estimated using the net asset value per share of the investments.

^d Includes an investment in a perpetual LLC as an investor. The fair value of the investment in this fund has been estimated using the net asset value per share of the investments.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

6. Fair Value Measurements (continued)

The table below sets forth a summary of changes in the fair value of MH's Level 3 assets for the period from October 1, 2023 to September 30, 2025.

	Beneficial Interest in Trusts	Investments in Farmland	Total
Total as of October 1, 2023	\$ 112,398	\$ 109,209	\$ 221,607
Trust distribution	(1,615)	—	(1,615)
Contributions	—	29	29
Realized and unrealized gains (losses)	(274)	(3,882)	(4,156)
Total as of September 30, 2024	110,509	105,356	215,865
Trust distribution	(1,622)	—	(1,622)
Contributions	—	—	—
Realized and unrealized gains (losses)	(249)	(4,748)	(4,997)
Total as of September 30, 2025	<u>\$ 108,638</u>	<u>\$ 100,608</u>	<u>\$ 209,246</u>
	Year Ended September 30		
			2025 2024
Unrealized gains (losses) related to Level 3 financial instruments held		\$ (4,997)	\$ (4,155)

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

7. Property, Plant, and Equipment

The following is a summary of property, plant, and equipment:

	September 30	
	2025	2024
Land	\$ 45,209	\$ 48,651
Land improvements	59,494	59,561
Buildings	970,219	976,262
Equipment	513,819	474,032
Construction-in-progress	66,274	95,234
Subtotal	1,655,015	1,653,740
Less accumulated depreciation	945,178	917,257
Property, plant, and equipment, net	<u>\$ 709,837</u>	<u>\$ 736,483</u>

Capitalized interest was \$414 and \$81 for the fiscal years ended September 30, 2025 and 2024, respectively. Cost and the related accumulated depreciation for buildings and equipment under finance lease obligations were \$70,744 and \$8,874, respectively, at September 30, 2025, and \$70,633 and \$6,791, respectively, at September 30, 2024. Cost and the related accumulated depreciation for land, land improvements, buildings, and equipment leased to unrelated entities under operating lease agreements were \$196,018 and \$105,043, respectively, at September 30, 2025, and \$236,668 and \$124,831, respectively, at September 30, 2024.

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

8. Long-Term Debt Obligations

Long-term debt obligations are as follows:

	September 30	
	2025	2024
Obligated Group:		
Taxable Direct Note Obligation 2012C at a stated annual fixed interest rate of 4.32% as of September 30, 2025 and 2024	\$ 30,413	\$ 33,504
Tax-Exempt Revenue Refunding Bonds (Series 2015), privately placed, issued by JMH and guaranteed by the Obligated Group, puttable starting in 2024, at an annual fixed rate of 1.79% as of September 30, 2024	—	12,075
Tax-Exempt Revenue Refunding Bonds (Series 2024), secured by pledged revenues of the MH Obligated Group at a variable interest rate of 3.25% as of September 30, 2025	10,645	—
Tax-exempt Revenue Bonds (Series 2019) secured by pledged revenues of the MH Obligated Group at an annual fixed interest rate of 5.00% as of September 30, 2025 and 2024	103,980	109,030
Taxable Direct Note Obligation 2020 secured by pledged revenues of the MH Obligated Group at an annual fixed rate of 1.73% as of September 30, 2025 and 2024	52,210	54,500
Tax-exempt Revenue Bonds (Series 2020) secured by pledged revenues of the MH Obligated Group at an annual fixed interest rate of 1.41% as of September 30, 2025 and 2024	47,350	49,100
Taxable commercial paper secured by self-liquidity, at interest rates ranging from 4.30% to 4.44% as of September 30, 2025	49,493	49,666
Finance lease obligations, at imputed interest rates between 1.23% and 4.57%	6,604	7,043
Obligated Group debt subtotal	300,695	314,918
Other entities:		
Finance lease obligations, at imputed interest rates between 2.11% and 4.50%	47,708	53,807
Total long-term obligations	348,403	368,725
Less current installments of long-term obligations	54,647	18,230
Less short-term borrowings	49,493	49,666
Less unamortized debt issuance costs, discounts, and (premiums)	(8,152)	(9,349)
Long-term debt obligations, net	\$ 252,415	\$ 310,178

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

8. Long-Term Debt Obligations (continued)

All of MH's debt is under an amended and restated Master Trust Indenture (MTI), dated December 1, 2009. The membership of the Obligated Group under the MTI consists of Corporate, SMH, JMH, LMH, and TMH. The MTI requires the Obligated Group to maintain debt covenants, including meeting a minimum debt service coverage ratio, minimum days cash on hand, and a minimum rating requirement, all as defined in the MTI. Management believes the Obligated Group is in compliance with these covenants and conditions as of September 30, 2025.

MH holds a one-year \$50,000 revolving line of credit agreement and had no amounts outstanding under the facility as of September 30, 2025. In October 2025, MH renewed the facility for another one-year term.

In December 2025, MH entered into a \$50,000 Direct Note Obligation (Series 2025). The loan carries a fixed rate of interest of 4.50% through a mandatory put date in December 2032, with a maturity date in December 2050. The proceeds from the Series 2025 loan will be used to reduce borrowings on MH's taxable commercial paper program.

In December 2024, MH refinanced the Series 2015 bonds with proceeds from Tax-Exempt Revenue Refunding Bonds, Series 2024 (Series 2024). The Series 2024 bonds were privately placed at a variable rate of interest indexed to the federal funds rate, as adjusted by an applicable credit spread and the commitment runs through final maturity of the bonds in December 2031.

Aggregate maturities of long-term obligations at September 30, 2025, are as follows:

Fiscal year ending September 30:	
2026	\$ 104,140
2027	15,371
2028	15,878
2029	16,449
2030	17,079
Thereafter	179,486
Long-term debt obligations	<u>\$ 348,403</u>

Interest expense is \$10,725 and \$11,749 for the fiscal years ended September 30, 2025 and 2024, respectively.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

9. Liability Programs

MH is involved in litigation arising in the ordinary course of business. Claims alleging professional or general liability have been asserted against MH and are currently in various stages of litigation. MH has a self-insured retention for SMH, DMH, JMH, LMH, and TMH, with \$10,000 aggregate and commercial excess claims-made coverage of \$5,000, \$5,000 second excess layer coverage, \$5,000 third excess layer coverage, \$10,000 fourth excess layer coverage, and \$5,000 fifth excess layer coverage all with external insurance carriers.

The self-insured retention for SMH, DMH, JMH, LMH, and TMH is \$2,000 per claim/\$2,000 aggregate excess of \$3,000 per claim/\$15,000 aggregate self-insured retention.

Accruals related to the estimated self-insurance liability and the corresponding charge to expense are actuarially determined for asserted and unasserted claims using historical claims experience and other relevant industry and hospital-specific factors and trends, discounted at an annual interest rate of 2.95% and 2.29% as of September 30, 2025 and 2024.

The general and professional liability was \$44,997 and \$50,046 at September 30, 2025 and 2024, respectively, including tail coverage on the claims-made policy. Of the total liability, \$5,095 and \$5,453 is recorded in other current liabilities at September 30, 2025 and 2024, respectively. Insurance receivables related to excess coverage are \$12,421 and \$18,600 at September 30, 2025 and 2024, respectively. Amounts charged to purchased services and other expense on the consolidated statements of operations and changes in net assets are as follows:

	Year Ended September 30	
	2025	2024
Self-insurance	\$ 7,233	\$ 5,442
Insured	<u>2,564</u>	<u>7,099</u>
Total	<u>\$ 9,797</u>	<u>\$ 12,541</u>

MH maintains a revocable general and professional liability trust fund containing investments of \$31,669 and \$29,747 at September 30, 2025 and 2024, respectively.

ATTACHMENT 36

Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

9. Liability Programs (continued)

MH also provides for workers' compensation through a self-insurance trust or through insured programs. The funding level for this trust and estimation of the related liability are actuarially determined. Amounts charged to expense for this coverage for the fiscal years ended September 30, 2025 and 2024, were \$2,548 and \$3,659, respectively, and are included in employee benefits on the consolidated statements of operations and changes in net assets. The workers' compensation liability was \$7,433 and \$7,581 at September 30, 2025 and 2024, respectively, discounted at 3.89% and 3.40% as of September 30, 2025 and 2024, respectively. Of the total liability, \$3,306 and \$3,087 is recorded in other current liabilities at September 30, 2025 and 2024, respectively. The insurance receivable related to excess coverage is \$770 and \$1,066 at September 30, 2025 and 2024, respectively. MH maintains a revocable workers' compensation liability trust fund containing investments of \$6,795 and \$6,257 at September 30, 2025 and 2024, respectively.

10. Retirement Plans

Defined Contribution Plans

The MH DC Plan is intended to qualify as a profit-sharing plan under Code Section 401(a) and includes a cash or deferred arrangement that is approved to qualify under Code Section 401(k). The plan allows employee contributions and an employer matching contribution of up to 3% of eligible pay and provides a discretionary service-based employer contribution of between 3% and 7%. All eligible employees of Corporate, SMH, DMH, JMH, LMH, TMH, MMG, MHC, and MBH are included in the MH DC Plan.

MH contributes the employer match throughout the year as the employee contributes to the plan through payroll deduction. The service-based contributions for the MH DC Plan calendar plan year are discretionary and subject to approval by the MH Board of Directors.

Effective January 1, 2026, MH has amended its MH DC Plan to eliminate service-based employer contributions and has increased its employer matching contributions of up to 6% of eligible pay.

Defined contribution retirement expense for the MH DC Plan totaled \$39,319 and \$38,713 for the years ended September 30, 2025 and 2024, respectively.

ATTACHMENT 36 **Financial Viability**

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

11. Post-Employment and Other Benefits

MH provides unfunded post-employment benefit plans to certain employees. The costs for these plans were \$297 and \$213 for the fiscal years ended September 30, 2025 and 2024, respectively. As of September 30, 2025 and 2024, the accumulated post-employment benefit obligation was \$7,692 and \$7,678, respectively. Annual discount rates ranged from 5.00% to 5.40%. The plans assume a medical plan trend rate of 7.00% in 2025, grading down to the ultimate rate of 4.50% in 2043.

A one-percentage-point increase in the assumed medical plan trend rates would have increased the accumulated post-employment benefit obligation by \$972 and \$1,047 at September 30, 2025 and 2024, respectively. A one-percentage-point decrease in the assumed medical plan trend rates would have decreased the accumulated post-employment benefit obligation by \$812 and \$867 at September 30, 2025 and 2024, respectively.

Included in net assets without donor restrictions are the following amounts that have not yet been recognized in net periodic post-employment benefit cost:

	September 30	
	2025	2024
Unrecognized actuarial (gains) losses	\$ (1,545)	\$ (1,654)

Other post-employment and other benefit plans liabilities include continuation of medical benefits to employees on long-term disability and the paid sick time program to current active employees, which were \$3,601 and \$3,590 at September 30, 2025 and 2024, respectively.

12. Leases

Lessee

MH leases certain health care equipment, vehicles, and real property. Most leases include options to renew, and index and non-index escalation clauses, and very few have options to purchase the leased property, all of which are factored into the determination of lease payments when appropriate.

ATTACHMENT 36

Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

12. Leases (continued)

For leases with a term greater than 12 months, MH records the related right-of-use assets and liabilities at the present value of lease payments over the term of the lease. MH includes lease liabilities classified as finance leases within the long-term debt obligations line on the consolidated balance sheets. Lease payments are discounted using either the rate implicit in the lease (if readily determinable) or the risk-free rate. MH has elected not to separate lease and non-lease components for all classes of assets under the applicable practical expedient. MH elected not to apply the recognition requirements of ASC 842, *Leases*, to short-term leases. MH recognizes short-term lease payments as an operating expense reported in purchased services and other on a straight-line basis over the lease term and variable lease payments in the period in which the obligation for those payments is incurred. MH also elected the package of transition provisions available that allowed a carryforward of the historical assessment of (1) whether contracts are or contain leases, (2) lease classification, and (3) initial direct costs.

The amounts relating to MH's lease expense are as follows:

	September 30	
	2025	2024
Lease cost:		
Finance lease cost:		
Amortization of right-of-use assets	\$ 2,161	\$ 2,389
Interest on lease liabilities	1,943	2,164
Operating lease cost	4,322	3,667
Short-term lease expense	13	1,018
Variable lease expense	184	52
Total lease cost	<u>\$ 8,623</u>	<u>\$ 9,290</u>

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

12. Leases (continued)

	September 30	
	2025	2024
Other lease information:		
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from leases	\$ 2,528	\$ 5,165
Financing cash flows from leases	8,306	7,482
Right-of-use assets obtained in exchange for new lease liabilities	5,486	66
Weighted average remaining lease term – finance leases (in years)	5	6
Weighted average remaining lease term – operating leases (in years)	7	9
Weighted average discount rate – finance leases	3.34%	3.35%
Weighted average discount rate – operating leases	2.77	2.42
Sublease income	2,890	2,334

Future annual undiscounted cash flows for operating lease liabilities are as follows:

Fiscal year ending September 30:	
2026	\$ 5,067
2027	4,756
2028	4,480
2029	3,209
2030	2,839
Thereafter	7,693
Total	28,044
Less interest	(3,694)
Operating lease liability (current and noncurrent portion)	\$ 24,350

Future annual undiscounted cash flows for finance lease liabilities are included in Note 8.

ATTACHMENT 36 Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

12. Leases (continued)

Lessor

MH leases certain land, building, and equipment to non-MH organizations also providing health care services within MH's service area. Most leases include options to renew, and index and non-index escalation clauses, but do not include options to purchase the leased property, all of which are factored into the determination of lease payments when appropriate. MH has elected not to separate lease and non-lease components for all classes of assets under the applicable practical expedient. MH has determined its leases are properly classified as operating leases.

The amounts relating to MH's lease income are as follows:

	<u>2025</u>	<u>2024</u>
Lease income:		
Operating lease and sublease income	\$ 17,261	\$ 17,685

Future annual undiscounted cash flows from operating lease income payments are as follows:

Fiscal year ending September 30:	
2026	\$ 14,346
2027	12,387
2028	11,964
2029	11,640
2030	10,902
Thereafter	70,596
Total future operating lease income payments	<u>\$ 131,835</u>

ATTACHMENT 36
Financial Viability

Memorial Health and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

13. Commitments and Contingencies

Firm commitments for construction-in-progress totaled \$18,081 as of September 30, 2025.

Regulatory Compliance

The U.S. Department of Justice and other federal and state agencies are increasing resources dedicated to regulatory investigations and compliance audits of health care providers. MH is not exempt from these regulatory efforts and has received inquiries from federal and state agencies with regard to such initiatives. In consultation with legal counsel, management estimates these matters will be resolved without material adverse effect on MH's consolidated balance sheets or consolidated statements of operations and changes in net assets. MH has a formal corporate compliance function, which management believes will help monitor MH's compliance with applicable laws and regulations.

Litigation

MH is involved in litigation arising in the normal course of business. After consultation with legal counsel, it is management's opinion that these matters will be resolved without a material adverse effect on MH's consolidated balance sheets or consolidated statements of operations or changes in net assets.

14. Subsequent Events

MH evaluated events and transactions occurring subsequent to September 30, 2025 through December 17, 2025, the date the accompanying consolidated financial statements were available to be issued.

ATTACHMENT 36
Financial Viability

Supplementary Information

ATTACHMENT 36 Financial Viability

Memorial Health
Consolidating Balance Sheet
September 30, 2024
(Values in Thousands)

	Hospital Group			Ambulatory Group			System Medical Group			Foundation			Total
	Assets	Liabilities	Equity	Assets	Liabilities	Equity	Assets	Liabilities	Equity	Assets	Liabilities	Equity	
Assets													
Current assets:													
Cash and cash equivalents	24,908	1,729	6,126	7,121	5	6,793	20,104	5	20,104	12	4	13	50,047
Accounts receivable	1,100	7,478	2,998	262	17	245	18,072	717	18,072	31	31	31	31,116
Prepaid expenses and other	2,604	-	-	-	-	-	8,802	-	8,802	-	-	-	22,133
Due from/to related parties	11,642	7,436	12,641	10,617	473	9,944	18,018	84	18,018	14	5	4	50,989
Inventory	4,607	14,300	40	40	236	790	1,201	20	1,201	22	14	6	4,642
Prepaid insurance	1,807	9,194	9,609	1,028	1,803	1,281	1,568	646	1,568	-	-	-	20,752
Other receivables	17,311	6,194	1,309	1,309	1,803	1,281	1,568	646	1,568	-	-	-	20,752
Total current assets	64,979	44,433	33,683	33,683	33,683	33,683	64,979	44,433	64,979	64	64	64	129,943
Non-current assets:													
Property and equipment, net	142,112	90	142,022	25,728	-	10,771	18,758	36,333	92,462	46,235	4,441	6,733	224,511
Goodwill	4,015	9,218	7,507	-	47	83	29,940	18,155	7,726	40	309	64	39,945
Deferred intangible assets, net	6,015	3,362	2,653	-	27	63	24,022	18,155	7,726	40	309	64	39,945
Total non-current assets	152,142	12,570	151,582	25,728	74	10,917	54,902	56,548	25,492	80	348	128	264,403
Total assets	297,121	57,003	185,265	59,411	10,984	44,600	119,881	100,981	90,471	144	352	192	394,346
Liabilities													
Current liabilities:													
Accounts payable	1,028	3,742	2,714	2,714	9	2,705	18,018	84	18,018	22	14	6	4,642
Accrued salaries and wages	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307
Accrued expenses	2,108	1,308	200	228	84	191	1,212	4	1,212	15	15	15	5,148
Due to related parties	11,642	14,300	40	40	236	790	1,201	20	1,201	22	14	6	4,642
Total current liabilities	16,085	19,657	2,261	2,998	2,998	2,998	20,752	1,309	20,752	63	47	21	45,525
Non-current liabilities:													
Long-term debt	178,629	7,617	6,879	13,241	-	-	41,828	-	41,828	-	-	-	224,457
Total non-current liabilities	178,629	7,617	6,879	13,241	-	-	41,828	-	41,828	-	-	-	224,457
Total liabilities	185,714	27,274	13,140	16,239	2,998	2,998	62,580	1,309	62,580	63	47	21	269,982
Equity													
Contributed capital	100	100	100	100	100	100	100	100	100	100	100	100	400
Retained earnings	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	80,000
Total equity	20,100	20,100	20,100	20,100	20,100	20,100	20,100	20,100	20,100	20,100	20,100	20,100	100,100
Total equity and liabilities	205,814	47,374	33,240	36,339	2,998	2,998	82,680	1,309	82,680	163	67	41	370,082

ATTACHMENT 36 Financial Viability

Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2013
(Audited by Deloitte)

	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990	1989	1988	1987	1986	1985	1984	1983	1982	1981	1980	1979	1978	1977	1976	1975	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965	1964	1963	1962	1961	1960	1959	1958	1957	1956	1955	1954	1953	1952	1951	1950	1949	1948	1947	1946	1945	1944	1943	1942	1941	1940	1939	1938	1937	1936	1935	1934	1933	1932	1931	1930	1929	1928	1927	1926	1925	1924	1923	1922	1921	1920	1919	1918	1917	1916	1915	1914	1913	1912	1911	1910	1909	1908	1907	1906	1905	1904	1903	1902	1901	1900	1899	1898	1897	1896	1895	1894	1893	1892	1891	1890	1889	1888	1887	1886	1885	1884	1883	1882	1881	1880	1879	1878	1877	1876	1875	1874	1873	1872	1871	1870	1869	1868	1867	1866	1865	1864	1863	1862	1861	1860	1859	1858	1857	1856	1855	1854	1853	1852	1851	1850	1849	1848	1847	1846	1845	1844	1843	1842	1841	1840	1839	1838	1837	1836	1835	1834	1833	1832	1831	1830	1829	1828	1827	1826	1825	1824	1823	1822	1821	1820	1819	1818	1817	1816	1815	1814	1813	1812	1811	1810	1809	1808	1807	1806	1805	1804	1803	1802	1801	1800	1799	1798	1797	1796	1795	1794	1793	1792	1791	1790	1789	1788	1787	1786	1785	1784	1783	1782	1781	1780	1779	1778	1777	1776	1775	1774	1773	1772	1771	1770	1769	1768	1767	1766	1765	1764	1763	1762	1761	1760	1759	1758	1757	1756	1755	1754	1753	1752	1751	1750	1749	1748	1747	1746	1745	1744	1743	1742	1741	1740	1739	1738	1737	1736	1735	1734	1733	1732	1731	1730	1729	1728	1727	1726	1725	1724	1723	1722	1721	1720	1719	1718	1717	1716	1715	1714	1713	1712	1711	1710	1709	1708	1707	1706	1705	1704	1703	1702	1701	1700	1699	1698	1697	1696	1695	1694	1693	1692	1691	1690	1689	1688	1687	1686	1685	1684	1683	1682	1681	1680	1679	1678	1677	1676	1675	1674	1673	1672	1671	1670	1669	1668	1667	1666	1665	1664	1663	1662	1661	1660	1659	1658	1657	1656	1655	1654	1653	1652	1651	1650	1649	1648	1647	1646	1645	1644	1643	1642	1641	1640	1639	1638	1637	1636	1635	1634	1633	1632	1631	1630	1629	1628	1627	1626	1625	1624	1623	1622	1621	1620	1619	1618	1617	1616	1615	1614	1613	1612	1611	1610	1609	1608	1607	1606	1605	1604	1603	1602	1601	1600	1599	1598	1597	1596	1595	1594	1593	1592	1591	1590	1589	1588	1587	1586	1585	1584	1583	1582	1581	1580	1579	1578	1577	1576	1575	1574	1573	1572	1571	1570	1569	1568	1567	1566	1565	1564	1563	1562	1561	1560	1559	1558	1557	1556	1555	1554	1553	1552	1551	1550	1549	1548	1547	1546	1545	1544	1543	1542	1541	1540	1539	1538	1537	1536	1535	1534	1533	1532	1531	1530	1529	1528	1527	1526	1525	1524	1523	1522	1521	1520	1519	1518	1517	1516	1515	1514	1513	1512	1511	1510	1509	1508	1507	1506	1505	1504	1503	1502	1501	1500	1499	1498	1497	1496	1495	1494	1493	1492	1491	1490	1489	1488	1487	1486	1485	1484	1483	1482	1481	1480	1479	1478	1477	1476	1475	1474	1473	1472	1471	1470	1469	1468	1467	1466	1465	1464	1463	1462	1461	1460	1459	1458	1457	1456	1455	1454	1453	1452	1451	1450	1449	1448	1447	1446	1445	1444	1443	1442	1441	1440	1439	1438	1437	1436	1435	1434	1433	1432	1431	1430	1429	1428	1427	1426	1425	1424	1423	1422	1421	1420	1419	1418	1417	1416	1415	1414	1413	1412	1411	1410	1409	1408	1407	1406	1405	1404	1403	1402	1401	1400	1399	1398	1397	1396	1395	1394	1393	1392	1391	1390	1389	1388	1387	1386	1385	1384	1383	1382	1381	1380	1379	1378	1377	1376	1375	1374	1373	1372	1371	1370	1369	1368	1367	1366	1365	1364	1363	1362	1361	1360	1359	1358	1357	1356	1355	1354	1353	1352	1351	1350	1349	1348	1347	1346	1345	1344	1343	1342	1341	1340	1339	1338	1337	1336	1335	1334	1333	1332	1331	1330	1329	1328	1327	1326	1325	1324	1323	1322	1321	1320	1319	1318	1317	1316	1315	1314	1313	1312	1311	1310	1309	1308	1307	1306	1305	1304	1303	1302	1301	1300	1299	1298	1297	1296	1295	1294	1293	1292	1291	1290	1289	1288	1287	1286	1285	1284	1283	1282	1281	1280	1279	1278	1277	1276	1275	1274	1273	1272	1271	1270	1269	1268	1267	1266	1265	1264	1263	1262	1261	1260	1259	1258	1257	1256	1255	1254	1253	1252	1251	1250	1249	1248	1247	1246	1245	1244	1243	1242	1241	1240	1239	1238	1237	1236	1235	1234	1233	1232	1231	1230	1229	1228	1227	1226	1225	1224	1223	1222	1221	1220	1219	1218	1217	1216	1215	1214	1213	1212	1211	1210	1209	1208	1207	1206	1205	1204	1203	1202	1201	1200	1199	1198	1197	1196	1195	1194	1193	1192	1191	1190	1189	1188	1187	1186	1185	1184	1183	1182	1181	1180	1179	1178	1177	1176	1175	1174	1173	1172	1171	1170	1169	1168	1167	1166	1165	1164	1163	1162	1161	1160	1159	1158	1157	1156	1155	1154	1153	1152	1151	1150	1149	1148	1147	1146	1145	1144	1143	1142	1141	1140	1139	1138	1137	1136	1135	1134	1133	1132	1131	1130	1129	1128	1127	1126	1125	1124	1123	1122	1121	1120	1119	1118	1117	1116	1115	1114	1113	1112	1111	1110	1109	1108	1107	1106	1105	1104	1103	1102	1101	1100	1099	1098	1097	1096	1095	1094	1093	1092	1091	1090	1089	1088	1087	1086	1085	1084	1083	1082	1081	1080	1079	1078	1077	1076	1075	1074	1073	1072	1071	1070	1069	1068	1067	1066	1065	1064	1063	1062	1061	1060	1059	1058	1057	1056	1055	1054	1053	1052	1051	1050	1049	1048	1047	1046	1045	1044	1043	1042	1041	1040	1039	1038	1037	1036	1035	1034	1033	1032	1031	1030	1029	1028	1027	1026	1025	1024	1023	1022	1021	1020	1019	1018	1017	1016	1015	1014	1013	1012	1011	1010	1009	1008	1007	1006	1005	1004	1003	1002	1001	1000	999	998	997	996	995	994	993	992	991	990	989	988	987	986	985	984	983	982	981	980	979	978	977	976	975	974	973	972	971	970	969	968	967	966	965	964	963	962	961	960	959	958	957	956	955	954	953	952	951	950	949	948	947	946	945	944	943	942	941	940	939	938	937	936	935	934	933	932	931	930	929	928	927	926	925	924	923	922	921	920	919	918	917	916	915	914	913	912	911	910	909	908	907	906	905	904	903	902	901	900	899	898	897	896	895	894	893	892	891	890	889	888	887	886	885	884	883	882	881	880	879	878	877	876	875	874	873	872	871	870	869	868	867	866	865	864	863	862	861	860	859	858	857	856	855	854	853	852	851	850	849	848	847	846	845	844	843	842	841	840	839	838	837	836	835	834	833	832	831	830	829	828	827	826	825	824	823	822	821	820	819	818	817	816	815	814	813	812	811	810	809	808	807	806	805	804	803	802	801	800	799	798	797	796	795	794	793	792	791	790	789	788	787	786	785	784	783	782	781	780	779	778	777	776	775	774	773	772	771	770	769	768	767	766	765	764	763	762	761	760	759	758	757	756	755	754	753	752	751	750	749	748	747	746	745	744	743	742	741	740	739	738	737	736	735	734	733	732	731	730	729	728	727	726	725	724	723	722	721	720	719	718	717	716	715	714	713	712	711	710	709	708	707	706	705	704	703	702	701	700	699	698	697	696	695	694	693	692	691	690	689	688	687	686	685	684	683	682	681	680	679	678	677	676	675	674	673	672	671	670	669	668	667	666	665	664	663	662	661	660	659	658	657	656	655	654	653	652	651	650	649	648	647	646	645	644	643	642	641	640	639	638	637	636	635	634	633	632	631	630	629	628	627	626	625	624	623	622	621	620	619
--	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

ATTACHMENT 36 Financial Viability

Statement	Financial Group		1999		1998		1997		1996		1995		1994		1993		1992		1991		1990		1989		1988		1987		1986		1985		1984		1983		1982		1981		1980		1979		1978		1977		1976		1975		1974		1973		1972		1971		1970		1969		1968		1967		1966		1965		1964		1963		1962		1961		1960		1959		1958		1957		1956		1955		1954		1953		1952		1951		1950		1949		1948		1947		1946		1945		1944		1943		1942		1941		1940		1939		1938		1937		1936		1935		1934		1933		1932		1931		1930		1929		1928		1927		1926		1925		1924		1923		1922		1921		1920		1919		1918		1917		1916		1915		1914		1913		1912		1911		1910		1909		1908		1907		1906		1905		1904		1903		1902		1901		1900		1899		1898		1897		1896		1895		1894		1893		1892		1891		1890		1889		1888		1887		1886		1885		1884		1883		1882		1881		1880		1879		1878		1877		1876		1875		1874		1873		1872		1871		1870		1869		1868		1867		1866		1865		1864		1863		1862		1861		1860		1859		1858		1857		1856		1855		1854		1853		1852		1851		1850		1849		1848		1847		1846		1845		1844		1843		1842		1841		1840		1839		1838		1837		1836		1835		1834		1833		1832		1831		1830		1829		1828		1827		1826		1825		1824		1823		1822		1821		1820		1819		1818		1817		1816		1815		1814		1813		1812		1811		1810		1809		1808		1807		1806		1805		1804		1803		1802		1801		1800		1799		1798		1797		1796		1795		1794		1793		1792		1791		1790		1789		1788		1787		1786		1785		1784		1783		1782		1781		1780		1779		1778		1777		1776		1775		1774		1773		1772		1771		1770		1769		1768		1767		1766		1765		1764		1763		1762		1761		1760		1759		1758		1757		1756		1755		1754		1753		1752		1751		1750		1749		1748		1747		1746		1745		1744		1743		1742		1741		1740		1739		1738		1737		1736		1735		1734		1733		1732		1731		1730		1729		1728		1727		1726		1725		1724		1723		1722		1721		1720		1719		1718		1717		1716		1715		1714		1713		1712		1711		1710		1709		1708		1707		1706		1705		1704		1703		1702		1701		1700		1699		1698		1697		1696		1695		1694		1693		1692		1691		1690		1689		1688		1687		1686		1685		1684		1683		1682		1681		1680		1679		1678		1677		1676		1675		1674		1673		1672		1671		1670		1669		1668		1667		1666		1665		1664		1663		1662		1661	
-----------	-----------------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--	------	--

ATTACHMENT 36 Financial Viability

Memorial Health
Consolidating Statement of Cash Flows
For the Year Ended September 30, 2023
(Dollars in Thousands)

	Management Group			Ambulatory Group			Hospital			Rehabilitation			Total		
	2023	2022	2021	2023	2022	2021	2023	2022	2021	2023	2022	2021	2023	2022	2021
Cash, beginning of year	\$ 102.30	\$ 128.40	\$ 128.40	\$ 102.30	\$ 128.40	\$ 128.40	\$ 102.30	\$ 128.40	\$ 128.40	\$ 102.30	\$ 128.40	\$ 128.40	\$ 102.30	\$ 128.40	\$ 128.40
Operating activities															
Net income	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Depreciation and amortization	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Provision for doubtful accounts	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Change in accounts receivable	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Change in accounts payable	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Change in other assets	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Change in other liabilities	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Net cash provided by operating activities	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Investing activities															
Capital expenditures	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Acquisition of other businesses	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Proceeds from sale of other businesses	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Proceeds from sale of other assets	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Change in other assets	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Change in other liabilities	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Net cash provided by investing activities	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Financing activities															
Proceeds from issuance of common stock	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Proceeds from issuance of preferred stock	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Proceeds from sale of other securities	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Change in other assets	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Change in other liabilities	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Net cash provided by financing activities	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Net change in cash	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40	102.30	128.40	128.40
Cash, end of year	\$ 204.60	\$ 256.80	\$ 256.80	\$ 204.60	\$ 256.80	\$ 256.80	\$ 204.60	\$ 256.80	\$ 256.80	\$ 204.60	\$ 256.80	\$ 256.80	\$ 204.60	\$ 256.80	\$ 256.80

ATTACHMENT 36 Financial Viability

46

Memorial Health

Consolidating Balance Sheet

September 30, 2024

(In dollars in thousands)

Assets	Current Assets	Long-Term Assets	Liabilities	Current Liabilities	Long-Term Liabilities	Equity
Current Assets			Current Liabilities			
Cash and cash equivalents	1,176		Accounts payable	1,176		
Accounts receivable	143		Notes payable	143		
Prepaid expenses	2,381		Accrued liabilities	2,381		
Other current assets	1,176		Other current liabilities	1,176		
Long-Term Assets			Long-Term Liabilities			
Property, plant, and equipment		1,176	Long-Term Debt		1,176	
Intangible assets		143	Other long-term liabilities		143	
Goodwill		2,381	Other long-term liabilities		2,381	
Other long-term assets		1,176	Other long-term liabilities		1,176	
Equity			Equity			
Common stock			Common stock			1,176
Retained earnings			Retained earnings			143
Accumulated other comprehensive income			Accumulated other comprehensive income			2,381
Other equity			Other equity			1,176
Total	1,176	1,176	Total	1,176	1,176	1,176

ATTACHMENT 36 Financial Viability

Memorial Health
Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2024
(Dollar in Thousands)

	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990	1989	1988	1987	1986	1985	1984	1983	1982	1981	1980	1979	1978	1977	1976	1975	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965	1964	1963	1962	1961	1960	1959	1958	1957	1956	1955	1954	1953	1952	1951	1950	1949	1948	1947	1946	1945	1944	1943	1942	1941	1940	1939	1938	1937	1936	1935	1934	1933	1932	1931	1930	1929	1928	1927	1926	1925	1924	1923	1922	1921	1920	1919	1918	1917	1916	1915	1914	1913	1912	1911	1910	1909	1908	1907	1906	1905	1904	1903	1902	1901	1900	1899	1898	1897	1896	1895	1894	1893	1892	1891	1890	1889	1888	1887	1886	1885	1884	1883	1882	1881	1880	1879	1878	1877	1876	1875	1874	1873	1872	1871	1870	1869	1868	1867	1866	1865	1864	1863	1862	1861	1860	1859	1858	1857	1856	1855	1854	1853	1852	1851	1850	1849	1848	1847	1846	1845	1844	1843	1842	1841	1840	1839	1838	1837	1836	1835	1834	1833	1832	1831	1830	1829	1828	1827	1826	1825	1824	1823	1822	1821	1820	1819	1818	1817	1816	1815	1814	1813	1812	1811	1810	1809	1808	1807	1806	1805	1804	1803	1802	1801	1800	1799	1798	1797	1796	1795	1794	1793	1792	1791	1790	1789	1788	1787	1786	1785	1784	1783	1782	1781	1780	1779	1778	1777	1776	1775	1774	1773	1772	1771	1770	1769	1768	1767	1766	1765	1764	1763	1762	1761	1760	1759	1758	1757	1756	1755	1754	1753	1752	1751	1750	1749	1748	1747	1746	1745	1744	1743	1742	1741	1740	1739	1738	1737	1736	1735	1734	1733	1732	1731	1730	1729	1728	1727	1726	1725	1724	1723	1722	1721	1720	1719	1718	1717	1716	1715	1714	1713	1712	1711	1710	1709	1708	1707	1706	1705	1704	1703	1702	1701	1700	1699	1698	1697	1696	1695	1694	1693	1692	1691	1690	1689	1688	1687	1686	1685	1684	1683	1682	1681	1680	1679	1678	1677	1676	1675	1674	1673	1672	1671	1670	1669	1668	1667	1666	1665	1664	1663	1662	1661	1660	1659	1658	1657	1656	1655	1654	1653	1652	1651	1650	1649	1648	1647	1646	1645	1644	1643	1642	1641	1640	1639	1638	1637	1636	1635	1634	1633	1632	1631	1630	1629	1628	1627	1626	1625	1624	1623	1622	1621	1620	1619	1618	1617	1616	1615	1614	1613	1612	1611	1610	1609	1608	1607	1606	1605	1604	1603	1602	1601	1600	1599	1598	1597	1596	1595	1594	1593	1592	1591	1590	1589	1588	1587	1586	1585	1584	1583	1582	1581	1580	1579	1578	1577	1576	1575	1574	1573	1572	1571	1570	1569	1568	1567	1566	1565	1564	1563	1562	1561	1560	1559	1558	1557	1556	1555	1554	1553	1552	1551	1550	1549	1548	1547	1546	1545	1544	1543	1542	1541	1540	1539	1538	1537	1536	1535	1534	1533	1532	1531	1530	1529	1528	1527	1526	1525	1524	1523	1522	1521	1520	1519	1518	1517	1516	1515	1514	1513	1512	1511	1510	1509	1508	1507	1506	1505	1504	1503	1502	1501	1500	1499	1498	1497	1496	1495	1494	1493	1492	1491	1490	1489	1488	1487	1486	1485	1484	1483	1482	1481	1480	1479	1478	1477	1476	1475	1474	1473	1472	1471	1470	1469	1468	1467	1466	1465	1464	1463	1462	1461	1460	1459	1458	1457	1456	1455	1454	1453	1452	1451	1450	1449	1448	1447	1446	1445	1444	1443	1442	1441	1440	1439	1438	1437	1436	1435	1434	1433	1432	1431	1430	1429	1428	1427	1426	1425	1424	1423	1422	1421	1420	1419	1418	1417	1416	1415	1414	1413	1412	1411	1410	1409	1408	1407	1406	1405	1404	1403	1402	1401	1400	1399	1398	1397	1396	1395	1394	1393	1392	1391	1390	1389	1388	1387	1386	1385	1384	1383	1382	1381	1380	1379	1378	1377	1376	1375	1374	1373	1372	1371	1370	1369	1368	1367	1366	1365	1364	1363	1362	1361	1360	1359	1358	1357	1356	1355	1354	1353	1352	1351	1350	1349	1348	1347	1346	1345	1344	1343	1342	1341	1340	1339	1338	1337	1336	1335	1334	1333	1332	1331	1330	1329	1328	1327	1326	1325	1324	1323	1322	1321	1320	1319	1318	1317	1316	1315	1314	1313	1312	1311	1310	1309	1308	1307	1306	1305	1304	1303	1302	1301	1300	1299	1298	1297	1296	1295	1294	1293	1292	1291	1290	1289	1288	1287	1286	1285	1284	1283	1282	1281	1280	1279	1278	1277	1276	1275	1274	1273	1272	1271	1270	1269	1268	1267	1266	1265	1264	1263	1262	1261	1260	1259	1258	1257	1256	1255	1254	1253	1252	1251	1250	1249	1248	1247	1246	1245	1244	1243	1242	1241	1240	1239	1238	1237	1236	1235	1234	1233	1232	1231	1230	1229	1228	1227	1226	1225	1224	1223	1222	1221	1220	1219	1218	1217	1216	1215	1214	1213	1212	1211	1210	1209	1208	1207	1206	1205	1204	1203	1202	1201	1200	1199	1198	1197	1196	1195	1194	1193	1192	1191	1190	1189	1188	1187	1186	1185	1184	1183	1182	1181	1180	1179	1178	1177	1176	1175	1174	1173	1172	1171	1170	1169	1168	1167	1166	1165	1164	1163	1162	1161	1160	1159	1158	1157	1156	1155	1154	1153	1152	1151	1150	1149	1148	1147	1146	1145	1144	1143	1142	1141	1140	1139	1138	1137	1136	1135	1134	1133	1132	1131	1130	1129	1128	1127	1126	1125	1124	1123	1122	1121	1120	1119	1118	1117	1116	1115	1114	1113	1112	1111	1110	1109	1108	1107	1106	1105	1104	1103	1102	1101	1100	1099	1098	1097	1096	1095	1094	1093	1092	1091	1090	1089	1088	1087	1086	1085	1084	1083	1082	1081	1080	1079	1078	1077	1076	1075	1074	1073	1072	1071	1070	1069	1068	1067	1066	1065	1064	1063	1062	1061	1060	1059	1058	1057	1056	1055	1054	1053	1052	1051	1050	1049	1048	1047	1046	1045	1044	1043	1042	1041	1040	1039	1038	1037	1036	1035	1034	1033	1032	1031	1030	1029	1028	1027	1026	1025	1024	1023	1022	1021	1020	1019	1018	1017	1016	1015	1014	1013	1012	1011	1010	1009	1008	1007	1006	1005	1004	1003	1002	1001	1000	999	998	997	996	995	994	993	992	991	990	989	988	987	986	985	984	983	982	981	980	979	978	977	976	975	974	973	972	971	970	969	968	967	966	965	964	963	962	961	960	959	958	957	956	955	954	953	952	951	950	949	948	947	946	945	944	943	942	941	940	939	938	937	936	935	934	933	932	931	930	929	928	927	926	925	924	923	922	921	920	919	918	917	916	915	914	913	912	911	910	909	908	907	906	905	904	903	902	901	900	899	898	897	896	895	894	893	892	891	890	889	888	887	886	885	884	883	882	881	880	879	878	877	876	875	874	873	872	871	870	869	868	867	866	865	864	863	862	861	860	859	858	857	856	855	854	853	852	851	850	849	848	847	846	845	844	843	842	841	840	839	838	837	836	835	834	833	832	831	830	829	828	827	826	825	824	823	822	821	820	819	818	817	816	815	814	813	812	811	810	809	808	807	806	805	804	803	802	801	800	799	798	797	796	795	794	793	792	791	790	789	788	787	786	785	784	783	782	781	780	779	778	777	776	775	774	773	772	771	770	769	768	767	766	765	764	763	762	761	760	759	758	757	756	755	754	753	752	751	750	749	748	747	746	745	744	743	742	741	740	739	738	737	736	735	734	733	732	731	730	729	728	727	726	725	724	723	722	721	720	719	718	717	716	715	714	713	712	711	710	709	708	707	706	705	704	703	702	701	700	699	698	697	696	695	694	693	692	691	690	689	688	687	686	685	684	683	682	681	680	679	678	677	676	675	674	673	672	671	670	669	668	667	666	665	664	663	662	661	660	659	658	657	656	655	654	653	652	651	650	649	648	647	646	645	644	643	642	641	640	639	638	637	636	635	634	633	632
--	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

ATTACHMENT 36
Financial Viability

Memorial Health
Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2024
(Dollars in Thousands)

	Hospital Group		Ambulatory Group		Syracuse Group		Foundation		Total	
	DAHL	LMH	DAHL	LMH	DAHL	LMH	DAHL	LMH	DAHL	LMH
Net assets without donor restrictions	\$ 43,342	\$ 282,949	\$ 49,823	\$ 34,989	\$ 26,243	\$ 26,243	\$ 1,794	\$ 5,860	\$ 1,794	\$ 5,860
Excess of revenues over expenses	(24,323)	(11,909)	(17,488)	(11,115)	(6,679)	(6,679)	(1,231)	(1,231)	(1,231)	(1,231)
Post-employment liability adjustments	3,724	3,644	832	284	213	213	794	794	794	794
Transfers to (from) related organizations	8,738	(17,233)	33,277	21,138	10,391	10,391	890	890	890	890
Transfers from (to) related organizations										
Net assets without donor restrictions	\$ 31,471	\$ 198,131	\$ 66,435	\$ 45,576	\$ 30,167	\$ 30,167	\$ 1,257	\$ 5,813	\$ 1,257	\$ 5,813
Net assets with donor restrictions	519	211	211	6	6	6	669	669	669	669
Contributions	956	563	563	48	48	48	1,501	1,501	1,501	1,501
Net investment gain (loss)	(2,992)	(1,251)	(1,251)	(8)	(8)	(8)	(193)	(193)	(193)	(193)
Net assets with donor restrictions	\$ 3,483	\$ 1,423	\$ 3,483	\$ 38	\$ 38	\$ 38	\$ 1,308	\$ 1,308	\$ 1,308	\$ 1,308
Transfers to (from) related organizations										
Transfers from (to) related organizations										
Net assets with donor restrictions	\$ 3,483	\$ 1,423	\$ 3,483	\$ 38	\$ 38	\$ 38	\$ 1,308	\$ 1,308	\$ 1,308	\$ 1,308
Net assets without donor restrictions	\$ 34,954	\$ 199,554	\$ 69,918	\$ 45,614	\$ 30,205	\$ 30,205	\$ 1,263	\$ 5,826	\$ 1,263	\$ 5,826
Net assets with donor restrictions	\$ 519	\$ 211	\$ 211	\$ 6	\$ 6	\$ 6	\$ 669	\$ 669	\$ 669	\$ 669
Net assets, beginning of period	\$ 35,473	\$ 199,765	\$ 70,129	\$ 45,620	\$ 30,211	\$ 30,211	\$ 1,272	\$ 5,832	\$ 1,272	\$ 5,832
Net assets, end of period	\$ 38,952	\$ 200,976	\$ 73,610	\$ 45,626	\$ 30,217	\$ 30,217	\$ 1,278	\$ 5,838	\$ 1,278	\$ 5,838

ATTACHMENT 36 Financial Viability

Memorial Health Consolidating Statement of Cash Flows For the Year Ended September 30, 2024 (Dollars in Thousands)

	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990	1989	1988	1987	1986	1985	1984	1983	1982	1981	1980	1979	1978	1977	1976	1975	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965	1964	1963	1962	1961	1960	1959	1958	1957	1956	1955	1954	1953	1952	1951	1950	1949	1948	1947	1946	1945	1944	1943	1942	1941	1940	1939	1938	1937	1936	1935	1934	1933	1932	1931	1930	1929	1928	1927	1926	1925	1924	1923	1922	1921	1920	1919	1918	1917	1916	1915	1914	1913	1912	1911	1910	1909	1908	1907	1906	1905	1904	1903	1902	1901	1900	1899	1898	1897	1896	1895	1894	1893	1892	1891	1890	1889	1888	1887	1886	1885	1884	1883	1882	1881	1880	1879	1878	1877	1876	1875	1874	1873	1872	1871	1870	1869	1868	1867	1866	1865	1864	1863	1862	1861	1860	1859	1858	1857	1856	1855	1854	1853	1852	1851	1850	1849	1848	1847	1846	1845	1844	1843	1842	1841	1840	1839	1838	1837	1836	1835	1834	1833	1832	1831	1830	1829	1828	1827	1826	1825	1824	1823	1822	1821	1820	1819	1818	1817	1816	1815	1814	1813	1812	1811	1810	1809	1808	1807	1806	1805	1804	1803	1802	1801	1800	1799	1798	1797	1796	1795	1794	1793	1792	1791	1790	1789	1788	1787	1786	1785	1784	1783	1782	1781	1780	1779	1778	1777	1776	1775	1774	1773	1772	1771	1770	1769	1768	1767	1766	1765	1764	1763	1762	1761	1760	1759	1758	1757	1756	1755	1754	1753	1752	1751	1750	1749	1748	1747	1746	1745	1744	1743	1742	1741	1740	1739	1738	1737	1736	1735	1734	1733	1732	1731	1730	1729	1728	1727	1726	1725	1724	1723	1722	1721	1720	1719	1718	1717	1716	1715	1714	1713	1712	1711	1710	1709	1708	1707	1706	1705	1704	1703	1702	1701	1700	1699	1698	1697	1696	1695	1694	1693	1692	1691	1690	1689	1688	1687	1686	1685	1684	1683	1682	1681	1680	1679	1678	1677	1676	1675	1674	1673	1672	1671	1670	1669	1668	1667	1666	1665	1664	1663	1662	1661	1660	1659	1658	1657	1656	1655	1654	1653	1652	1651	1650	1649	1648	1647	1646	1645	1644	1643	1642	1641	1640	1639	1638	1637	1636	1635	1634	1633	1632	1631	1630	1629	1628	1627	1626	1625	1624	1623	1622	1621	1620	1619	1618	1617	1616	1615	1614	1613	1612	1611	1610	1609	1608	1607	1606	1605	1604	1603	1602	1601	1600	1599	1598	1597	1596	1595	1594	1593	1592	1591	1590	1589	1588	1587	1586	1585	1584	1583	1582	1581	1580	1579	1578	1577	1576	1575	1574	1573	1572	1571	1570	1569	1568	1567	1566	1565	1564	1563	1562	1561	1560	1559	1558	1557	1556	1555	1554	1553	1552	1551	1550	1549	1548	1547	1546	1545	1544	1543	1542	1541	1540	1539	1538	1537	1536	1535	1534	1533	1532	1531	1530	1529	1528	1527	1526	1525	1524	1523	1522	1521	1520	1519	1518	1517	1516	1515	1514	1513	1512	1511	1510	1509	1508	1507	1506	1505	1504	1503	1502	1501	1500	1499	1498	1497	1496	1495	1494	1493	1492	1491	1490	1489	1488	1487	1486	1485	1484	1483	1482	1481	1480	1479	1478	1477	1476	1475	1474	1473	1472	1471	1470	1469	1468	1467	1466	1465	1464	1463	1462	1461	1460	1459	1458	1457	1456	1455	1454	1453	1452	1451	1450	1449	1448	1447	1446	1445	1444	1443	1442	1441	1440	1439	1438	1437	1436	1435	1434	1433	1432	1431	1430	1429	1428	1427	1426	1425	1424	1423	1422	1421	1420	1419	1418	1417	1416	1415	1414	1413	1412	1411	1410	1409	1408	1407	1406	1405	1404	1403	1402	1401	1400	1399	1398	1397	1396	1395	1394	1393	1392	1391	1390	1389	1388	1387	1386	1385	1384	1383	1382	1381	1380	1379	1378	1377	1376	1375	1374	1373	1372	1371	1370	1369	1368	1367	1366	1365	1364	1363	1362	1361	1360	1359	1358	1357	1356	1355	1354	1353	1352	1351	1350	1349	1348	1347	1346	1345	1344	1343	1342	1341	1340	1339	1338	1337	1336	1335	1334	1333	1332	1331	1330	1329	1328	1327	1326	1325	1324	1323	1322	1321	1320	1319	1318	1317	1316	1315	1314	1313	1312	1311	1310	1309	1308	1307	1306	1305	1304	1303	1302	1301	1300	1299	1298	1297	1296	1295	1294	1293	1292	1291	1290	1289	1288	1287	1286	1285	1284	1283	1282	1281	1280	1279	1278	1277	1276	1275	1274	1273	1272	1271	1270	1269	1268	1267	1266	1265	1264	1263	1262	1261	1260	1259	1258	1257	1256	1255	1254	1253	1252	1251	1250	1249	1248	1247	1246	1245	1244	1243	1242	1241	1240	1239	1238	1237	1236	1235	1234	1233	1232	1231	1230	1229	1228	1227	1226	1225	1224	1223	1222	1221	1220	1219	1218	1217	1216	1215	1214	1213	1212	1211	1210	1209	1208	1207	1206	1205	1204	1203	1202	1201	1200	1199	1198	1197	1196	1195	1194	1193	1192	1191	1190	1189	1188	1187	1186	1185	1184	1183	1182	1181	1180	1179	1178	1177	1176	1175	1174	1173	1172	1171	1170	1169	1168	1167	1166	1165	1164	1163	1162	1161	1160	1159	1158	1157	1156	1155	1154	1153	1152	1151	1150	1149	1148	1147	1146	1145	1144	1143	1142	1141	1140	1139	1138	1137	1136	1135	1134	1133	1132	1131	1130	1129	1128	1127	1126	1125	1124	1123	1122	1121	1120	1119	1118	1117	1116	1115	1114	1113	1112	1111	1110	1109	1108	1107	1106	1105	1104	1103	1102	1101	1100	1099	1098	1097	1096	1095	1094	1093	1092	1091	1090	1089	1088	1087	1086	1085	1084	1083	1082	1081	1080	1079	1078	1077	1076	1075	1074	1073	1072	1071	1070	1069	1068	1067	1066	1065	1064	1063	1062	1061	1060	1059	1058	1057	1056	1055	1054	1053	1052	1051	1050	1049	1048	1047	1046	1045	1044	1043	1042	1041	1040	1039	1038	1037	1036	1035	1034	1033	1032	1031	1030	1029	1028	1027	1026	1025	1024	1023	1022	1021	1020	1019	1018	1017	1016	1015	1014	1013	1012	1011	1010	1009	1008	1007	1006	1005	1004	1003	1002	1001	1000	999	998	997	996	995	994	993	992	991	990	989	988	987	986	985	984	983	982	981	980	979	978	977	976	975	974	973	972	971	970	969	968	967	966	965	964	963	962	961	960	959	958	957	956	955	954	953	952	951	950	949	948	947	946	945	944	943	942	941	940	939	938	937	936	935	934	933	932	931	930	929	928	927	926	925	924	923	922	921	920	919	918	917	916	915	914	913	912	911	910	909	908	907	906	905	904	903	902	901	900	899	898	897	896	895	894	893	892	891	890	889	888	887	886	885	884	883	882	881	880	879	878	877	876	875	874	873	872	871	870	869	868	867	866	865	864	863	862	861	860	859	858	857	856	855	854	853	852	851	850	849	848	847	846	845	844	843	842	841	840	839	838	837	836	835	834	833	832	831	830	829	828	827	826	825	824	823	822	821	820	819	818	817	816	815	814	813	812	811	810	809	808	807	806	805	804	803	802	801	800	799	798	797	796	795	794	793	792	791	790	789	788	787	786	785	784	783	782	781	780	779	778	777	776	775	774	773	772	771	770	769	768	767	766	765	764	763	762	761	760	759	758	757	756	755	754	753	752	751	750	749	748	747	746	745	744	743	742	741	740	739	738	737	736	735	734	733	732	731	730	729	728	727	726	725	724	723	722	721	720	719	718	717	716	715	714	713	712	711	710	709	708	707	706	705	704	703	702	701	700	699	698	697	696	695	694	693	692	691	690	689	688	687	686	685	684	683	682	681	680	679	678	677	676	675	674	673	672	671	670	669	668	667	666	665	664	663	662	661	660	659	658	657	656	655	654	653	652	651	650	649	648	647	646	645	644	643	642	641	640	639	638	637	636	635	634	633	632
--	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

ATTACHMENT 36 Financial Viability

Memorial Health
Obligated Group Balance Sheet
September 30, 2025
(Dollars in Thousands)

	SMH	JMH	EMH	TMH	MHC	Fibrinations	Obligated Group Total	Non-Obligated Group Total	Consolidated Total
Assets									
Current assets:									
Cash and cash equivalents	\$ 28,508	\$ 6,126	\$ 7,313	\$ 6,701	\$ 20,149	\$ -	\$ 68,936	\$ 7,758	\$ 76,697
Short-term investments	8,480	7,867	7,198	5,043	10,072	-	38,763	1,388	39,928
Assets where use is limited	2,656	-	-	-	8,802	-	11,058	358	11,116
Receivables:									
Net patient accounts receivable	119,662	27,136	12,911	10,677	-	-	170,719	53,712	224,131
Receivables from third-party payors	43,462	618	491	424	-	-	44,905	14,404	59,309
Due from affiliates	6,047	65	16	-	169,918	(3,761)	172,285	(172,285)	-
Other receivables	17,823	3,609	1,629	1,269	10,877	-	35,307	18,755	54,042
Inventories	18,128	2,113	694	411	-	-	21,346	5,406	26,752
Prepaid expenses	8,805	1,491	531	412	13,036	-	24,295	5,818	30,113
Total current assets	253,001	49,435	30,756	25,041	232,494	(3,761)	587,616	(64,926)	522,688
Long-term investments:									
Unrestricted investments	156,242	154,355	123,032	83,520	10,768	-	528,817	199,707	728,324
Assets where use is limited	1,455	2,867	-	-	59,438	-	63,860	37,452	101,312
Total long-term investments	157,697	157,222	123,032	83,520	70,206	-	592,677	237,159	829,836
Net property, plant, and equipment	265,670	51,960	22,100	47,452	172,078	-	559,195	251,552	799,837
Right of use asset - operating leases	3,325	-	267	-	3,667	-	7,259	16,391	13,640
Other assets:									
Investments in partnerships	-	-	-	-	503	-	503	7,238	7,741
Interest in net assets of foundation	17,080	1,289	38,623	6,749	-	-	63,741	(99,711)	-
Beneficial interest in trusts	40,791	23,456	-	-	-	-	64,247	44,391	108,638
Other	61	27	507	630	32,757	-	33,982	5,139	39,121
Total other assets	67,912	24,772	39,130	7,379	33,260	-	148,373	(42,973)	105,500
Total assets	\$ 768,236	\$ 289,519	\$ 216,185	\$ 163,392	\$ 511,699	\$ (3,761)	\$ 1,915,220	\$ -62,801	\$ 2,211,511
Liabilities and net assets									
Current liabilities:									
Long-term debt	\$ 8,314	\$ 1,174	\$ -	\$ 795	\$ 4,013	\$ -	\$ 14,596	\$ 40,051	\$ 54,647
Short-term borrowings	-	-	-	-	49,493	-	49,493	-	49,493
Operating lease liability - current portion	1,008	-	81	-	351	-	1,440	2,586	4,026
Accounts payable	71,377	5,693	2,667	2,694	18,799	-	105,870	32,901	138,771
Accrued payroll	32,842	5,231	2,820	2,790	17,342	-	61,015	24,520	85,535
Interest payable	2,148	306	320	320	413	-	3,187	3,187	3,187
Due to affiliates	37	(1,261)	1,249	1,263	1,764	(3,761)	1,813	(1,813)	-
Payables to third-party payors	31,748	5,248	812	858	-	-	38,666	14,764	53,430
Other	16,888	3,538	1,210	1,000	13,325	-	35,961	11,972	47,933
Total current liabilities	167,362	23,041	8,334	9,120	105,440	(3,761)	312,041	124,981	437,023
Noncurrent liabilities:									
Long-term debt obligations, net	178,609	9,079	-	13,241	43,829	-	244,758	(12,912)	252,415
Operating lease liability - noncurrent portion	2,327	-	187	-	3,382	-	5,896	1,418	7,315
Deferred compensation and benefits	-	-	-	-	29,453	-	29,453	-	29,453
Self-insurance accrued expenses	-	-	-	-	44,030	-	44,030	-	44,030
Accrued employee benefits	-	108	-	-	14,427	-	14,535	-	14,535
Other	109	9	-	-	-	-	204	493	697
Total noncurrent liabilities	181,134	9,193	187	13,241	127,691	-	328,876	2,000	361,454
Total liabilities	\$ 348,496	\$ 32,234	\$ 9,026	\$ 22,361	\$ 233,131	\$ (3,761)	\$ 640,917	\$ 126,981	\$ 800,477
Net assets									
Without donor restrictions	360,779	237,983	205,528	140,897	271,138	-	1,206,327	84,753	1,291,080
With donor restrictions	59,811	27,200	1,634	134	-	-	87,779	(53,976)	33,803
Total net assets	\$ 419,590	\$ 265,183	\$ 207,162	\$ 141,031	\$ 271,138	\$ -	\$ 1,294,106	\$ 30,777	\$ 1,324,883
Total liabilities and net assets	\$ 768,236	\$ 289,519	\$ 216,185	\$ 163,392	\$ 511,699	\$ (3,761)	\$ 1,915,220	\$ -62,801	\$ 2,211,511

ATTACHMENT 36 Financial Viability

Memorial Health

Obligated Group Statement of Operations and Changes in Net Assets

For the Year Ended September 30, 2025
(Dollars in Thousands)

	TMH	JMH	LHH	TMH	MHC	Elkhartview	Obligated Group Total	Non-Obligated Group Total	Consolidated Total
Gross patient service charges									
Inpatient charges	\$ 1,748,467	\$ 85,525	\$ 32,016	\$ 19,757	\$ -	\$ -	\$ 1,885,041	\$ 469,522	\$ 2,354,563
Outpatient charges	1,900,457	90,835	181,781	202,488	-	-	2,797,061	1,148,911	3,945,972
Total gross patient service charges	3,648,924	176,360	213,800	222,245	-	-	4,685,102	1,618,433	6,303,535
Deductions from charges									
Financial assistance (charity)	8,241	3,324	933	360	-	-	12,858	5,243	18,101
Explicit price concessions (contractual allowances)	2,720,810	428,361	140,859	142,064	-	-	3,432,094	1,220,100	4,652,194
Implicit price concessions (provision for doubtful accounts)	3,781	10,375	6,614	6,842	-	-	68,780	25,926	94,706
Total deductions from charges	2,732,832	442,060	148,406	149,266	-	-	3,409,532	1,251,269	4,660,801
Net patient service revenue	916,092	134,299	65,394	72,979	-	-	1,176,569	367,164	1,543,733
% of total gross patient service charges	24.9%	27.0%	31.3%	32.8%	-	-	25.1%	22.6%	24.4%
Capital asset revenue	-	-	-	-	-	-	-	94,726	94,726
Other revenues									
Management fees	13,248	861	(90)	144	99,623	(68,449)	26,544	(20,560)	6,011
Other	13,248	861	(90)	144	56,213	(52,113)	65,143	25,864	90,171
Total other revenues	26,496	1,722	(180)	288	155,836	(120,562)	91,687	5,304	96,182
Total revenues	942,588	136,021	65,214	73,267	155,836	(120,562)	1,268,256	427,768	1,696,024
Expenses									
Salaries and wages	310,001	43,339	21,869	20,779	72,880	-	447,969	242,137	690,106
Employee benefits	77,375	12,100	5,173	5,770	16,781	-	117,509	56,921	174,430
Physician fees	95,304	14,723	5,304	4,350	3	-	119,720	22,964	142,684
Medical	8,078	1,516	716	733	4,063	(962)	14,144	4,183	18,327
Pharmaceutical supplies	11,219	9,817	2,200	3,050	-	-	46,086	18,115	64,201
Food	-	-	-	-	-	-	-	7,718	7,718
Patient service supplies	(32,351)	8,489	2,011	3,613	-	-	11,062	18,123	29,185
System management fee	51,321	8,243	9,401	3,509	-	(6,513)	66,560	51,869	118,429
Purchased services and other	15,156	15,629	4,861	6,401	33,440	(5213)	64,463	19,681	84,144
Hospital provider assessment	10,440	1,500	3,324	2,774	-	-	68,449	33,365	101,814
Purchased medical services	-	-	-	-	-	-	-	18,857	18,857
Depreciation	26,742	9,836	3,841	6,421	13,439	-	69,391	(1,022)	68,369
Amortization of debt premiums, discounts, and issuance costs	(805)	21	-	(142)	(102)	-	(1,022)	-	(1,022)
Interest expense and other financing costs	9,619	345	-	665	1,500	-	13,029	4,683	17,712
Total expenses	602,237	101,873	40,900	51,223	135,276	(120,562)	526,224	290,796	817,020
Income (loss) from operations	340,351	34,148	24,314	22,044	20,560	-	741,932	136,972	878,904
% of total operating revenue	36.2%	25.1%	37.3%	30.1%	13.2%	-	58.5%	32.0%	52.4%
Nonoperating gains (losses)									
Interest and dividends	2,674	2,510	2,644	1,273	2,179	-	11,280	3,317	14,596
Realized gains (losses) on investments, net	9,405	5,416	6,220	3,026	2,936	-	27,833	4,319	32,152
Unrealized gains (losses) on investments, net	2,312	1,384	1,139	1,745	1,910	-	8,710	1,310	10,020
Change in interest in net assets of investees	2,150	-	1,339	455	-	-	4,525	(9,525)	(4,999)
Provision for income taxes	(1,456)	(244)	(10)	-	(190)	-	(2,090)	87	(1,999)
Net periodic benefit cost	-	(10)	-	-	(270)	-	(280)	(176)	(456)
Other revenue (expense), net	(1,752)	(376)	90	316	(5,103)	-	(5,215)	915	(4,299)
Total nonoperating gains (losses), net	3,533	8,511	11,244	6,789	2,745	-	11,341	5,333	16,674
Excess (deficiency) of revenues over expenses	\$ 343,884	\$ 42,659	\$ 35,558	\$ 28,833	\$ 23,305	\$ -	\$ 753,273	\$ 142,305	\$ 895,578
Excess margin %	36.5%	31.0%	37.7%	32.1%	15.0%	-	58.9%	33.4%	53.4%

ATTACHMENT 36

Financial Viability

Memorial Health

Obligated Group Statement of Operations and Changes in Net Assets (continued)

For the Year Ended September 30, 2025
(Dollars in Thousands)

	S MH	JMH	L MH	T MH	MHC	Philanthropy	Obligated Group Total	Non-Obligated Group Total	Consolidated Total
Net assets without donor restrictions									
Excess of revenues over expenses	\$ 23,736	\$ 24,999	\$ 23,108	\$ 21,999	\$ 2,755	\$	\$ 45,397	\$ (9,090)	\$ 36,307
Donation and other post-employment liability adjustments		5			(109)			(104)	(104)
Transfers (to) related organizations	(36,874)	(31,827)	(25,830)	(12,374)	(52,566)	79,253	(79,253)	79,219	
Transfers from related organizations	11,519	234	139	117	101,742	(79,253)	34,319	(34,519)	
Increase (decrease) in net assets without donor restrictions	8,381	(5,989)	(2,523)	9,692	51,822		61,383	(22,500)	38,883
Net assets with donor restrictions									
Contributions	354	50					410	2,631	3,041
Net investment gain (loss)		(873)					(873)	2,086	1,213
Net assets released from restrictions	(732)	(832)					(832)	(3,192)	(4,024)
Change in fair value of split-dollar agreements	32	7					39	323	362
Change in interest in endowment foundation	2,503	96	(376)	(79)			2,153	(2,153)	
Increase (decrease) in net assets with donor restrictions	2,157	(862)	(376)	(79)			1,301	(955)	346
Increase (decrease) in net assets	10,538	(6,746)	(2,909)	9,613	51,822		62,684	(23,455)	39,229
Net assets, beginning of period	408,832	361,981	210,038	131,829	319,316		1,231,616	171,424	1,403,040
Net assets, end of period	\$ 419,370	\$ 355,235	\$ 207,129	\$ 141,442	\$ 271,138	\$	\$ 1,294,300	\$ 147,969	\$ 1,442,269

ATTACHMENT 36 Financial Viability

Memorial Health
Obligated Group Statements of Cash Flows

For the Year Ended September 30, 2025
(Dollars in Thousands)

	SMH	JMH	LCH	TMH	NH-C	Pharmacia	Obligated Group Total	Non-Obligated Group Total	Consolidated Total
Cash flows from operating activities	\$ 10,414	\$ (6,796)	\$ (2,899)	\$ 4,627	\$ 10,432	\$ -	\$ 26,607	\$ (22,693)	\$ 3,914
Adjustments to reconcile changes in net assets to net cash provided by (used in) operating activities:									
Income and dividends	(2,676)	(2,100)	(2,049)	(1,271)	(7,479)	-	(15,375)	(1,315)	(16,690)
Realized (gain) loss on investments, net	(5,685)	(5,860)	(6,220)	(3,024)	(2,936)	-	(23,725)	(2,146)	(25,871)
Unrealized (gain) loss on investments, net	(2,312)	(1,584)	(1,199)	(1,745)	(1,193)	-	(8,133)	(2,691)	(10,824)
Revised contributions and other	(354)	(50)	-	-	-	-	(404)	(219)	(623)
(Increase) decrease in contractual interest in trusts	(72)	678	-	-	-	-	606	(6,657)	(6,051)
Depreciation	26,742	9,866	3,841	4,421	13,130	-	60,000	16,657	76,657
Amortization of debt issuance costs (premiums)	(895)	2	-	(112)	102	-	(1,022)	44	(978)
(Gain) loss on disposal of assets	(359)	9	30	64	(26,207)	-	(26,353)	44	(26,309)
Deferred tax expense	1	-	-	-	(22)	-	(21)	(261)	(280)
Provision for bad debt	-	159	-	-	109	-	268	104	372
Change in assets and liabilities									
(Increase) decrease in:									
Accounts receivable	6,853	3,814	(1,123)	(729)	-	-	8,815	5,623	14,438
Inventory, right of use asset, and other assets	(10,795)	(1,161)	(812)	(948)	-	-	(13,716)	(4,373)	(18,089)
Amount due from affiliates	748	(79)	(7)	218	(17,687)	1,761	(16,695)	16,061	(634)
Increase (decrease) in:									
Liabilities due to third-party payor settlements	(29,777)	(9,564)	(2,222)	724	-	-	(34,274)	(8,406)	(42,680)
Accounts payable and other current liabilities	23,890	4,822	2,364	1,446	8,999	-	41,711	9,931	51,642
Self-insurance and other long-term liabilities	2,751	(15)	187	-	(2,476)	-	509	(1,977)	(1,468)
Amount due to affiliates	(1,725)	(12,124)	165	(83)	1,167	(1,761)	(18,176)	3,812	(14,364)
Change in interest in net assets of subsidiaries	15,115	11,984	25,671	2,217	(26,171)	-	33,696	(18,660)	15,036
Transfer to (from) debt-equity sub-re	11,913	2,020	13,038	2,332	(15,133)	-	11,940	(1,272)	10,668
Net cash provided by (used in) operating activities	\$ 11,913	\$ 2,020	\$ 13,038	\$ 2,332	\$ (15,133)	\$ -	\$ 11,940	\$ (1,272)	\$ 10,668
Cash flows from investing activities:									
Acquisition of property and equipment	(14,255)	(5,121)	(3,030)	(2,854)	(21,511)	-	(67,800)	(2,190)	(70,000)
Proceeds on sale of property	1,293	61	-	-	47,627	-	49,981	317	50,298
Acquisition of debt in investments, net	24,400	(7,423)	1,655	(1,408)	75,029	-	91,243	3,820	95,063
Other investment activity, net	(162)	(64)	(25)	(136)	(413)	-	(1,000)	(56)	(1,056)
Change in investment in partnerships	-	-	-	-	27	-	27	(67)	(40)
Net change in other assets	-	-	-	-	(105)	-	(105)	(38)	(143)
Net cash provided by (used in) investing activities	\$ (7,321)	\$ (7,547)	\$ (1,400)	\$ (1,408)	\$ 20,705	\$ -	\$ 13,839	\$ (2,603)	\$ 11,236
Cash flows from financing activities:									
Repayment of debt	354	50	-	-	-	-	404	2,691	3,095
Repayment of long-term debt	(7,985)	(1,103)	-	(767)	(7,876)	-	(18,731)	(1,315)	(20,046)
Proceeds from short-term borrowings	-	10,645	-	-	-	-	10,645	-	10,645
Repayment of short-term borrowings	-	-	-	-	119,356	-	119,356	-	119,356
Repayment of long-term debt, net of debt issuance cost payments	-	(10,816)	-	-	(119,529)	-	(130,345)	-	(130,345)
Distributions from contractual interest in trusts	-	250	-	-	-	-	250	1,366	1,616
Distributions from contractual interest in trusts	9,487	(9,487)	(4,350)	67	(31,519)	-	(35,629)	15,625	(20,004)
Transfer to (from) debt-equity sub-re	2,332	(10,718)	(4,350)	(640)	(15,521)	-	(18,306)	35,411	17,105
Net cash provided by (used in) financing activities	\$ 2,458	\$ (1,656)	\$ (4,350)	\$ (700)	\$ (26,109)	\$ -	\$ (29,306)	\$ 14,707	\$ (24,548)
Net increase (decrease) in cash and cash equivalents and restricted cash	\$ 7,040	\$ (3,223)	\$ 5,238	\$ 514	\$ (10,507)	\$ -	\$ (7,366)	\$ 12,132	\$ 4,766
Cash, cash equivalents and restricted cash, beginning of period	\$ 40,515	\$ 6,726	\$ 1,341	\$ 6,761	\$ 26,109	\$ -	\$ 75,461	\$ 8,149	\$ 83,610
Cash, cash equivalents and restricted cash, end of period	\$ 47,555	\$ 3,503	\$ 6,579	\$ 7,275	\$ 15,592	\$ -	\$ 68,095	\$ 20,281	\$ 88,376
Cash & cash equivalents	\$ 28,598	\$ 6,026	\$ 7,243	\$ 6,762	\$ 20,168	\$ -	\$ 68,694	\$ 7,734	\$ 76,428
Restricted cash	1,957	-	-	-	-	-	1,957	1,547	3,504
Cash, cash equivalents and restricted cash, end of period	\$ 30,555	\$ 6,026	\$ 7,243	\$ 6,762	\$ 20,168	\$ -	\$ 70,651	\$ 9,281	\$ 80,000

ATTACHMENT 36 **Financial Viability**

EY | Building a better working world

EY is building a better working world by creating new value for clients, people, society and the planet, while building trust in capital markets.

Enabled by data, AI and advanced technology, EY teams help clients shape the future with confidence and develop answers for the most pressing issues of today and tomorrow.

EY teams work across a full spectrum of services in assurance, consulting, tax, strategy and transactions. Fueled by sector insights, a globally connected, multidisciplinary network and diverse ecosystem partners, EY teams can provide services in more than 150 countries and territories.

All in to shape the future with confidence.

EY refers to the global organization, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. Information about how EY collects and uses personal data and a description of the rights individuals have under data protection legislation are available via ey.com/privacy. EY member firms do not practice law where prohibited by local laws. For more information about our organization, please visit ey.com.

Ernst & Young LLP is a client-serving member firm of Ernst & Young Global Limited operating in the US.

© 2025 Ernst & Young LLP.
All Rights Reserved.

ey.com

ATTACHMENT 37 Economic Feasibility



Edmund M. Fay
Senior Vice President & Treasurer
9001 Liberty Parkway
Birmingham, AL 35242

205 970.7875
encompasshealth.com

August 20, 2026

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

**Re: Rehabilitation Institute of Springfield, LLC
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.120(a) Available Funds Certification
Criterion 1120.140A. Reasonableness of Financing Arrangements**

Dear Mr. Kniery,

In accordance with the verification requirements of 735 ILCS 5/1-109 of the Illinois Code of Civil Procedure, I hereby certify under the penalty of perjury the following:

1. Rehabilitation Institute of Springfield, LLC Project costs will be entirely funded by Encompass Health Corporation, an Applicant, from internal cash resources including cash and equivalents.
2. Encompass Health Corporation, an Applicant, will fund a portion of the necessary working capital and operating deficits through the first full fiscal year at which time the Project is expected to achieve the target utilization of 85% occupancy (*i.e.*, Project Year 2).
3. Encompass Health Corporation, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. In 2025, Encompass Health Corporation's operating activities generated \$1,175.6 Million and as of the end of 2025, the company had \$72.2 Million of unrestricted cash on its balance sheet. In addition, Encompass Health Corporation has at its discretion a \$1,000 Million Revolving Credit Facility, of which approximately \$746 Million was available as of June 30, 2026. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed Project. We have sufficient resources to fully fund these expenditures in addition to our other ongoing obligations.

ATTACHMENT 37
Economic Feasibility



Edmund M. Fay
Senior Vice President & Treasurer
9001 Liberty Parkway
Birmingham, AL 35242

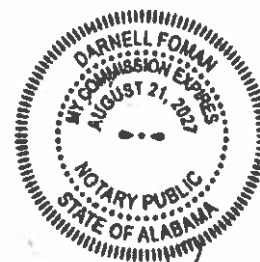
205.970.7875
encompasshealth.com

This letter shall also serve as a confirmation of our analysis of the funding options for this Project. Funding the Project through cash and securities is the lowest cost option. I hereby certify this is true and based upon my personal knowledge and under the penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely yours,

A handwritten signature in blue ink, appearing to read 'Edmund Fay', written over a light blue horizontal line.

Edmund Fay
Senior Vice President and Treasurer
Encompass Health Corporation



A handwritten signature in black ink, appearing to read 'Darnell Foman', written below the notary seal.

ATTACHMENT 37
Economic Feasibility



August 31, 2026

John Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street - Second Floor
Springfield, IL 62761-0001

Re: **Rehabilitation Institute of Springfield, LLC**
Application for Permit to Establish a New Rehabilitation Hospital
Criterion 1120.120(a) Available Funds Certification
Criterion 1120.140A. Reasonableness of Financing Arrangements

Dear Mr. Kniery,

In accordance with the verification requirements of 735 ILCS 5/1-109 of the Illinois Code of Civil Procedure, I hereby certify under the penalty of perjury the following:

1. Rehabilitation Institute of Springfield, LLC Project costs will be entirely funded by Encompass Health Corporation, an Applicant, from internal cash resources including cash and equivalents.
2. Memorial Health System, an Applicant, will fund a portion of the necessary working capital and operating deficits through the first full fiscal year at which time the Project is expected to achieve the target utilization of 85% occupancy (*i.e.*, Project Year 2).
3. Memorial Health System, an Applicant, has sufficient and readily accessible internal resources to fund the obligations required by the Project. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed Project. We have sufficient resources to fully fund these expenditures in addition to our other ongoing obligations.

This letter shall also serve as a confirmation of our analysis of the funding options for this Project. Funding the Project through cash and securities is the lowest cost option.

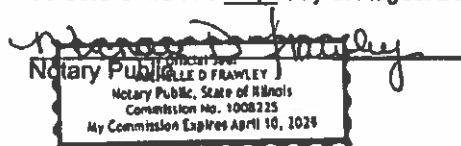
I hereby certify this is true and based upon my personal knowledge and under the penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

A handwritten signature in black ink that reads "Mandy C. Eaton".

Mandy C. Eaton
President and Chief Executive Officer
Memorial Health

SUBSCRIBED AND SWORN
To before me this 27 day of August 2026



340 W. Miller St.
Springfield, IL 62702
717-788-3000
memorial.health

Economic Feasibility*Rehabilitation Institute of Springfield, LLC***ATTACHMENT 37
Economic Feasibility**

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Sq. Ft. New Mod.		Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
New Construction	\$ 673.37	-	63,250	-	-	-	\$ 42,590,316	-	\$42,590,316
Contingency	\$ 55.34	-	63,250	-	-	-	\$ 3,500,000	-	\$3,500,000
TOTALS	\$ 728.71	-	63,250	-	-	-	\$ 46,090,316	-	\$46,090,316

* Include the percentage (%) of space for circulation

Projected Operating Costs

The projected operating costs for Rehabilitation Institute of Springfield in the first full fiscal year when the Project achieves target utilization are as follows:

Factor	CON Year 2
Salaries and Wages	\$ 15,548,400
Benefits	3,700,600
Supplies	1,398,300
Total Operating Costs	\$ 20,647,300
Patient Days	16,718
Cost per Day	\$ 1,235.03

Total Effect of the Project on Capital Costs

The projected capital costs for Rehabilitation Institute of Springfield in the first full fiscal year when the Project achieves target utilization are as follows:

Factor	CON Year 2
Depreciation	\$ 2,897,400
Total Capital Costs	\$ 2,897,400
Patient Days	16,718
Cost per Day	\$ 173.31

ATTACHMENT 38
Safety Net Impact Statement

Rehabilitation Institute of Springfield Safety Net Table		
	CON Year 1	CON Year 2
Charity Care		
# of Patients		
Inpatient	3	4
Outpatient	-	-
Total	3	4
Cost		
Inpatient	\$62,533	\$78,988
Outpatient	-	-
Total	\$62,533	\$78,988
Medicaid		
# of Patients		
Inpatient	94	135
Outpatient	-	-
Total	94	135
Net Revenue		
Inpatient	\$1,441,687	\$2,127,879
Outpatient	-	-
Total	\$1,441,687	\$2,127,879

ATTACHMENT 38
Safety Net Impact Statement

The Rehabilitation Institute of Southern Illinois (Shiloh)			
Indicator	2023	2024	2025
Charity Care			
# of Patients			
Inpatients	2	1	2
Outpatients	-	-	-
Total	2	1	2
Cost			
Inpatient	\$-	\$42,312	\$33,390
Outpatient	\$-	\$-	\$-
Total	\$-	\$42,312	\$33,390
Medicaid			
# of Patients			
Inpatient	109	95	127
Outpatient	-	-	-
Total	109	95	127
Net Revenue			
Inpatient	\$2,675,718	\$1,335,413	\$1,649,690
Outpatient	\$-	\$-	\$-
Total	\$2,675,718	\$1,335,413	\$1,649,690
Source: IL Annual Hospital Questionnaire.			

ATTACHMENT 38
Safety Net Impact Statement

Encompass Rehabilitation Institute of Libertyville			
Indicator	2023	2024	2025
Charity Care			
# of Patients			
Inpatients	3	2	1
Outpatients	-	-	-
Total	3	2	1
Cost			
Inpatient	\$68,470	\$41,451	\$17,057
Outpatient	\$-	\$-	\$-
Total	\$68,470	\$41,451	\$17,057
Medicaid			
# of Patients	2023	2024	2025
Inpatient	80	77	81
Outpatient	-	-	-
Total	80	77	81
Net Revenue			
Inpatient	\$741,584	\$1,092,291	\$1,151,510
Outpatient	\$-	\$-	\$-
Total	\$741,584	\$1,092,291	\$1,151,510
Source: IL Annual Hospital Questionnaire; Internal Records.			

ATTACHMENT 38 Safety Net Impact Statement

Van Matre Encompass Rehabilitation Hospital			
Indicator	2023	2024	2025
Medicaid			
# of Patients			
Inpatient	226	222	206
Outpatient	-	-	-
Total	226	222	206
Net Revenue			
Inpatient	\$3,665,039	\$3,444,891	\$2,863,145
Outpatient			
Total	\$3,665,039	\$3,444,891	\$2,863,145
Source: IL Annual Hospital Questionnaire.			
Note: no charity care was provided 2023 – 2025.			

The Quad Cities Rehabilitation Institute			
Indicator	2023	2024	2025
Charity Care			
# of Patients			
Inpatients	-	-	1
Outpatients	-	-	-
Total	-	-	1
Cost			
Inpatient	\$-	\$-	\$52,086
Outpatient	\$-	\$-	\$-
Total	\$-	\$-	\$52,086
Medicaid			
# of Patients			
Inpatient	43	69	69
Outpatient			-
Total	43	69	69
Net Revenue			
Inpatient	\$175,555	\$825,237	\$852,749
Outpatient	\$-	\$-	\$-
Total	\$175,555	\$825,237	\$852,749
Source: IL Annual Hospital Questionnaire.			

ATTACHMENT 38

Safety Net Impact Statement

Memorial Medical Center DBA Springfield Memorial Hospital			
Indicator	2023	2024	2025
Charity Care			
# of Patients			
Inpatients	123	106	131
Outpatients	1,116	1,202	894
Total	1,308	1,308	1,025
Cost			
Inpatient	\$1,495,880	\$2,537,215	\$4,345,877
Outpatient	\$1,043,733	\$1,929,394	\$2,265,169
Total	\$2,539,613	\$4,466,609	\$6,611,046
Medicaid			
# of Patients			
Inpatient	3,860	3,609	3,675
Outpatient	106,000	92,349	85,243
Total	109,860	95,958	88,918
Net Revenue			
Inpatient	\$58,497,024	\$58,422,866	\$71,871,283
Outpatient	\$77,304,360	\$63,259,344	\$99,333,563
Total	\$135,801,384	\$121,682,210	\$171,204,846
Source: IL Annual Hospital Questionnaire.			

ATTACHMENT 38 Safety Net Impact Statement

Jacksonville Memorial Hospital			
Indicator	2023	2024	2025
Charity Care			
# of Patients			
Inpatients	15	14	10
Outpatients	421	327	401
Total	436	341	411
Cost			
Inpatient	\$123,322	\$79,204	\$230,868
Outpatient	\$358,281	\$187,427	\$696,399
Total	\$481,603	\$266,631	\$927,267
Medicaid			
# of Patients			
Inpatient	465	513	378
Outpatient	21,973	20,296	19,636
Total	22,438	20,809	20,014
Net Revenue			
Inpatient	\$5,075,520	\$4,309,981	\$6,766,462
Outpatient	\$23,538,452	\$22,897,028	\$23,967,848
Total	\$28,613,972	\$27,207,009	\$30,734,310
Source: IL Annual Hospital Questionnaire.			

ATTACHMENT 38
Safety Net Impact Statement

Lincoln Memorial Hospital			
Indicator	2023	2024	2025
Charity Care			
# of Patients			
Inpatients	38	8	1
Outpatients	1,338	139	128
Total	1,376	147	129
Cost			
Inpatient	\$13,142	\$13,836	\$16,640
Outpatient	\$815,601	\$229,008	\$216,689
Total	\$828,743	\$242,844	\$233,329
Medicaid			
# of Patients			
Inpatient	47	37	29
Outpatient	11,540	9,893	8,960
Total	11,587	9,930	8,989
Net Revenue			
Inpatient	\$792,571	\$680,494	\$405,176
Outpatient	\$10,271,547	\$7,712,299	\$8,712,843
Total	\$11,064,118	\$8,392,793	\$9,118,019
Source: IL Annual Hospital Questionnaire.			

ATTACHMENT 38
Safety Net Impact Statement

Taylorville Memorial Hospital			
Indicator	2023	2024	2025
Charity Care			
# of Patients			
Inpatients	38	0	1
Outpatients	1,338	77	49
Total	1,376	77	50
Cost			
Inpatient	\$11,256	\$8,836	\$6,579
Outpatient	\$580,002	\$197,467	\$93,943
Total	\$591,258	\$206,303	\$100,522
Medicaid			
# of Patients			
Inpatient	20	24	27
Outpatient	8,771	8,151	7,786
Total	8,791	8,175	7,813
Net Revenue			
Inpatient	\$204,148	\$54,872	\$211,127
Outpatient	\$8,987,194	\$7,903,946	\$8,801,017
Total	\$9,191,342	\$7,958,818	\$9,012,144
Source: IL Annual Hospital Questionnaire.			

ATTACHMENT 38 Safety Net Impact Statement

Decatur Memorial Hospital			
Indicator	2023	2024	2025
Charity Care			
# of Patients			
Inpatients	12	65	64
Outpatients	126	767	732
Total	138	832	796
Cost			
Inpatient	\$59,852	\$250,978	\$1,306,723
Outpatient	\$139,656	\$239,029	\$1,385,124
Total	\$199,508	\$490,007	\$2,691,847
Medicaid			
# of Patients			
Inpatient	1,391	1,414	1,620
Outpatient	51,366	50,860	52,618
Total	52,757	52,274	54,238
Net Revenue			
Inpatient	\$19,849,525	\$18,844,698	\$19,567,996
Outpatient	\$37,153,829	\$33,990,004	\$55,458,956
Total	\$57,003,354	\$52,834,702	\$75,026,952
Source: IL Annual Hospital Questionnaire.			

Charity Care Information
Rehabilitation Institute of Springfield, LLC

ATTACHMENT 39
Charity Care Information

Rehabilitation Institute of Springfield		
	CON Year 1	CON Year 2
Net Patient Revenue	\$20,883,400	\$30,823,300
Amount of Charity Care (Charges)	\$105,793	\$156,146
Cost of Charity Care	\$62,533	\$78,988
Charity Care Cost % of Net Pat Rev	0.3%	0.3%

The Rehabilitation Institute of Southern Illinois (Shiloh)			
Charity Care Factor	2023	2024	2025
Net Patient Revenue	\$13,818,701	\$22,282,534	\$24,061,714
Amount of Charity Care (Charges)	-	-	\$65,243
Cost of Charity Care	-	42,312	\$33,390
Charity Care Cost % of Net Pat Rev	0.0%	0.2%	0.1%
Source: IL Annual Hospital Questionnaire; Internal Records.			

Encompass Rehabilitation Institute of Libertyville			
Charity Care Factor	2023	2024	2025
Net Patient Revenue	\$17,119,887	\$23,753,965	\$30,745,174
Amount of Charity Care (Charges)	\$94,826	\$69,074	\$28,966
Cost of Charity Care	\$68,470	\$41,451	\$17,057
Charity Care Cost % of Net Pat Rev	0.4%	0.2%	0.1%
Source: IL Annual Hospital Questionnaire; Internal Records.			

Van Matre Encompass Health Rehabilitation Hospital			
Charity Care Factor	2023	2024	2025
Net Patient Revenue	\$33,102,590	\$34,172,285	\$35,156,857
Amount of Charity Care (Charges)	-	-	-
Cost of Charity Care	-	-	-
Charity Care Cost % of Net Pat Rev	0.0%	0.0%	0.0%
Source: IL Annual Hospital Questionnaire.			

Charity Care Information*Rehabilitation Institute of Springfield, LLC*

ATTACHMENT 39

Safety Net Impact Statement

The Quad Cities Rehabilitation Institute			
Charity Care Factor	2023	2024	2025
Net Patient Revenue	\$3,725,086	\$15,406,562	\$18,098,734
Amount of Charity Care (Charges)	-	-	\$56,509
Cost of Charity Care	-	-	\$52,086
Charity Care Cost % of Net Pat Rev	0.0%	0.0%	0.3%
Source: IL Annual Hospital Questionnaire; Internal Records.			

Charity Care Springfield Memorial Hospital

The amount of charity care provided by Springfield Memorial Hospital for the last three **audited** fiscal years, the cost of charity care and the ratio of charity care cost to net patient revenue are shown below. 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 – Springfield Memorial Hospital			
	FY 2023	FY 2024	FY 2025
Net Patient Service Revenue	\$783,972,009	\$815,445,499	\$889,212,969
Amount of Charity Care (charges)	\$10,553,179	\$20,184,399	\$28,836,211
Cost of Charity Care	\$2,539,613	\$4,466,609	\$6,611,046
Ratio of Cost of Charity Care to Net Patient Service Revenue	0.32%	0.55%	0.74%

Charity Care – Memorial Health

The amount of charity care provided by Memorial Health Affiliates - Decatur Memorial Hospital, Springfield Memorial Hospital, Taylorville Memorial Hospital, Lincoln Memorial Hospital and Jacksonville Memorial Hospital - for the last three **audited** fiscal years, the cost of charity care and the ratio of charity care cost to net patient revenue are shown below.

CHARITY CARE - Memorial Health System			
	FY 2023	FY 2024	FY 2025
Net Patient Service Revenue	\$1,239,767,862	\$1,402,527,484	\$1,513,774,168
Amount of Charity Care (charges)	\$14,100,043	\$26,259,884	\$46,446,003
Cost of Charity Care	\$4,640,725	\$5,672,394	\$10,564,011
Ratio of Cost of Charity Care to Net Patient Service Revenue	0.37%	0.40%	0.70%

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1.	Applicant Identification including Certificate of Good Standing	33-43
2.	Site Ownership	44-49
3.	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership	50-52
4.	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	53-55
5.	Flood Plain Requirements	56-58
6.	Historic Preservation Act Requirements	59-63
7.	Project and Sources of Funds Itemization	64-65
8.	Financial Commitment Document if required	66
9.	Cost Space Requirements	67-70
10.	Discontinuation	N/A
11.	Background of the Applicant	71-77
12.	Purpose of the Project	78-151
13.	Alternatives to the Project	152-153
14.	Size of the Project	154-160
15.	Project Service Utilization	161
16.	Unfinished or Shell Space	162
17.	Assurances for Unfinished/Shell Space	163
18.	Master Design and Related Projects	N/A
Service Specific:		
19.	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
20.	Comprehensive Physical Rehabilitation	164-218
21.	Acute Mental Illness	N/A
22.	Open Heart Surgery	N/A
23.	Cardiac Catheterization	N/A
24.	In-Center Hemodialysis	N/A
25.	Non-Hospital Based Ambulatory Surgery	N/A
26.	Selected Organ Transplantation	N/A
27.	Kidney Transplantation	N/A
28.	Subacute Care Hospital Model	N/A
29.	Community-Based Residential Rehabilitation Center	N/A
30.	Long Term Acute Care Hospital	N/A
31.	Clinical Service Areas Other than Categories of Service	N/A
32.	Freestanding Emergency Center Medical Services	N/A
33.	Birth Center	N/A
Financial and Economic Feasibility:		
34.	Availability of Funds	219-222
35.	Financial Waiver	N/A
36.	Financial Viability	223-332
37.	Economic Feasibility	333-336
38.	Safety Net Impact Statement	337-345
39.	Charity Care Information	346-347