ENCOMPASS HEALTH REHABILITATION HOSPITAL OF SOUTHERN MARYLAND, LLC

A 60 Bed Inpatient Rehabilitation Hospital

APRIL 20, 2018

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For internal staff use

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Encompass Health Rehabilitation Hospital of Southern Maryland

Address:

Melford Blvd. & Marconi Dr.	(Southeast Corner) Bowie	20715	PG
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: Encompass Health Rehabilitation Hospital of Southern Maryland, LLC

3. APPLICANT. ***If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.***

Legal Name of Project Applicant
Encompass Health Rehabilitation Hospital of Southern Maryland, LLC

Address: The Corporation Trust Incorporated

2405 York Road	Lutherville	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: (205) 967-7116

Name of Owner/Chief Executive: Encompass Health Corporation (See Organizational Chart at Exhibit 1)

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐
B.	Corporation	
	(1) Non-profit	☐
	(2) For-profit	☐
	(3) Close	☐ State & date of incorporation ☐
C.	Partnership	
	General	☐
	Limited	☐
	Limited liability partnership	☐
	Limited liability limited partnership	☐
	Other (Specify):	
D.	Limited Liability Company	☒
E.	Other (Specify):	
	To be formed:	☐
	Existing:	☒

PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Walter Smith, Director, State Regulatory Affairs, Encompass Health

Mailing Address:

9001 Liberty Parkway	**Birmingham**	**35242**	**AL**
Street	City	Zip	State

Telephone: **(205) 970-7926**
E-mail Address (required): **walter.smith@encompasshealth.com**
Fax: **(205) 262-4292**

B. Additional or alternate contact:

Name and Title: Carolyn Jacobs, Jacobs & Dembert, P.A.

Mailing Address:

One South Street, Suite 2100	**Baltimore**	**21202**	**MD**
Street	City	Zip	State

Telephone: **(410) 727-4433**
E-mail Address (required): **cjacobs@jdlaw.com**
Fax: **(410) 752-8105**

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1) A new health care facility built, developed, or established ☒
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: ☐
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

See Attached – 8A

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

See Attached – 8B

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

8. Project Description

A. EXECUTIVE SUMMARY

(1) Brief description of the project - what the applicant proposes to do

Encompass Health Rehabilitation Hospital of Southern Maryland, LLC, a Delaware limited liability company ("EHRHSM") and an indirect subsidiary of Encompass Health Corporation (formerly known as HealthSouth Corporation and referred to herein as "Encompass Health") (see Exhibit 1) proposes to build a new 60-bed acute inpatient rehabilitation special hospital in Bowie, Prince George's County (the "Project") to serve the Southern Maryland Health Planning Region and the southern communities of Anne Arundel County (together the "Southern Maryland Region"). The Project will be particularly well-positioned to support residents of the Southern Maryland Region and the new University of Maryland Capital Regional Medical Center (the former Dimensions Health System) to be built in Largo. EHRHSM anticipates the full support of the University of Maryland Medical System. See Exhibit 2, Letter of Support from Robert Chrencik, President and Chief Executive Officer, University of Maryland Medical System.

As a CARF and Joint Commission accredited inpatient rehabilitation hospital ("IRF"), EHRHSM will provide qualified patients with three (3) hours of intensive therapy daily, close medical oversight by rehabilitation physicians including a minimum of face-to-face visits three (3) times weekly, the availability of 24/7 nursing care by registered nurses, many of whom are Certified Rehabilitation Registered Nurses (CRRNs), as well as physical therapists, occupational therapists, and speech therapists. These specialized services will permit admission of medically complex patients and help shorten acute care lengths of stay at the acute care hospital. The Project will have state-of-the-art rehabilitation technology and architectural design.

Evidence indicates that intensive rehabilitation in an IRF produces superior outcomes for appropriate patients with certain diagnoses compared to rehabilitation care provided in skilled nursing facilities. Studies also have shown that inpatient stays in an IRF correlate with shorter acute care hospital stays, lower readmission rates, fewer ER visits, higher return rate to the community, and lower total costs of care. Based on this evidence, the American Heart Association and American Stroke Association published clinical practice guidelines (2016) (see Exhibit 3) specifying that stroke patients are best served at settings with intensive multidisciplinary treatment to maximize patients' rehabilitation potential in an IRF setting. Given both the evidence and the formal clinical practice guidelines, residents of the Southern Maryland Region should have access to intensive rehabilitation in the IRF setting. Moreover, the delivery of high quality cost effective care requires access to all levels of post-acute care; especially care designed to return patients to the community at optimal functional levels.

Although EHRHSM will admit adult patients over 18 years of age, most inpatient rehabilitation patients are over 65 years of age ("over-65"). The average age for Encompass

Health IRF patients is 71 years (with an average of 76 years for Medicare fee for service patients). Encompass Health defines high potential rehabilitation diagnoses ("HPRDs") based on DRGs and ICD-10 codes that have historically accounted for more than 60% of discharges to its rehabilitation hospitals.[1] High potential rehabilitation diagnoses include patient cohorts with the following diagnoses:

1. Stroke
2. Brain injury
3. Amputation
4. Spinal cord
5. Fracture of the femur
6. Neurological disorder
7. Multiple trauma
8. Congenital deformity
9. Burns
10. Osteoarthritis (after less intensive setting)
11. Rheumatoid arthritis (after less intensive setting)
12. Joint replacement (if Bilateral, Age $\geq$ 85 or Body Mass Index >50)
13. Systemic vasculitides (after less-intensive setting)

The goals for all Encompass Health hospitals across the country are aligned with the goals of the Maryland waiver: readmission reduction, timely discharge to the community, and lower costs of care. The track record of Encompass Health along these performance measures is stellar relative to industry benchmarks.

(2) Rationale for the Project - the need and/or business case for the proposed project

The Southern Maryland Region is home to nearly 1.4 million people and is one of the fastest growing regions in the State, particularly for the over-65 population. By Calendar Year 2023, there will be nearly 70,000 additional over-65 residents in the Southern Maryland Region representing 16% of the total population (and growing at more than 5% annually). Use rates for acute rehabilitation in the Southern Maryland Region are among the lowest use rates in the State presumably as a result of the lack of access to rehabilitation services. Moreover, and notwithstanding this large and growing over-65 population, there is only one acute rehabilitation program in the Southern Maryland Region, a 28-bed hospital-based rehabilitation unit operating at University of Maryland Laurel Regional Hospital ("Laurel Regional"), and there is no freestanding IRF in the Southern Maryland Region. Furthermore, soon there will be fewer resources for the Southern Maryland Region. The University of Maryland Capital Region Health

[1] These cohort definitions are aligned with CMS definitions for "CMS13" cohorts admitted to rehabilitation programs: CMS regulation requires that at least 60% of acute rehabilitation program admissions are represented by these CMS13 diagnoses. Therefore, these cohort definitions provide a relevant base for projecting market demand for acute rehab services.

("UM Capital Region") has provided notice to the Maryland Health Care Commission that with respect to the 28-beds at Laurel Regional, UM Capital Region intends to relocate ten (10) of those beds to University of Maryland Prince George's Hospital Center and intends to provide notice of temporary de-licensure of the remaining 18 beds prior to such relocation. Given the lack of resources in the Southern Maryland Region, 90% of service area patients (more than 1,400 patients) travel out of area for inpatient rehabilitation services; and more than half of these patients (853 patients) travel as far as the District of Columbia to receive IRF care.

(3) Cost - the total cost of implementing the proposed project

The total cost of implementing the proposed project is $ $36,698,893.

(4) Master Facility Plans - how the proposed project fits in long term plans

The Project fits well within Encompass Health's long-term plans. Demographic trends, such as over-65 population aging, should increase long-term demand for facility-based and home-based post-acute care services; the number of Medicare enrollees nationally is expected to grow approximately 3% per year for the foreseeable future, while the compound annual growth rate or "CAGR" for the population in Encompass Health's average patient age range is ~5%. Encompass Health believes the demand for facility-based and home-based post-acute care services will continue to increase as the U.S. population ages. These factors align with Encompass Health's strengths in, and focus on, post-acute services. In addition, Encompass Health's business model includes plans to meet the demand for facility-based post-acute care services in markets where it currently does not have a presence by constructing or acquiring new hospitals.

As set forth herein, the Southern Maryland Region is underserved for inpatient rehabilitation. Furthermore:

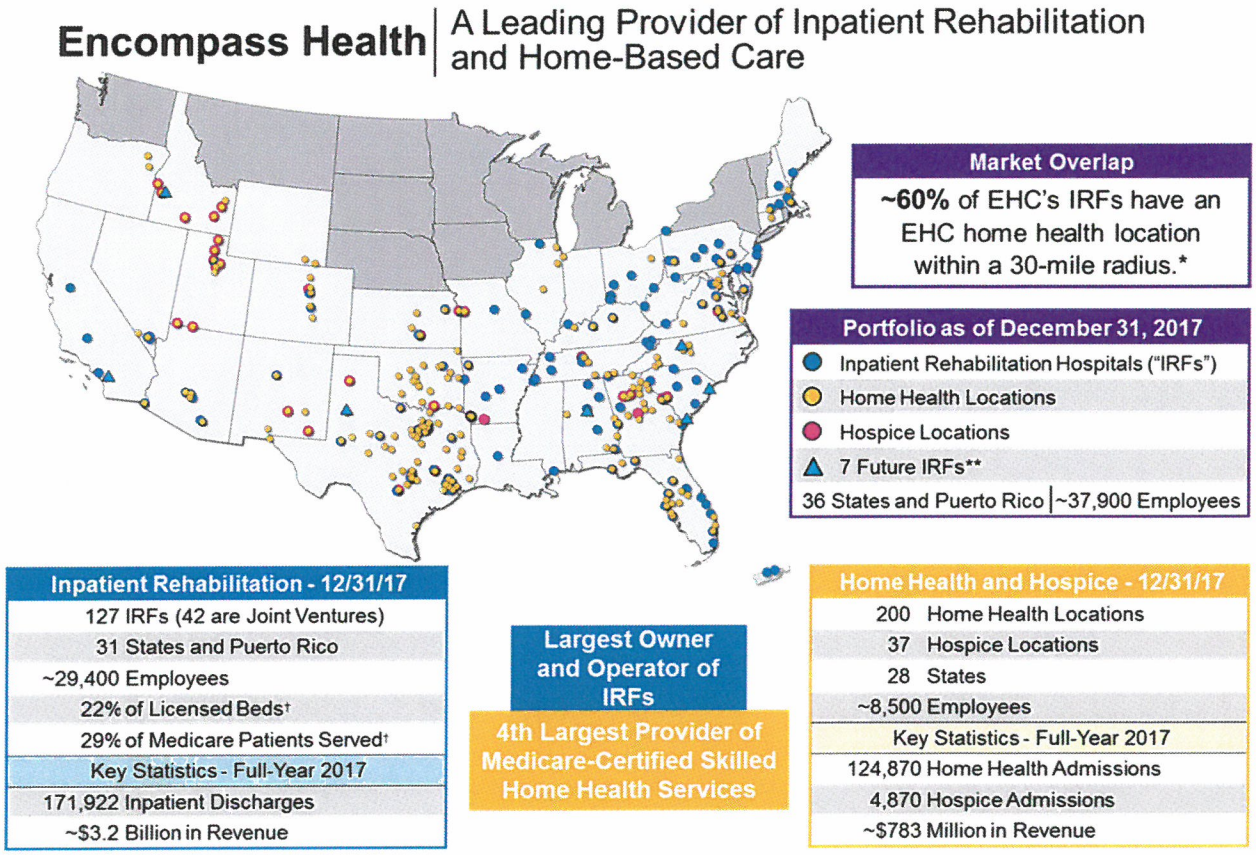
- Encompass Health routinely searches for markets that are underserved for inpatient rehabilitation based on a wide variety of factors in the projected service area including: demographics favorable to the patient population served, current distance and drive times to high-quality, comparable existing providers, and if the state recognizes the need based on their need methodology.

- Bowie, Maryland will be an excellent addition to Encompass Health's Mid-Atlantic Region which currently includes 19 hospitals in five (5) states, including locations in Salisbury, Maryland; Fredericksburg, Virginia; and Aldie, Virginia.

(5) Encompass Health

Encompass Health is the result of the union between HealthSouth Corporation and Encompass Home Health & Hospice The name Encompass Health signals a commitment to creating a seamless system where high-quality care is coordinated by clinical teams across the inpatient and home settings. (Please note that the name of all "HealthSouth" hospitals referenced in this Application have been or will be changed to Encompass Health.)

As a national leader of inpatient rehabilitation hospitals and home-based care, Encompass Health (NYSE:EHC) offers facility-based and home-based patient care through its network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. Encompass Health has a national footprint (as of 3/13/2018) that spans 127 hospitals and 237 home health & hospice agencies in 36 states and Puerto Rico (including HealthSouth Chesapeake in Salisbury, Maryland):



Encompass Health is ranked as one of Fortune's 100 Best Companies to Work For, as well as Modern Healthcare's Best Places to Work. Encompass Health is uniquely positioned to coordinate care across the healthcare continuum by leveraging its clinical and operational

expertise and its advanced information technology to serve as a value-added partner to acute care hospitals, physicians, and payors.

Encompass Health is committed to delivering high-quality, cost-effective care across the post-acute continuum. As the health care delivery system continues to evolve, providers must be able to adapt to changes, build strategic relationships across the health care continuum, and consistently provide high quality, cost effective patient care to remain successful. The Encompass Health foundation is strong and Encompass Health is well positioned for continued success in this evolving environment. Encompass Health is proud of "The Encompass Health Way":

Our Purpose & Core Values

At Encompass Health, we are committed to delivering connected care and superior outcomes. We believe integrated care delivery across the healthcare continuum is critical to achieving the best outcomes for patients. We exist to provide a better way to care that elevates expectations and outcomes.

THE ENCOMPASS HEALTH WAY

Set the standard

We are committed to going above and beyond, never settling for anything less than excellence. We pride ourselves on being industry leaders and challenge ourselves to continuously improve.

Lead with empathy

We start with empathy, taking the time to understand the physical, mental and emotional needs of each other and those we support. We listen, make deep connections and engage on a personal level to better serve others.

Do what's right

We do the right thing the right way, no matter how difficult, even when no one is looking. We're not afraid to have hard conversations. If we make a mistake, we acknowledge it, proactively find a resolution and make it right going forward.

Focus on the positive

We have a positive spirit and find the light even in the most difficult situations. We bring our whole self to work. We celebrate successes and inspire others to create meaningful impact.

Stronger together

We believe our individual strengths make us stronger together. We take accountability for our actions, connect across all teams and lean in to get it done - at all levels of the company.

8. Project Description

B. COMPREHENSIVE PROJECT DESCRIPTION

The proposed project is a new freestanding 60-bed inpatient rehabilitation hospital. The new construction will be a single story 61,810 square foot building. It will be designed with 60 private rooms. It will have at a minimum, 60 patient beds, kitchen, patient dining room, occupational and physical therapy services, day room, medical records, business office, nurse station with medication room, nourishment area, clean and soiled utilities, staff lounge and dictation area. The hospital will be fully sprinklered, designed and constructed to meet all applicable requirements of the International Building Code and National Fire Protection Agency.

SPECIAL FUNCTION DESCRIPTIONS

A. Patient Rooms: The patient room design is a model utilized on all new Encompass Health facilities. The layout has been refined over the years to allow the patient maximum mobility in the room. The private room area, including casework and bathroom, is 247 NSF. This allows the room to meet all national handicap requirements and at the same time provide the patient with visual privacy. The patient toilet layout utilizes a roll-in shower allowing the patient the ability to shower with minimum assistance from the nursing staff. An additional sink is located in the patient room which allows the patient and staff access to the sink without having to enter the toilet room. The patient wardrobe is designed for access for a wheelchair and has room to store patient belongings.

B. Finishes: The color scheme will enhance the patient's quality of life and aid in the recovery. The patient room will have three walls of one color of paint and the head wall will be of an accent color that will be pleasing to the patient. The corridors walls will have coordinated paint colors that match the scheme developed for the patient rooms.

C. Resident choices of furniture and decoration: All patient rooms allow for the patient to display personal items such as cards and flowers. The standard furniture layout includes a bed, patient wardrobe, beside table and a visitor's chair.

D. Resident/staff communication: Each patient bed will have access to a nurse call pull station. Nurse call pull stations will also be located in toilets, tub rooms, dayroom and therapy spaces. Each patient room will be equipped with a phone.

E. Design for privacy: Each patient room has a handicap accessible bathroom with shower directly off the patient room.

F. Residence independence: The layout of the proposed hospital unit allows for the self-motivation of patients. The facility will be designed to meet 100% of the applicable provisions of the Americans with Disabilities Act.

BUILDING SYSTEMS

The proposed structural system will be a combination of brick veneer exterior walls and steel framing. Interior columns will be structural steel and roof construction will be steel framing with metal roof decking. The hospital will be fully sprinklered and designed and constructed to meet all the applicable requirements of the current International Building Code.

The mechanical system will be packaged direct expansion cooling with variable air volume supply and electric heating to meet the building cooling and heating needs. The system will be designed in accordance with the current edition of the International Mechanical Code. The electrical systems will be provided with a 480-277 V electrical service with all appropriate 120/208 V systems as required to meet the lighting, power and equipment needs of the facility. The electrical systems will be designed to meet the current edition of the National Electric Code and National Fire Alarm code.

PATIENT SAFETY

Encompass Health Rehabilitation Hospitals train all medical staff and employees on the significance of patient safety. Encompass Health utilizes a Patient Safety Task Force as described below:

- Task Force is comprised of multidisciplinary group that meets monthly by phone and annually face-to-face to focus on patient safety initiatives
- Members represent all areas within the organization such as nurses, therapists, dieticians plant engineers, case managers and quality and risk and operations
- Each year the group defines a set of patient safety projects and divides into work groups to collect data, research industry best practices, and develop innovative strategies to improve patient safety in these areas

In addition, Encompass Health developed and has implemented the "STOP" program (Stop, Think, Organize, Position)

- Encompass Health's culture of safety focused on safe patient mobilization
- The focus is on frequent assessment to ensure the safest possible transfer at the bedside
- Smart slide sheets, lifts and slings are considered personal protective equipment (PPE)

Design features such as appropriate floor material and finishes, critically placed handrails, strategically placed lighting to assist in patient movement, and a centrally located nurse station for quick response and visual control are just a few features that have evolved from constant review and development of Encompass Health standards.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 6.45 acres

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO __X__ (If NO, describe below the current status and timetable for receiving necessary approvals.)

See Exhibit 4

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: _____
Please provide a copy of the deed.

(2) Options to purchase held by: _____
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

(5) Other: Letter of Intent
Explain and provide legal documents as an attachment.

See Letter of Intent at Exhibit 5 (Purchase and Sale Agreement is being finalized)

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	10	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	1	months
Completion of project from capital obligation or purchase order, as applicable	18	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

See Project Drawings and Site Plan at Exhibit 6

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

See Exhibit 7

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Note Response: The estimates of cost for the Project are based on historical data using two recent Encompass Health (formerly HealthSouth) projects adjusting for location. These are two recent projects of a similar size, adjusted for location. The cost of construction was determined to be $275 per square foot. Because this estimate was derived from last year's averages and construction is not anticipated to commence until 2019, an adjustment for inflation was added to arrive at the $289 per square foot used in the application.

The source for additional costs, such as the cost of equipment, is based on the experience of Encompass Health in building and equipping 127 hospitals and its significant purchasing power to purchase such items. Encompass Health adds four (4) to six (6) hospitals per year to its portfolio.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project.

   (a) Owner - Encompass Health Corporation (See Exhibit 1)
   (b) Individual Responsible - Edward Mowen, Regional President - MidAtlantic Region

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

   See Exhibit 8

3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions)? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   No

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

See Exhibit 9

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

4/20/2018
Date

Edward Mowen
Signature of Owner or Board-designated Official

Encompass Health, Regional President, Mid-Atlantic
Position/Title

Edward Mowen
Printed Name

PART IV

CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)

COMAR 10.24.01.08G(3)(b) Need

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs

(A) Introduction: Key Terms/Definitions/Technical Notes

For purposes of the discussion below, the following definitions are provided:

Inpatient Rehabilitation Facility (IRF) - According to the Medicare Payment Advisory Commission, an inpatient rehabilitation hospital (IRF) provides intensive rehabilitation services to patients after an illness, injury, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech-language pathology, and prosthetic and orthotic services. Reference to an IRF in this market refers to HealthSouth Chesapeake Rehabilitation Hospital ("HealthSouth Chesapeake"), Adventist HealthCare Rehabilitation ("Adventist"), MedStar National Rehabilitation Hospital ("NRH"), and George Washington University Rehabilitation Program ("GWU"). The University of Maryland Orthopaedic and Rehabilitation Institute does not hold IRF status and is licensed as an acute care hospital, but is Joint Commission certified and CARF-accredited with specialty accreditation for Brain Injury and Spinal Cord Injury System of Care and Comprehensive Integrated Inpatient Rehabilitation Program.

Acute Rehabilitation Discharges, HSCRC Abstract Data - Acute rehabilitation discharges in CY2016 are documented based on the definitions provided by the Emergency Proposed Regulations for Acute Inpatient Rehabilitation Services[2] (COMAR 10.24.09). The definition for acute rehabilitation discharges in CY2016 is based on (a) Nature of Admission code or (b) the Daily Service Code, regardless of DRG. The definition for acute rehabilitation cases prior to ICD10 adoption is based on earlier COMAR regulations. For Adventist and HealthSouth Chesapeake in Maryland, total discharges for patients age 18+ years in CY2012-2015 have been counted as acute rehabilitation volume, per direction from MHCC staff. Finally, the volume of acute rehabilitation discharges from Johns Hopkins Bayview Medical Center was provided to Encompass Health as a separate dataset from MHCC staff.

Acute Rehabilitation Discharges, DCHA Database - For CY2012-2015 prior to ICD-10 adoption, acute rehabilitation discharges were defined consistent with COMAR regulation. However, for Quarter 4 of CY2015 (under ICD10 coding), total discharge volume at MedStar

[2] Proposed Emergency Regulations, November 16, 2017

NRH was classified as rehabilitation irrespective of coding.[3] For CY2016, a database of acute rehabilitation discharges for Washington, DC hospitals was provided. For purposes of most analyses in this application, discharges for patients age 18+ were examined (see below).

Adult Discharges - All references to adult discharges mean age 18+ years, consistent with the State Health Plan age cohort divisions for acute rehabilitation. For purposes of consistent analyses across the Maryland and the District of Columbia market, most analyses are presented for the adult population.

Base Year - All use rate and market share analyses are based on CY2016 data, representing the most current year for which data was made available for DCHA hospitals and Medicare claims analyses.

CMS13 Discharges - These are clinical cohorts that have been defined by CMS in context of IRF program operations and reimbursement. The Medicare program requires that 60% of the Medicare discharges at IRFs must have one of these 13 diagnoses if the rehabilitation program is to qualify for payment as an Inpatient Rehabilitation Facility. This CON application refers to these diagnoses as CMS 13 discharges. At Encompass Health hospitals nationally, approximately 67% of discharges are classified as CMS 13 discharges.

This same classification method is routinely adopted by Encompass Health to analyze potential referral volume from acute care hospitals. While CMS 13 categories are not recognized by Medicare for any purpose in general acute care hospitals, Encompass Health uses a set of DRG/ICD-10 groupings to align with CMS 13 groupings; these acute care codes serve to identify "high potential rehabilitation discharges" in the acute care setting. These groupings function as a construct for market analyses to estimate the number of rehabilitation referrals likely to be generated from the acute care setting and are referred to herein as High Potential Rehabilitation Discharges (HPRDs) (see below).

High Potential Rehabilitation Diagnoses or Discharges (HPRD's) - These are DRG/ICD-10 code clusters used by Encompass Health to define acute care patients with a high likelihood of referral to acute rehabilitation. These DRG/ICD-10 groupings are aligned with the CMS 13 definitions utilized by the Medicare program in context of IRF program operations (see above). These clinical cohorts include DRG clusters such as stroke, hip fractures, neurological conditions, traumatic brain injury, spinal cord injury, and major multiple trauma. These groupings serve as the basis for projecting acute rehabilitation discharges, as these patients are "high potential" or most likely candidates for acute rehabilitation care following an acute care episode.

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[3] Based on directive from the Maryland Health Care Commission, July 2017; this reflects ICD-10 coding of discharges in Quarter 4 which does not permit direct application of the Maryland State Health Plan definition

Encompass Health Service Area - The proposed service area for EHRHSM is the Southern Maryland Health Planning Region comprised of Prince George's County, Charles County, Calvert County and St. Mary's County and 18 additional zip codes in southern Anne Arundel County (together referred to herein as the "Southern Maryland Region"). All references to the service area refer to this combined region.

(B) Regional Context: The Maryland and District of Columbia Market for Acute Rehabilitation

The table below identifies acute rehabilitation programs by Health Planning Region. Two maps displaying the geographic distribution of programs are provided on the pages following.

Adult Rehabilitation Programs: Licensed Beds by Health Planning Region

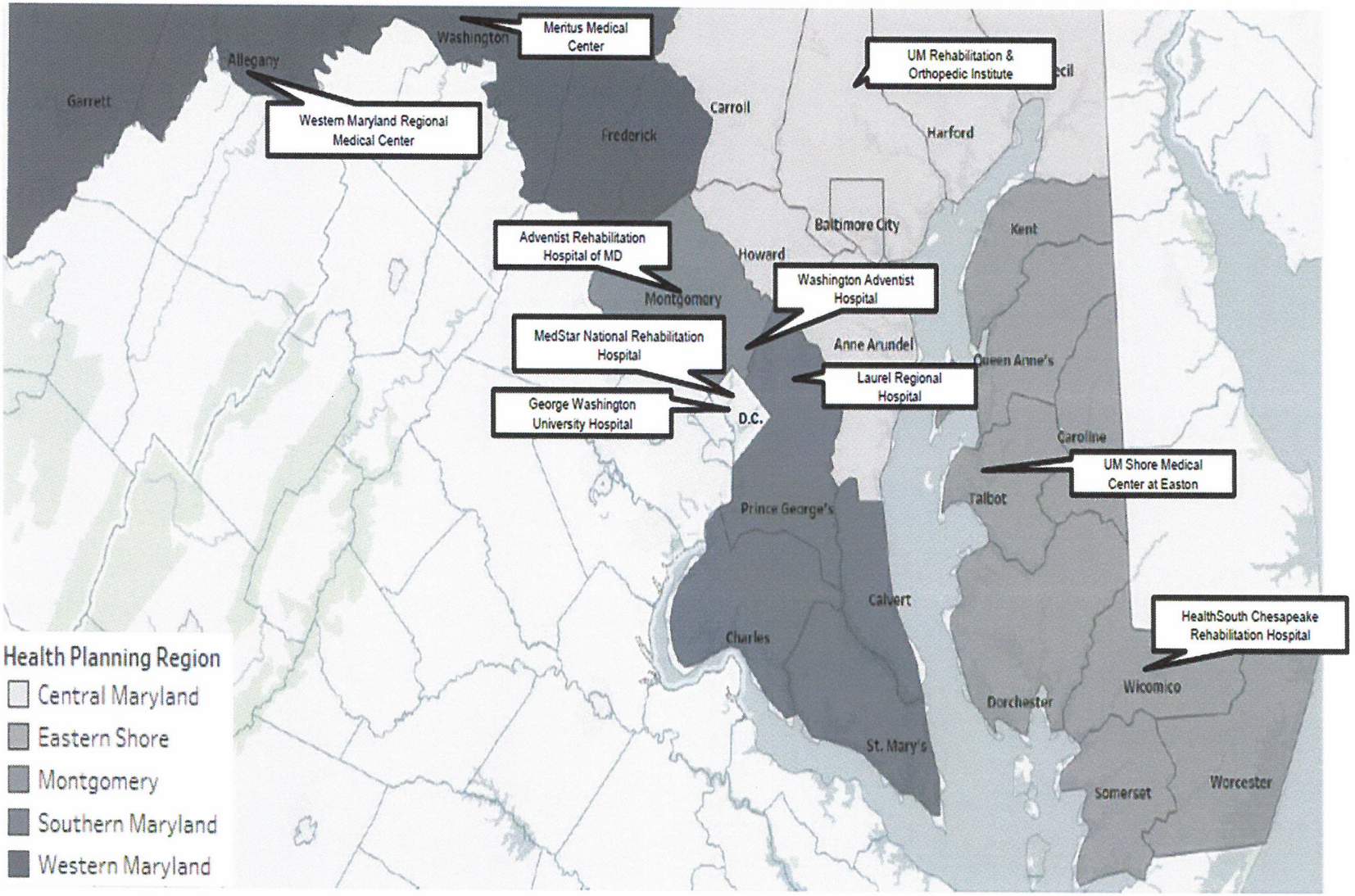
Health Planning Region	Facility	Licensed Rehabilitation Beds
Central Maryland	UM Rehabilitation & Orthopaedic Institute	98[1]
Central Maryland	MedStar Good Samaritan Hospital	51
Central Maryland	Johns Hopkins Bayview Medical Center	9
Central Maryland	Sinai Hospital	57
Central Maryland	Johns Hopkins Hospital	18
Central Maryland	Levindale	20
Central Maryland	MedStar Union Memorial Hospital	18
Eastern Shore	HealthSouth Chesapeake Rehabilitation Hospital	59
Eastern Shore	UM Shore Medical Center at Easton	20
Western Maryland	Meritus Medical Center	20
Western Maryland	Western Maryland Regional Medical Center	13
Montgomery	Adventist Rehabilitation Hospital of MD	87
Washington, DC	MedStar National Rehabilitation Hospital	157
Washington, DC	George Washington University	16
Southern Maryland	Laurel Regional Hospital	28

[1] Includes 82 licensed rehabilitation beds and 16 dually licensed chronic/rehabilitation beds

Acute Rehabilitation Programs Outside of Baltimore City

Maryland & Washington D.C.

By Health Planning Region



Acute Rehabilitation Programs

Baltimore City, Maryland

The total volume of acute rehabilitation discharges across Maryland and District of Columbia providers is presented below. Although the number of total discharges decreased between CY2012 to CY2016, the average daily census has increased by nine. This can be attributed to an increase in average length of stay from 12 days to 12.7 days.

Adult Acute Rehabilitation Discharges
Utilization Patterns
Total Maryland and Washington, DC Facilities
CY2012-2016

	CY2012	CY2013	CY2014	CY2015	CY2016
Total Discharges	12,906	12,652	12,872	12,501	12,479
Total Patient Days	154,632	149,382	153,993	151,276	157,907
ALOS	12.0	11.8	12.0	12.1	12.7
Average Daily Census	424	409	422	414	433

Sources:

[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2012 to CY2016 Final

[2] DC hospitals: DCHA Database; CY2012 to CY2016 Final

[3] HSCRC Rehabilitation Facility Database; CY2012 to CY2015 Q3 Final

Notes:

[a] Adult: Age 18+

[b] Acute Rehab: Based on State Health Plan definition (see technical notes)

[c] GWU, MedStar NRH CY2015 Q4 data annualized from CY2015 Q1-Q3

Total discharge volume, by hospital, is presented below. In CY2016, approximately 20% of total acute rehabilitation discharges across Maryland and District of Columbia programs were served at programs in the District of Columbia.

Adult Acute Rehabilitation Providers in Maryland and Washington, DC
Inpatient Volume
CY2014-2016

	Discharges			ALOS			ADC		
Hospital	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
Maryland Hospitals									
UM Rehabilitation & Orthopaedic Institute	2,056	2,003	1,743	10.8	10.7	11.9	61	59	57
Laurel Regional Hospital	312	346	259	6.7	7.4	9.3	6	7	7
Johns Hopkins Hospital	575	529	537	9.5	10.0	10.6	15	14	16
Sinai Hospital	1,282	1,191	1,195	9.3	9.5	9.7	33	31	32
MedStar Good Samaritan Hospital	1,479	1,374	1,313	9.1	9.2	9.8	37	35	35
Meritus Medical Center	506	495	436	9.1	9.0	10.3	13	12	12
UM Shore Medical Center at Easton	376	352	343	9.2	9.8	10.1	9	9	10
MedStar Union Memorial Hospital	333	276	55	8.4	8.4	8.4	8	6	1
Western Maryland Regional Medical Center	272	280	293	11.9	12.5	10.9	9	10	9
Levindale	34	41	78	22.4	21.2	28.3	2	2	6
Johns Hopkins Bayview Medical Center	188	219	433	13.1	12.0	15.0	7	7	18
Adventist Rehabilitation Hospital of MD	1,799	1,938	1,858	13.6	13.6	13.9	67	72	71
HealthSouth Chesapeake Rehab Hospital	1,326	1,326	1,466	13.7	13.6	13.4	50	49	54
Subtotal: Maryland Hospitals	10,538	10,370	10,009	10.9	11.1	11.9	315	315	326
Washington, DC Hospitals									
George Washington University	271	285	366	14.2	18.6	12.4	11	15	12
MedStar National Rehabilitation Hospital	2,063	1,845	2,104	17.0	16.8	16.3	96	85	94
Subtotal: Washington, DC Hospitals	2,334	2,131	2,470	16.7	17.0	15.7	106	99	106
Total	**12,872**	**12,501**	**12,479**	**12.0**	**12.1**	**12.7**	**422**	**414**	**433**

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2014 to CY2016 Final
[2] DC hospitals: DCHA Database; CY2014 to CY2016 Final
[3] Rehab hospitals: HSCRC Rehabilitation Facility Database; CY2014 to CY2015 Q3 Final
Notes:
[a] Adult: Age 18+
[b] Acute Rehab: Based on State Health Plan definition (see Technical Notes)
[c] MedStar NRH, GWU: Volume for CY2015 Q4 based on CY2015 Qtrs 1-3

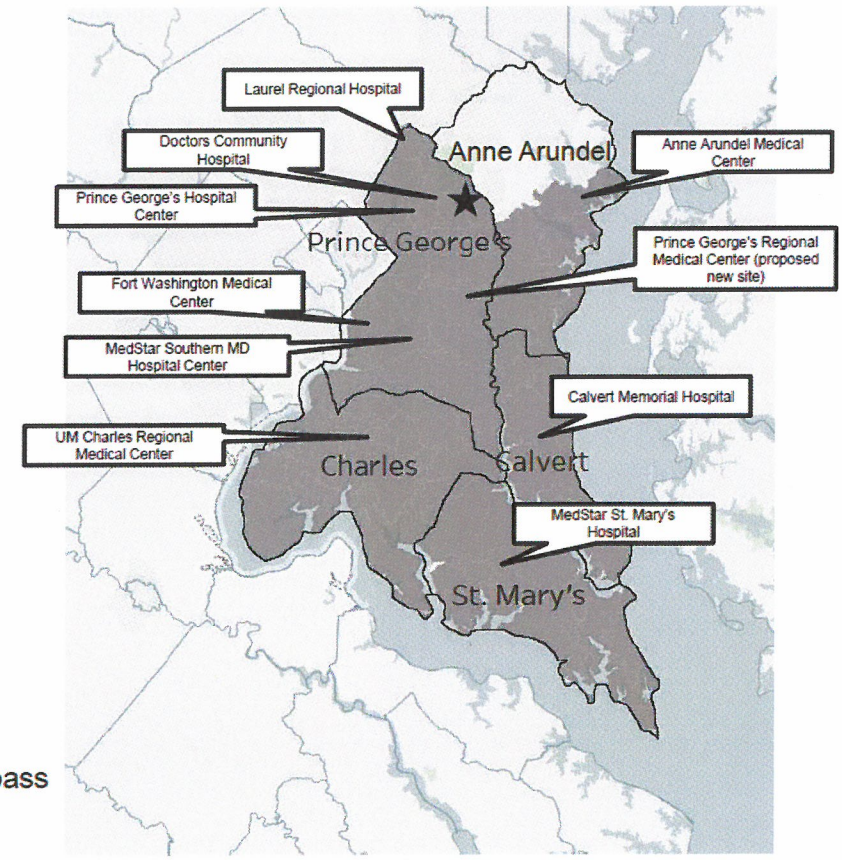
(C) Service Area for the Proposed Rehabilitation Specialty Hospital: Basis

Definition of Service Area - The service area for the new hospital includes the Southern Maryland Health Planning Region (four Counties) and an 18-zip code region in southern Anne Arundel County, contiguous with the Southern Maryland Health Planning Region. For purposes of analysis, the following service area definition was adopted:

Primary Service Area	Prince George's County Charles County Southern Anne Arundel County, 18 contiguous zip codes[4]
Secondary Service Area	Calvert County St Mary's County

[4] See Exhibit 10 for list of zip codes included.

Encompass Health Southern Maryland
Service Area for Acute Rehabilitation



★ New proposed location of Encompass Health

Demographics - The Encompass Health service area includes Southern Maryland and 18 contiguous zip codes in southern Anne Arundel County. The Southern Maryland Health Planning Region is a four County region comprised of Prince George's County, Charles County, Calvert County and St. Mary's County with a total population of approximately 1.2 million residents. Prince George's County is the second most populous county in the State of Maryland, and the four counties of Southern Maryland are among the fastest growing counties in Maryland.

The communities of southern Anne Arundel County extend east to include Annapolis and account for an additional 175,000 residents. The inclusion of southern Anne Arundel County was based on findings that this contiguous region demonstrates the same access barriers as does the Southern Maryland population, and that the Project can meet the needs of the southern Anne Arundel community.

In total, the Southern Maryland Region represents a population of nearly 1.4 million people. More than 12% of the service area population is over the age of 65, growing at more than 5% annually. By CY2023, the over-65 population will represent 16% of the total population;

between CY2015 and CY2023 there are projected to be an additional 69,000 over-65 residents in the service area.

Encompass Health Service Area
Population Growth by County & Age Cohort
CY 2016-2023

	Age 0-17		Age 18-64		Age 65+		Total Population	
County	**CY2016**	**CY2023**	**CY2016**	**CY2023**	**CY2016**	**CY2023**	**CY2016**	**CY2023**
Charles	36,599	35,068	98,312	104,884	17,854	25,219	152,765	165,171
Prince George's	206,094	216,163	595,173	607,536	110,357	155,094	911,624	978,794
Anne Arundel - South	36,516	37,707	109,072	109,796	30,100	38,982	175,688	186,486
Subtotal: Primary Service Area	279,209	288,939	802,557	822,217	158,311	219,295	1,240,077	1,330,451
St. Mary's	28,417	28,898	72,552	74,882	14,384	19,111	115,353	122,892
Calvert	16,916	15,518	15,328	72,641	9,664	13,038	41,908	101,197
Subtotal: Secondary Service Area	45,333	44,416	87,880	147,524	24,048	32,150	157,261	224,089
Total: Encompass Health Service Area	**324,542**	**333,355**	**890,437**	**969,741**	**182,359**	**251,444**	**1,397,338**	**1,554,540**
# Population Change, 2016-2023		8,813		79,304		69,085		157,203
Average Annual Growth Rate		0.39%		1.27%		5.41%		1.61%

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2015, CY2016 Final
[2] DC hospitals: DCHA Database; CY2015, CY2016 Final
[3] Population Data: Nielson-Claritas Population; CY2016 Estimate & CY2021 Projection

This service area definition was based on the following assessment:

Bed Need - In 2014, the MHCC identified Southern Maryland as a region with a substantial bed need, and the region reports markedly low use rates for rehabilitation services.

State of Maryland
Gross and Net Bed Need Projections for Acute Rehabilitation Beds: Maryland, 2017
Issued by the Maryland Health Care Commission

Health Planning Region	Minimum Occupancy Standard	Range	Total Days Projected	Current Licensed Bed Capacity	Available Bed Days	Gross Bed Need Range	Net Bed Need Range
Central	0.78	minimum	70,110	277	101,105	246	-31
		maximum	85,006			298	21
Eastern Shore	0.75	minimum	14,224	74	27,010	52	-22
		maximum	23,857			87	13
Montgomery	0.80	minimum	20,283	87	31,755	69	-18
		maximum	32,915			113	26
Southern	0.75	minimum	5,112	28	10,220	19	-9
		maximum	25,618			94	66
Western	0.75	minimum	10,488	33	12,045	38	5
		maximum	12,673			46	13

Source: Maryland Register,10/17/2014

Going forward, bed capacity for rehabilitation care will be further reduced. The reconfiguration of Laurel Regional will be accompanied by relocation of 10 acute rehabilitation beds to UM Prince George's Hospital Center and temporary delicensure of 18 acute rehabilitation beds at Laurel Regional. At that point, Southern Maryland will have only 10 rehabilitation beds operating in the Southern Maryland Region. The nearest IRF for most Southern Maryland residents will be NRH, entailing more than a one-hour drive for most residents of Southern Maryland.

Comparable Access Barriers for Southern Anne Arundel County (18 Zip Codes) - Anne Arundel County reports similarly low use rates for acute rehabilitation services, and the 18 communities of Southern Anne Arundel County face the same geographic access problems for rehabilitation care as do the residents of Southern Maryland. There are no acute rehabilitation beds operating in Anne Arundel County, and for residents of southern Anne Arundel County, the nearest acute rehabilitation program, other than Laurel Regional, is approximately 30 miles away, entailing approximately one-hour drive time.

Residents of Southern Anne Arundel County Utilize Southern Maryland Hospitals and Will be Well-Served by the Bowie Location - Adult residents from these 18 communities use Calvert Memorial Hospital as their second most utilized hospital for Medical/Surgical care (second after Anne Arundel Medical Center). EHRHSM will be well positioned to support care management for these southern Anne Arundel County residents.

(D) Service Area: Current Utilization Patterns for Rehabilitation Services

Use Rate for Acute Rehabilitation Services - Southern Maryland and Anne Arundel County counties are among the seven counties with the lowest use rates in the State of Maryland. These low use rates have been attributed to the limited capacity of the one unit that has operated in the region at Laurel Regional and the absence of an IRF in the Southern Maryland Region.

Current Volume of Acute Rehabilitation - In CY2016, the service area population accounted for 1,632 adult acute rehabilitation discharges, translating into **63 occupied beds for acute rehabilitation care**. This volume was generated even at the notably low rehabilitation use rate for this region (see below).

Encompass Health Service Area Residents: Adult Acute Rehabilitation Discharges CY2014-2016

	CY2012	CY2013	CY2014	CY2015	CY2016
Total Discharges	1,604	1,543	1,627	1,625	1,632
Total Patient Days	22,146	20,194	22,952	22,749	23,100
ALOS	13.8	13.1	14.1	14.0	14.2
Average Daily Census	61	55	63	62	63

Sources:

[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2012 to CY2016 Final

[2] DC hospitals: DCHA Database; CY2012 to CY2016 Final

[3] HSCRC Rehabilitation Facility Database; CY2012 to CY2015 Q3 Final

Notes:

[a] Adult: Age 18+

[b] Acute Rehab: Based on State Health Plan definition (see technical notes)

[c] GWU, MedStar NRH CY2015 Q4 data annualized from CY2015 Q1-Q3

As noted, the only acute rehabilitation program currently operating in Southern Maryland is a 28-bed hospital-based unit at Laurel Regional, a unit that has been operating with limited resources to accommodate high-need patients.

At the same time, the demand for an IRF from this region is considerable: More than 800 patients travelled from the service area to NRH and GWU in the District of Columbia and nearly 400 patients traveled to Adventist for IRF care. Discharge volume, by hospital, is documented below:

Adult Acute Rehabilitation Discharges
Encompass Health Service Area
Discharge Volume by Hospital
CY2016

Hospital	Discharges	% of Service Area
Maryland Hospitals		
Adventist Rehabilitation Hospital of MD	371	22.7%
UM Rehabilitation & Orthopaedic Institute	152	9.3%
Laurel Regional Hospital	143	8.8%
Johns Hopkins Hospital	48	2.9%
Sinai Hospital	23	1.4%
Johns Hopkins Bayview Medical Center	23	1.4%
MedStar Good Samaritan Hospital	15	0.9%
HealthSouth Chesapeake Rehab Hospital	4	0.2%
Subtotal: Maryland Hospitals	779	47.7%
Washington, DC Hospitals		
MedStar National Rehabilitation Hospital	788	48.3%
George Washington University	65	4.0%
Subtotal: Washington, DC Hospitals	853	52.3%
Total	**1,632**	**100.0%**

Sources:

[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2016 Final

[2] DC hospitals: DCHA Database; CY2016 Final

Notes:

[a] Adult: Age 18+

[b] Acute Rehab: Based on State Health Plan definition (see Defintion of Terms)

Payor Mix for the Service Area Population Utilizing Acute Rehabilitation - Less than half of Southern Maryland patients who are admitted for inpatient rehabilitation care are Medicare patients (see Table below). This notably low percentage of Medicare patients likely correlates with the lack of an IRF in the Region and the limited capacity in the one hospital-based program at Laurel Regional. Given that the Region is under bedded for acute rehabilitation, Medicare patients are frequently referred to SNFs or discharged home with less aggressive rehabilitation services and medical oversight (see below).

Payor Mix by Health Planning Region
Adult Acute Rehabilitation Discharges
CY2016

	Medicare		Medicaid		Commercial		Other		Total	
Health Planning Region	Total	% of Total	Total	% of Total	Total	% of Total	Total	% of Total	Total	% of Total
Eastern Shore	1,244	81.3%	62	4.0%	196	12.8%	29	1.9%	1,531	100.0%
Southern Maryland	703	46.3%	143	9.4%	580	38.2%	92	6.1%	1,518	100.0%
Montgomery	887	58.2%	77	5.0%	517	33.9%	44	2.9%	1,525	100.0%
Central Maryland	2,455	55.5%	693	15.7%	1,130	25.5%	147	3.3%	4,425	100.0%
Western Maryland	579	71.0%	59	7.2%	151	18.5%	26	3.2%	815	100.0%
District of Columbia	471	39.7%	231	19.5%	391	32.9%	94	7.9%	1,187	100.0%
Out of Area	653	62.5%	19	1.8%	289	27.7%	84	8.0%	1,045	100.0%
Total	**6,992**	**58.0%**	**1,284**	**10.7%**	**3,254**	**27.0%**	**516**	**4.3%**	**12,046**	**100.0%**

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2016 Final
[2] DC hospitals: DCHA Database; CY2016 Final
Notes:
[a] Adult: Age 18+
[b] Acute Rehab: Based on State Health Plan definition (see Technical Notes)
[c] Data excludes JHBMC due to lack of payer data

The payor mix for service area residents utilizing acute rehabilitation programs is consistent with this profile for the Health Planning Region. None of the programs serving service area patients document a Medicare percentage that is higher than 56%.

Payor Mix for Encompass Health Service Area Residents, by Hospital
Adult Acute Rehabilitation Discharges
CY2016

HealthSouth Service Area Residents Payor Mix Profile by Hospital
Adult Acute Rehabilitation Cases Age 18+
CY 2016

	Medicare		Medicaid		Commercial		Other		Total	
Hospital	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total
Maryland Hospitals										
UM Rehabilitation & Orthopaedic Institute	30	19.7%	37	24.3%	73	48.0%	12	7.9%	152	100.0%
Laurel Regional Hospital	78	54.5%	22	15.4%	42	29.4%	1	0.7%	143	100.0%
Johns Hopkins Hospital	27	56.3%	2	4.2%	14	29.2%	5	10.4%	48	100.0%
Sinai Hospital	12	52.2%	2	8.7%	7	30.4%	2	8.7%	23	100.0%
MedStar Good Samaritan Hospital	5	33.3%	2	13.3%	6	40.0%	2	13.3%	15	100.0%
Adventist Rehabilitation Hospital of MD	201	54.2%	47	12.7%	113	30.5%	10	2.7%	371	100.0%
HealthSouth Chesapeake Rehab Hospital	3	75.0%	-	0.0%	1	25.0%	-	0.0%	4	100.0%
Subtotal: Maryland Hospitals	356	47.1%	112	14.8%	256	33.9%	32	4.2%	756	100.0%
Washington, DC Hospitals										
George Washington University	-	0.0%	2	3.1%	25	38.5%	38	58.5%	65	100.0%
MedStar National Rehabilitation Hospital	383	48.6%	39	4.9%	340	43.1%	26	3.3%	788	100.0%
Subtotal: Washington, DC Hospitals	383	44.9%	41	4.8%	365	42.8%	64	7.5%	853	100.0%
Total	**739**	**45.9%**	**153**	**9.5%**	**621**	**38.6%**	**96**	**6.0%**	**1,609**	**100.0%**

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2016 Final
[2] DC hospitals: DCHA Database; CY2016 Final
Notes:
[a] Acute Rehab: Based on State Health Plan definition (see Defintion of Terms)
[b] Data exclude 23 discharges from JHBMC due to lack of payer information

Area Hospitals and Referral Base - There are nine acute care hospitals located in the Encompass Health service area, identified below:

- UM Prince George's Hospital Center
- UM Laurel Regional Hospital
- Doctors Community Hospital
- MedStar St. Mary's Hospital
- Calvert Memorial
- MedStar Southern Maryland Hospital Center
- UM Charles Regional
- Anne Arundel Medical Center
- Fort Washington Hospital

These hospitals will represent the largest referral sources for the proposed facility. The volume of "high potential rehabilitation diagnoses" ("HPRDs") was documented to assess the magnitude of referral volume; Encompass Health defines these HPRDs based on DRGs and ICD-10 codes that have historically accounted for more than 60% of discharges to its rehabilitation hospitals.[5] Therefore, this discharge base can be expected to account for the large majority of rehabilitation transfers. High potential rehabilitation discharges include patient cohorts with the following diagnoses:

- Stroke
- Neurological disorders
- Hip fracture
- Amputation
- Joint replacement
- Major multiple trauma
- Brain injury
- Spinal cord injury

In CY2016, the nine hospitals in the service area accounted for nearly 10,000 high potential rehabilitation discharges (HPRDs), of which 6,200 were Medicare discharges. This represents a substantial patient base upon which to establish EHRHSM.

Projected Growth of the New University of Maryland Capital Regional Prince George's Regional Medical Center - With the opening of the new UM Capital Regional Prince George's Regional Medical Center (PGRMC), this volume of High Potential Rehabilitation Discharges is projected to increase dramatically. The new PGRMC is expected to reduce the outmigration that now occurs to District of Columbia hospitals, and PGRMC projects a 30% acute care market share; as discharges grow, the demand for post-acute care will increase at a comparable rate.

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[5] These cohort definitions are aligned with CMS definitions for "CMS13" cohorts admitted to rehabilitation programs: CMS regulation requires that at least 60% of acute rehabilitation program admissions are represented by these CMS13 diagnoses. Therefore, these cohort definitions provide a relevant base for projecting market demand for acute rehabilitation services.

Local Trauma Center - University of Maryland Prince George's Hospital Center is the second highest volume trauma center in Maryland and served nearly 1,300 trauma visits in CY2017. The trauma center is a major referral source for acute rehabilitation services; currently, the large majority of patients are referred to programs 30-70 miles from home resulting in both family hardships and disruptions in continuity of care.

Chronic Disease Rates for Service Area Population - Multiple analyses prepared over the last five years have documented that Prince George's County residents experience higher prevalence rates for chronic disease relative to the State of Maryland and higher hospitalization rates for chronic disease. In particular, the Prince George's County population reports higher rates of diabetes, hypertension and heart disease. These prevalence rates correlate with higher disability rates and a high need for post-acute care. The availability of acute rehabilitation care local to Prince George's County residents will be particularly critical to population health management efforts and efforts to reduce the costs of care in this region.

(E) Evidence of Community Need

The Project responds to the following needs:

1. Bed Need in the Southern Maryland Region

Access to acute rehabilitation beds is seriously limited, and there is an inequitable distribution of rehabilitation beds across Health Planning Regions. With the anticipated 18-bed temporary delicensure at Laurel Regional, there will be only a 10-bed hospital-based unit operating at UM PGHC for a region of nearly 1.4 million residents.

Bed need is corroborated by the following evidence:

(a) *Published Bed Need* - The State of Maryland established the need for up to an additional 66 beds by the Year 2017 based on projected population growth rates and use rates for Southern Maryland. These bed need projections are documented below.

State of Maryland
Gross and Net Bed Need Projections for Acute Rehabilitation Beds: Maryland, 2017
Issued by the Maryland Health Care Commission

Health Planning Region	Minimum Occupancy Standard	Range	Total Days Projected	Current Licensed Bed Capacity	Available Bed Days	Gross Bed Need Range	Net Bed Need Range
		minimum	70,110			246	-31
Central	0.78	maximum	85,006	277	101,105	298	21
		minimum	14,224			52	-22
Eastern Shore	0.75	maximum	23,857	74	27,010	87	13
		minimum	20,283			69	-18
Montgomery	0.80	maximum	32,915	87	31,755	113	26
		minimum	5,112			19	-9
Southern	0.75	maximum	25,618	28	10,220	94	66
		minimum	10,488			38	5
Western	0.75	maximum	12,673	33	12,045	46	13

Source: Maryland I Register, 10/17/2014

(b) *Inequitable Distribution of Rehabilitation Beds* - There is an inequitable distribution of rehabilitation beds across Health Planning Regions in Maryland; rehabilitation beds are not distributed equitably or responsively across the State. This is evident based on the ratio of acute rehabilitation beds to the adult population: The ratio in Southern Maryland is strikingly low relative to other Health Planning Regions in the State. The figures below highlight that the Southern Maryland Region is the most under-bedded for rehabilitation care, when compared to the other health planning regions, correlating with the markedly low utilization of acute rehabilitation care by residents of the Southern Maryland Region.

Adult Population per Rehabilitation Bed in Maryland
By Health Planning Region
CY 2016

Health Planning Region	Adult Population Age 18+	# Licensed Rehab Beds	18+ Population : Rehab Bed Ratio
Eastern Shore	279,236	79	3,535:1
Central Maryland	2,219,888	255	8,705:1
Montgomery	812,040	87	9,334:1
Western Maryland	397,975	33	12,060:1
Southern Maryland	980,122	28	35,004:1
Total	**4,689,261**	**482**	**9,729:1**

Sources:

[1] Licensed Beds: Maryland Health Care Commission, 2017

[2] Population: Nielson-Claritas

Notes:

[a] UMROI includes 82 licensed rehabilitation beds and excludes 16 dually licensed chronic/rehabilitation beds

2. High Outmigration Rates and Travel Time

More than 90% of rehabilitation patients from this region travel out-of-area for services, imposing travel time, out-of-pocket costs, and added hardships for Southern Maryland Region patients/families. Out-of-area care also results in disjointed care and less effective care management.

Encompass Health Service Area Acute Rehab Discharges Market Share by County, By Hospital, Age 18+
CY 2016

	Prince George's		Calvert		Charles		Saint Mary's		Anne Arundel - South		HealthSouth Service Area	
Hospital	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
Maryland Hospitals												
UM Rehabilitation & Orthopaedic Institute	85	7.0%	9	12.7%	13	9.4%	4	4.9%	41	34.2%	152	9.3%
Laurel Regional Hospital	130	10.7%	2	2.8%	5	3.6%	2	2.4%	4	3.3%	143	8.8%
Johns Hopkins Hospital	21	1.7%	7	9.9%	6	4.3%	2	2.4%	12	10.0%	48	2.9%
Sinai Hospital	15	1.2%	2	2.8%	3	2.2%	2	2.4%	1	0.8%	23	1.4%
MedStar Good Samaritan Hospital	9	0.7%	-	0.0%	1	0.7%	-	0.0%	5	4.2%	15	0.9%
Johns Hopkins Bayview Medical Center	10	0.8%	3	4.2%	-	0.0%	1	1.2%	9	7.5%	23	1.4%
Adventist Rehabilitation Hospital of MD	337	27.6%	8	11.3%	11	7.9%	4	4.9%	11	9.2%	371	22.7%
HealthSouth Chesapeake Rehab Hospital	3	0.2%	-	0.0%	-	0.0%	-	0.0%	1	0.8%	4	0.2%
Subtotal: Maryland Hospitals	610	50.0%	31	43.7%	39	28.1%	15	18.3%	84	70.0%	779	47.7%
Washington, DC Hospitals												
George Washington University	44	3.6%	8	11.3%	11	7.9%	1	1.2%	1	0.8%	65	4.0%
MedStar National Rehabilitation Hospital	566	46.4%	32	45.1%	89	64.0%	66	80.5%	35	29.2%	788	48.3%
Subtotal: Washington, DC Hospitals	610	50.0%	40	56.3%	100	71.9%	67	81.7%	36	30.0%	853	52.3%
Total: HealthSouth Service Area	**1,220**	**100.0%**	**71**	**100.0%**	**139**	**100.0%**	**82**	**100.0%**	**120**	**100.0%**	**1,632**	**100.0%**

Sources:
[1] Source: HSCRC Abstract Inpatient Database; CY2016 Final
[2] Source: DCHA Database; CY2016 Final
Notes:
[a] Adult: Age 18+
[b] MedStar NRH, Adventist Rehab, HealthSouth Chesapeake includes all cases
[c] SHP definition is: Nature of Admission =8, Daily Service Code = 8

In CY2016, nearly 1,500 adult patients travelled outside the service area for rehabilitation care; nearly 800 of these patients (788 patients) travelled to NRH in the District of Columbia and nearly 400 patients (371 patients) travelled to Adventist in Montgomery County. This utilization pattern is evidence of the specific demand for a specialty rehabilitation hospital; an IRF should be located in reasonable driving distance to Southern Maryland Region residents.

For residents of Calvert, Charles, St. Mary's and Southern Anne Arundel Counties, drive time to NRH is 60-100 minutes often requiring driving on the Capital Beltway; this imposes travel costs and time off from work for family members who want to visit regularly and be actively engaged in the rehabilitation process. Drive times are particularly onerous given the average length of stay of two weeks for acute rehabilitation patients. Clinicians report that there are many families who choose to sacrifice the rehabilitation component because the "commuting" arrangement to visit family members is simply unworkable.

Long drive times that burden families/visitors also may discourage family education/family engagement in the recovery process; this makes care transitions more difficult and may slow down patient progress upon the patient's return home. Rehabilitation programs typically are designed to engage family members in the recovery process; the Encompass Health program, in particular, is designed to train and equip family members to allow patients to return to the community successfully. Encompass Health provides family education and training as part of the rehabilitation process, and Encompass Health hospitals are designed with accommodations for a family member to stay overnight before discharge and manage the support role before discharge. Family engagement becomes much more challenging if family members are struggling to get to the hospital and spend time with the patient/therapists in the course of the recovery process.

3. Population Growth Across the Broader Service Area

The over-65 population in the service area is projected to increase by more than 5% per year, further intensifying the demand for rehabilitation care across the Southern Maryland Region.

Currently, more than 12% of the service area population is over the age of 65, and this population is projected to increase by more than 5% annually. Between CY2015 and CY2023, there are projected to be nearly 70,000 additional over-65 residents in this region.

Encompass Health Service Area
Population Growth by County & Age Group
CY2016-2023

	Age 0-17		Age 18-64		Age 65+		Total Population	
County	**CY2016**	**CY2023**	**CY2016**	**CY2023**	**CY2016**	**CY2023**	**CY2016**	**CY2023**
Charles	36,599	35,068	98,312	104,884	17,854	25,219	152,765	165,171
Prince George's	206,094	216,163	595,173	607,536	110,357	155,094	911,624	978,794
Anne Arundel - South	36,516	37,707	109,072	109,796	30,100	38,982	175,688	186,486
Subtotal: Primary Service Area	279,209	288,939	802,557	822,217	158,311	219,295	1,240,077	1,330,451
St. Mary's	28,417	28,898	72,552	74,882	14,384	19,111	115,353	122,892
Calvert	16,916	15,518	15,328	72,641	9,664	13,038	41,908	101,197
Subtotal: Secondary Service Area	45,333	44,416	87,880	147,524	24,048	32,150	157,261	224,089
Total: HealthSouth Service Area	**324,542**	**333,355**	**890,437**	**969,741**	**182,359**	**251,444**	**1,397,338**	**1,554,540**
# Population Change, 2016-2023		8,813		79,304		69,085		157,203
Average Annual Growth Rate		0.39%		1.27%		5.41%		1.61%

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2015, CY2016 Final
[2] DC hospitals: DCHA Database; CY2015, CY2016 Final
[3] Population Data: Nielson-Claritas Population; CY2016 Estimate & CY2021 Projection

A high-level, population-based projection model demonstrates that *even at stable use rates*, the population growth in the service area region will support the need for additional beds, as presented below.

- At stable rehabilitation use rates, population growth is projected to generate nearly 300 additional acute rehabilitation discharges by the Year 2023 (from 1,661 discharges to 1,959 discharges); this would translate into growth from 63 occupied beds to approximately 72 occupied beds.[6]

- Assuming that this population growth is accompanied by a use rate increase (to approximate the State's average use rate), this dynamic would generate 1,100 incremental rehabilitation discharges by CY2023 (from 1,661 discharges to 2,780 discharges); this would translate into growth from 63 occupied beds to approximately 102 occupied beds.[7]

Encompass Health Service Area
Projected Acute Rehabilitation Discharges Based on Demographic Growth
At Current Use Rates and at State Average Use Rates
CY2016-2023

		Actual	At Service Area CY2016 Use Rate			Actual	At Statewide CY2016 Use Rate		
		Current	Year 1	Year 2	Year 3	Current	Year 1	Year 2	Year 3
	Age Group	**CY2016**	**CY2021**	**CY2022**	**CY2023**	**CY2016**	**CY2021**	**CY2022**	**CY2023**
Population	0-17	324,542	330,764	332,023	333,286	324,542	330,764	332,023	333,286
	18-64	920,869	937,311	940,634	943,970	920,869	937,311	940,634	943,970
	65+	182,359	229,369	240,135	251,407	182,359	229,369	240,135	251,407
	Total	**1,427,770**	**1,497,444**	**1,512,793**	**1,528,663**	**1,427,770**	**1,497,444**	**1,512,793**	**1,528,663**
Use Rate per 1,000	0-17	0.09	0.09	0.09	0.09	0.09	0.05	0.05	0.05
	18-64	0.99	0.99	0.99	0.99	0.99	1.14	1.14	1.14
	65+	3.97	3.97	3.97	3.97	3.97	6.72	6.72	6.72
	Total	**1.16**	**1.25**	**1.26**	**1.28**	**1.70**	**1.75**	**1.78**	**1.82**
Discharges	0-17	29	30	30	30	29	16	16	16
	18-64	908	924	927	931	908	1,067	1,071	1,075
	65+	724	911	953	998	724	1,540	1,613	1,688
	Total	**1,661**	**1,864**	**1,911**	**1,959**	**1,661**	**2,624**	**2,700**	**2,780**
Patient Days		23,100			26,246				37,247
# of Cases Change since 2016		-			298				1,119
Average Length of Stay		13.9			13.4				13.4
Average Daily Census		63			72				102

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2015, CY2016 Final
[2] DC hospitals: DCHA Database; CY2015, CY2016 Final
[3] Population Data: Nielson-Claritas Population; CY2016 Estimate & CY2021 Projection
Notes:
[a] Acute rehab: Based on State Health Plan definition (see Technical Notes)
[b] Average Length of Stay (ALOS) for Year 3 of Service Area Use Rate and Statewide Use Rate is half a day less than current ALOS
[c] TBI/SCI volume: Assumed to be 8% of total discharges based on CY2016 actual

[6] This figure represents the demand for service area residents only and does not include any out-of-area demand.

[7] This figure represents the demand for service area residents only and does not include any out-of-area demand.

4. Further Growth in the Demand for Acute Rehabilitation Beds

In addition to population growth, several other factors will further drive the demand for acute rehabilitation beds in this Region:

(a) *Volume Growth at the New UM Capital Regional Prince George's Regional Medical Center* - University of Maryland Capital Regional has projected that outmigration rates will be substantially reduced, and the hospital is premised on achieving a 30% market share in its service area. Therefore, UM Capital Regional PGRMC will be managing the care of thousands more hospital patients locally each year which will include local management of post-acute care needs.

(b) *Increase in Chronic Disease Rates* - Prince George's County reports high prevalence rates of diabetes, heart failure, and stroke in its population. These prevalence rates which are not reflected by pure demographic statistics used by the MHCC in its bed need projections are associated with high rates of disability and can be expected to increase the need for acute rehabilitation services going forward.

Prevalence Rates in Medicare FFS Population
Prince George's County
CY2015

Chronic Condition	% of Medicare FFS pop	Difference from Statewide Prevalence
Diabetes	34.3	5.78
Heart failure	14.7	1.06
Stroke	4.7	0.31

Source: CMS Chronic Condition Data Warehouse, 2015

(c) Expanded patient base - The State of Maryland's bed need projections only reflect current utilization patterns in Maryland and *the current functions* of acute rehabilitation programs. Acute rehabilitation programs, however, can be better leveraged if they are local to the community. Encompass Health hospitals have demonstrated that they can serve an expanded role, serving patient populations that are not fully reflected in current use rates for the State of Maryland. These patient populations include:

- Transplant patients: Transplant patients are increasingly being recognized as candidates for acute rehabilitation programs if the rehabilitation program can accommodate both rehabilitation and ongoing medical management requirements.
- Patients recovering from prolonged ICU stay but are no longer on ventilator support: These patients are often candidates for the close medical oversight provided

at an inpatient rehabilitation facility while receiving rehabilitation to maximize their functional status.

- While most Encompass Health's patients are admitted from an acute care unit, Encompass Health has the ability, unlike SNFs, to admit appropriate, qualifying patients directly from the ER.
- Direct admissions from the community: Encompass Health hospitals across the country report that admissions from physician offices/community now represent approximately 7% of total Encompass hospital admissions. These admissions are often identified by the patient's primary care physician during an office visit or by an emergency room physician where the patient demonstrates a noticeable decline in physical and/or cognitive functions, has challenges performing activities of daily living and is in need of medical attention and supervision. These patients typically do not need acute care hospitalization, however do require physician and nursing care to stabilize or prevent further decline in their medical conditions. These patients can benefit from the more intensive rehabilitative modalities of physical, occupational, and speech therapies to help them improve their overall functional status. Examples of such patients include those with advancing Parkinson's Disease, congestive heart failure, and post-stroke with residual physical and cognitive challenges.

5. Quality of Care: Underutilization of Rehabilitation Services and Consequences

Access barriers have discouraged use of acute rehabilitation service and use rates for rehabilitation are markedly low in Southern Maryland and Anne Arundel County. This fact raises concerns about underutilization and quality of care being provided to Southern Maryland residents.

Despite the clinical evidence documenting superior outcomes and despite studies which document lower costs of care with the use of IRFs, Southern Maryland Region patients are not referred for rehabilitation at rates comparable to other counties in Maryland: The Southern Maryland Region population shows the significantly lower use rates for acute rehabilitation services as compared with other Health Planning Regions, and Medicare referral rates for "high potential rehabilitation discharges" are markedly low relative to national benchmarks. Stated simply, rehabilitation care is underutilized and patient functional outcomes may be compromised. As a result of being under-resourced for rehabilitation services, the Southern Maryland region population is underserved.

Indicators of underutilization

- Southern Maryland Counties and Anne Arundel County residents are among the lowest users of acute rehabilitation services across all Health Planning Regions in Maryland. Underutilization is clearly evident by the use rates documented below:

Adult Acute Rehabilitation Discharges per 1,000 by County & Age Group
Based on SHP definition of acute rehabilitation
CY 2016

	Discharges				Population				Use Rate per 1,000			
County	0-17	18-64	65+	18+	0-17	18-64	65+	18+	0-17	18-64	65+	18+
Caroline	1	26	65	91	7,886	20,330	5,419	25,749	0.13	1.28	11.99	3.53
Dorchester	-	40	111	151	6,706	18,495	6,473	24,968	-	2.16	17.15	6.05
Kent	-	14	12	26	4,366	14,141	5,980	20,121	-	0.99	2.01	1.29
Queen Annes	-	23	42	65	9,710	26,672	7,797	34,469	-	0.86	5.39	1.89
Talbot	-	38	173	211	6,812	20,218	10,136	30,354	-	1.88	17.07	6.95
Somerset	-	18	66	84	4,217	15,950	3,760	19,710	-	1.13	17.55	4.26
Wicomico	-	130	449	579	22,275	63,537	15,035	78,572	-	2.05	29.86	7.37
Worcester	1	63	264	327	9,685	31,201	14,092	45,293	0.10	2.02	18.73	7.22
Subtotal: Eastern Shore	2	352	1,182	1,534	71,657	210,544	68,692	279,236	0.03	1.67	17.21	5.49
Charles	8	85	54	139	36,599	98,312	17,854	116,166	0.22	0.86	3.02	1.20
Calvert	2	49	42	91	21,464	58,742	12,748	71,490	0.09	0.83	3.29	1.27
Prince Georges	16	661	559	1,220	206,094	595,173	110,357	705,530	0.08	1.11	5.07	1.73
Saint Marys	3	50	32	82	28,417	72,552	14,384	86,936	0.11	0.69	2.22	0.94
Subtotal: Southern Maryland	29	845	687	1,532	292,574	824,779	155,343	980,122	0.10	1.02	4.42	1.56
Montgomery	23	594	944	1,538	246,181	661,182	150,858	812,040	0.09	0.90	6.26	1.89
Subtotal: Montgomery	23	594	944	1,538	246,181	661,182	150,858	812,040	0.09	0.90	6.26	1.89
Baltimore City	3	878	856	1,734	144,969	431,808	88,133	519,941	0.02	2.03	9.71	3.33
Baltimore	1	650	939	1,589	169,899	494,731	131,970	626,701	0.01	1.31	7.12	2.54
Carroll	1	76	119	195	35,068	102,814	26,796	129,610	0.03	0.74	4.44	1.50
Cecil	-	23	14	37	23,638	64,176	15,029	79,205	-	0.36	0.93	0.47
Harford	-	162	173	335	56,319	156,841	38,009	194,850	-	1.03	4.55	1.72
Howard	-	173	201	374	74,885	204,839	40,647	245,486	-	0.84	4.95	1.52
Anne Arundel	1	308	208	516	125,370	346,116	77,979	424,095	0.01	0.89	2.67	1.22
Subtotal: Central Maryland	6	2,270	2,510	4,780	630,148	1,801,325	418,563	2,219,888	0.01	1.26	6.00	2.15
Allegany	-	34	185	219	13,006	46,453	14,817	61,270	-	0.73	12.49	3.57
Frederick	4	121	115	236	60,409	163,014	34,846	197,860	0.07	0.74	3.30	1.19
Garrett	-	3	16	19	5,274	16,330	5,724	22,054	-	0.18	2.80	0.86
Washington	2	127	224	351	32,618	92,581	24,210	116,791	0.06	1.37	9.25	3.01
Subtotal: Western Maryland	6	285	540	825	111,307	318,378	79,597	397,975	0.05	0.90	6.78	2.07
Total: Maryland	**66**	**4,346**	**5,863**	**10,209**	**1,351,867**	**3,816,208**	**873,053**	**4,689,261**	**0.05**	**1.14**	**6.72**	**2.18**

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2016 Final
[2] DC hospitals: DCHA Database; CY2016 Final
[3] Population Data: Nielson-Claritas Population Data; CY2016
Notes:
[a] Acute Rehab: Based on State Health Plan definition (see Technical Notes)

- This underutilization is corroborated by a more refined analysis focused on specific Medicare patient populations, populations that can be expected to benefit most from acute rehabilitation services. An analysis was prepared of Medicare FFS claims for Maryland patients with "High Potential Rehabilitation Diagnoses;" these are patient populations expected to benefit most from acute rehabilitation services. The analysis showed that only 2.9% of Medicare patients from Southern Maryland discharged with these diagnoses were transferred for acute rehabilitation care as compared with 5.4% of Medicare patients in other regions of Maryland. Across Encompass markets, nationally, it is reported that approximately 13% of fee for service Medicare patients in these diagnostic categories receive acute rehabilitation care.

Underutilization of rehabilitation services can have significant consequences. These concerns are further defined and validated in the "Need" statements below. (Quality of Care, #6-8, below)

6. Quality of Care: Long Institutional Stays at SNFs

The reliance on SNFs for rehabilitation care in the Southern Maryland Region results in dramatically longer institutional stays; this may negatively impact functional outcomes and patient experience of care.

A review of CY 2016 Medicare FFS claims of Maryland residents compares utilization patterns of comparable patient cohorts ("High Potential Rehabilitation Diagnoses") who were discharged to IRFs and SNFs. As noted in the table below, the length of stay at the acute hospital for patients discharged to SNFs was over two days longer compared to those patients discharged to IRF. In addition, the length of stay at the SNF was more than double the length of the stay at the IRF (19.5 days longer). Long stays at both the acute and the post-acute setting are inconsistent with the goals of the cost-effective care and returning the patient to the community as soon as possible.

Utilization Comparisons: Medicare FFS Patients, Maryland Residents
Average Length of Stay for Originating Hospital Stay and Post-Acute Stay
Based on Discharge Setting: IRF patients vs. SNF patients with Rehabilitation Services
CY2016

	ALOS: Acute Stay		ALOS: Rehabilitation Stay	
	IRF	SNF w/ Rehabilitation	IRF	SNF w/ Rehabilitation
Stroke	5.3	7.9	14.9	41.1
Neurological Disorders	6.1	7.3	13.5	37.3
Hip Fracture	4.0	5.4	13.7	38.9
Amputation	6.0	11.2	9.5	38.3
Major Multiple Trauma	2.7	4.1	12.3	27.6
Joint Replacement	3.0	6.1	14.0	38.1
Brain Injury	6.4	9.4	14.3	34.7
Spinal Cord Injury	7.6	8.1	17.5	36.1
ALOS: HPRD patients	**6.9**	**9.2**	**15.5**	**35.0**

Source: CMS Standard Analytic File (CY2016)

7. Quality of Care: Clinical Practice Guidelines and Optimal Patient Progress

Recently published clinical practice guidelines strongly recommend the IRF setting for post-stroke rehabilitation in order to obtain the best clinical outcomes for stroke patients. Clinicians, patients, and payors will increasingly demand an IRF level of care for rehabilitation of stroke patients.

In 2016, the American Heart Association and the American Stroke Association issued clinical practice guidelines for rehabilitation of stroke patients (see Exhibit 3). The guidelines recommend a multidisciplinary care team, 24/7 rehabilitation nursing care, specially trained rehabilitation staff, including the care of a rehabilitation physician and state-of-the-art technology for stroke patients. An IRF setting provides the intensive therapy, advanced technology, and the multidisciplinary approach that is recommended in the guidelines and unavailable in a SNF or rehabilitation unit, both of which are limited in therapeutic space, and may not have the clinical expertise of a stroke specific team. Patients in Maryland should be offered the recommended IRF setting, as specified by the AHA/ASA guideline, in order to maximize their functional outcome and reduce risk of complications and rehospitalization after a stroke.

8. Quality of Care: Quality Reporting and Patient Expectations

The Medicare Payment Advisory Commission recently recommended that hospital discharge planners be permitted to recommend specific post-acute facilities to patients based on quality performance indicators.

Hospital discharge planners are expected to be equipped with more data/more evidence going forward, and IRF care will be supported both by professional guidelines and published studies. IRF bed capacity should be made more available to meet the growing demand and patient/family expectations for IRF care.

9. Cost of Care: Acute Rehabilitation Services

The dependence on NRH results in higher Medicare spending for Maryland.

Payment rates documented for NRH indicate that the CY2016 average per diem Medicare payment was nearly 15% higher at NRH relative to the average per diem payment at HealthSouth Chesapeake; this resulted in higher Medicare spending for Maryland residents admitted to NRH. Maryland would benefit from another lower cost IRF to serve more of its population, reduce the total costs of care under the Waiver, and reduce the out-of-pocket costs of care for patients who will be shouldering an increasing portion of health care costs.

10. Quality of Care: Need for Local, More Effective Care Management

A locally-based IRF is needed to strengthen care management and support the effective transition between hospital and home-based services.

Care management is most effective when professional teams from the hospital are closely tied with local community-based resources; discharge planners at out-of-area facilities are simply not as familiar and integrated with local community service providers. A locally-based IRF will maintain ongoing relationships with community-based providers in Southern Maryland and will be better positioned to leverage these resources, stay in touch with patients, and modify care plans more immediately.

In addition, Encompass Health's proprietary rehabilitation specific clinical information system ("ACE-IT," and described further herein) can integrate with the clinical information systems of acute care hospitals to facilitate patient transfers.

11. Maryland Waiver Targets: Total Costs of Care and Quality Performance

Under Phase II of the Waiver, Maryland requires experienced post-acute providers to achieve its cost and quality performance targets.

Successful performance will depend heavily on high quality, experienced, outcomes-oriented, and cost-focused providers of rehabilitation and home care services. Successful performance will also depend on information technology tools for outcomes measurement and benchmarking systems to support best practices and continuous quality improvement. The State of Maryland needs post-acute providers such as Encompass Health with a track record of high quality and cost-focused post-acute care, and the sophistication to participate in risk-based partnerships. As stated above, ACE-IT allows for integration with acute care hospitals which facilitates patient transfers, reduces readmissions, and enhances patient outcomes.

12. Maryland Waiver Targets: Downstream Costs and Population Health Improvement Goals

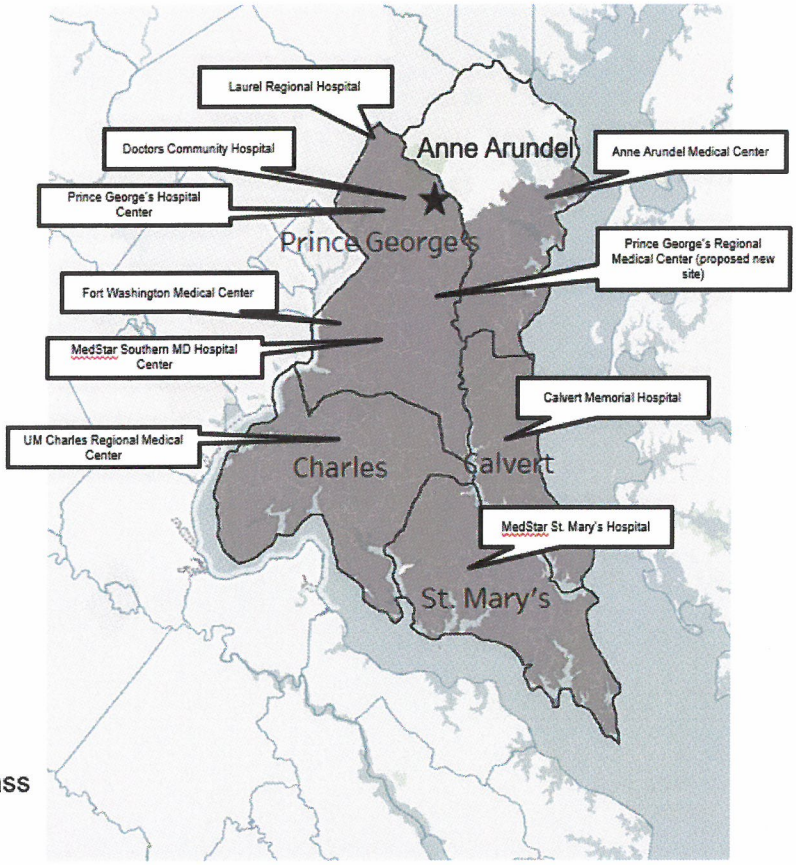
Maryland must invest in population health improvement initiatives to meet the longer-term goals of the Waiver including prevention and cost avoidance; falls prevention is an explicit target for Maryland and represents an enormous opportunity area for cost of care reductions. Under the Phase II agreement with CMS, Maryland defined a number of longer-term goals for population health improvement including falls prevention. National statistics document that falls among the elderly account for 25% of all hospital admissions and 40% of all nursing home admissions. Approximately half of older adults who are discharged for fall-related hip fractures reportedly experience another fall within six months. Acute care hospitals in Maryland can provide only limited resources for prevention activities, and there is no identified provider in Southern Maryland providing community-based services to reduce the number of high cost falls. The State of Maryland needs an experienced provider like Encompass Health to prioritize and provide this community-based service.

The Encompass Health Safe Patient Mobility Program addresses the high risk of falls in the elderly population:

- Hospital policies that include assessment of all patients upon admission and reassessment throughout the stay, using the Morse Fall scale, a nationally accepted fall assessment tool.
- Specialized training for staff in fall precautions and fall prevention.
- Color-coded armbands for patients at high risk for falls.
- National Fall Task Force that monitors the fall rate in each hospital and explores innovative ways to reduce falls.
- Patient and family education on how to reduce falls in the home.
- Annual celebration of National Patient Safety Awareness Week, which includes patient, family, and community awareness of safety issues, including falls.
- Bed Safety program designed to reduce risk of falls in patient rooms.

(F) Expected Impact: How Will Applicant Address Community Need?

Encompass Health Southern Maryland
Service Area for Acute Rehabilitation



★ New proposed location of Encompass Health

EHRHSM will be well-positioned geographically and programmatically to improve access to rehabilitation services, promote effective use of acute rehabilitation services, support continuity of care, and provide Southern Maryland residents with more options for high quality rehabilitation services.

1. The proposed facility will increase bed capacity and will be located in Bowie near densely populated communities in Prince George's County and southern Anne Arundel County.

The Project will increase bed capacity and will reduce current travel times for residents of Southern Maryland and southern Anne Arundel County. A table showing reduced travel time, by County, is presented below:

Current Travel Time to Nearest Acute Rehabilitation Program, By County and Effect of New Hospital (excluding Laurel Regional)

	Average Travel Time and Distance									
TO	Anne Arundel County		Calvert County		Charles County		Prince George's County		St.Mary's County	
From	Travel Time	Distance (mi)	Travel Time	Distance (mi)	Travel Time	Distance (mi)	Travel Time	Distance (mi)	Travel Time	Distance (mi)
MedStar National Rehabilitation Hospital	56	32	82	51	71	41	38	15	106	70
George Washington University Hospital	54	34	76	52	98	41	39	18	103	69
Adventist Rehabilitation Hospital of Maryland	77	51	106	73	104	65	59	33	134	91
University of Maryland Rehabilitation and Orthopaedic Inst	68	44	107	72	113	75	68	41	140	96
Johns Hopkins Hospital	74	45	114	71	118	72	73	39	145	94
Johns Hopkins Bayview Medical Center	70	40	110	68	120	75	72	40	143	94
Sinai Hospital and Levindale	82	48	123	76	128	78	83	44	154	100
MedStar Good Samaritan	86	46	124	74	133	81	87	46	158	100
MedStar Union Memorial	76	42	126	70	122	74	78	40	149	95
HealthSouth Chesapeake	128	105	164	134	177	145	138	118	201	160
UM Shore Medical Center	79	55	114	84	126	95	86	68	150	110
Meritus Medical Center	125	98	162	120	158	112	115	80	187	138
Encompass Health	29	20	59	42	69	45	27	18	93	65

2. The proposed facility will be located approximately 9.5 miles from Largo where the new Prince George's Regional Medical Center will operate and will support continuity of care and effective care management.

EHRHSM in Bowie will be well-positioned to meet the need for post-acute services where volume is expected to grow most dramatically. The new UM Capital Regional Prince George's Regional Medical Center in Largo is projected to serve more than 30% of Prince George's County inpatients; this represents a dramatic growth in the number of acute care patients who will be served in Prince George's County, with an accompanying increase in local demand for inpatient rehabilitation services.

3. Encompass Health will increase access by admitting more patients with complex medical needs, patients who previously have not been admitted by area SNFs.

In contrast to SNFs, Encompass Health is equipped to admit patients with complex medical management needs and comorbidities. Encompass Health provides 24/7 rehabilitation nursing

care with many nurses having the Certified Rehabilitation Registered Nurse (CRRN) distinction. In addition, all patients are seen a minimum of three times per week by a physician with special training and expertise in rehabilitation medicine. Medical directors provide full-time coverage. The availability of this level of medical care will increase access to clinicians with specialized training in rehabilitation and improved outcomes. Encompass Health will increase acute care hospital flow-through by accepting higher acuity patients earlier than other post-acute settings, thereby decreasing the length of stay at acute care hospitals. This feature will further encourage utilization of Encompass Health as a post-acute provider.

4. Encompass Health will seek CARF-accreditation by The Joint Commission and will seek to be accredited for disease-specific programs. Several of these programs will align with disease management programs now operating across hospitals in Southern Maryland and will support Maryland's goals for chronic disease management.

Many of Encompass Health hospitals operate disease-specific certified stroke programs supported by state-of-the-art equipment and professionals who have completed specialty program training. Encompass Health's Stroke Centers of Excellence will bring a professional team with extensive training in the rehabilitation of stroke patients. This team will collaborate with physicians in the region, build awareness of these disease-specific programs, and share the evidence and clinical practice guidelines and outcomes that support the use of IRFs for stroke patients. This will encourage use of intensive rehabilitation services and increase access to care.

As stated earlier, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility, and "the studies that have compared outcomes in hospitalized stroke patients first discharged to an IRF, a SNF, or a nursing home have generally shown that IRF patients have higher rates of return to community living and greater functional recovery, whereas patients discharged to a SNF or a nursing home have higher rehospitalization rates and substantially poorer survival." [8]

5. Encompass will become a presence at all area hospitals through its team of Rehabilitation Liaisons to provide timely evaluation and smooth transfer of patients.

All Encompass Rehabilitation Liaisons are clinically trained and will conduct screenings and have discussions with health care personnel and with families of patients to assess clinical needs and determine appropriateness for admission to a rehabilitation hospital to coordinate a timely transfer. Often, this process occurs within hours of patient identification. Lengths of stay in the acute hospital will be minimized by the close working relationship with hospitals and by this efficient system for transfer.

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[8] "Guidelines for Adult Stroke Rehabilitation and Recovery," issued May 2016 (stroke.ahajournals.org)

The Care Management Program at Encompass Health hospitals focuses on promoting effective communication and coordination across care settings to ensure a smooth transition from hospital to community and a seamless integration of services to help make the transition from hospital to the next level of care safe and effective.

6. Encompass Health will increase access by accommodating direct admissions.

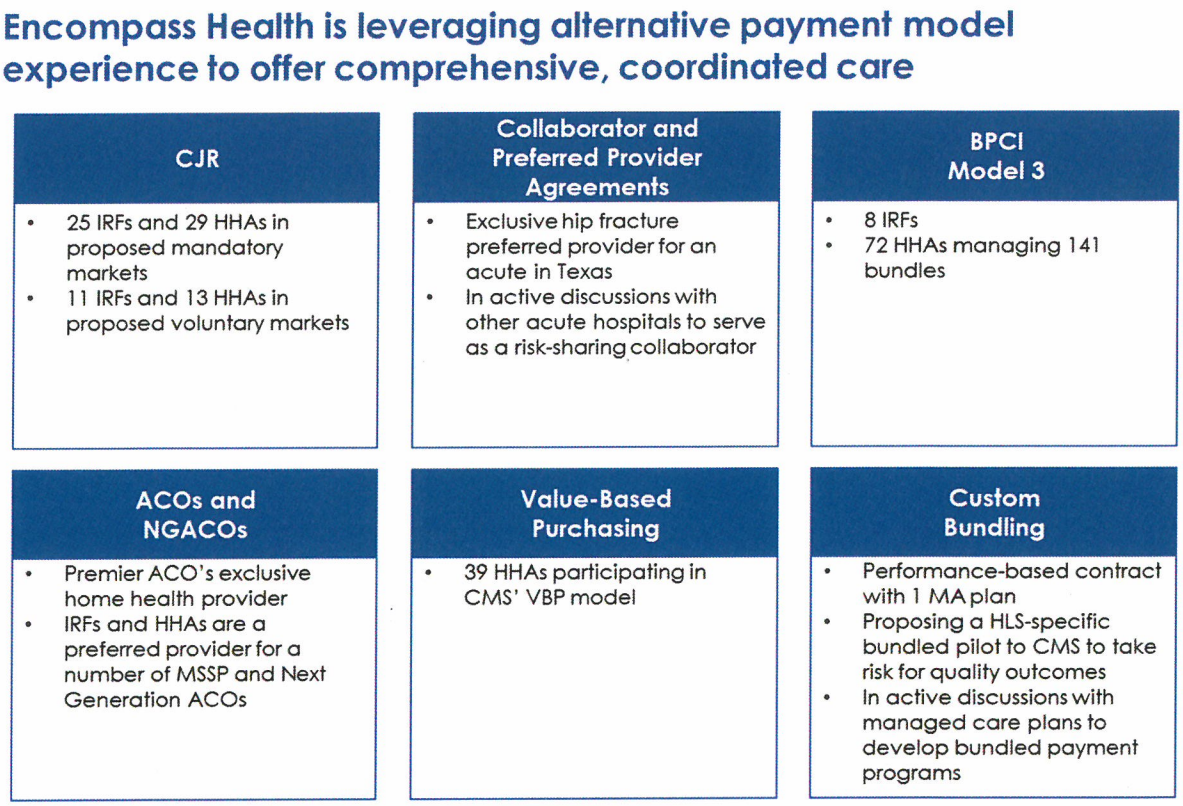
Across the country, approximately 7% of Encompass's admissions are now direct admissions from the community. Because Encompass Health is recognized as a hospital by CMS, EHRSM can admit appropriate patients from a physician's office or the community. Appropriate patients can be provided intensive rehabilitation in a setting designed explicitly for restoring patients' strength and mobility. Protocols for direct admissions from the ER have helped to avoid costly ER visits, reduce ER backlog, reduce the number of acute care admissions, restore functional status after illness, and prevent falls after an episode. The opportunity for direct admissions will increase access to intensive rehabilitation and reduce the cost of inpatient stays at Southern Maryland hospitals.

7. Encompass Health will increase access through working partnerships with area hospitals and ACOs, and through participation in Medicare Advantage contracts.

Encompass Health will serve as a highly experienced and well-equipped partner for care management of the Southern Maryland population. Encompass Health will evaluate opportunities to contract with area hospitals and ACOs under bundled payment/episode payment models and will work to build collaborative models with acute care hospitals to reduce readmissions and reduce the total costs of care under the Waiver. Encompass Health brings extensive experience in working with both acute care teams and community-based teams:

- Eight (8) Encompass Health hospitals across the country currently participate as risk-bearing participants in Medicare's Bundled Payment for Care Improvement Initiative and 72 of Encompass Health home health agencies are participating in 141 bundled payment initiatives. Encompass Health's home health agencies across the country are also actively participating in ACO's.

- Encompass Health expects to contract directly with Medicare Advantage plans. At this time, Encompass Health contracts with Medicare Advantage plans in every state in which it operates.



8. Area hospitals/area clinicians have indicated that the availability of an IRF in the region will improve the quality of care for residents of Southern Maryland.

Community-based clinicians and hospital-based clinicians in Southern Maryland have described the current access barriers to rehabilitation care and have expressed strong support for the proposed rehabilitation hospital (see Exhibit 11 for Letters of Support). More specifically, area physicians and the Stroke Program Coordinator at Prince George's Hospital Center have emphasized the need for intensive post-acute rehabilitation and the capabilities of an IRF. Their statements best convey the obligation to patients and the value that the proposed project will provide to the region. Statements include the following:

> "Patients who are cared for in an acute inpatient rehabilitation hospital improve their functional capabilities much faster and more comprehensively compared to those in a skilled nursing facility…it is well known that those cared for in an acute inpatient rehabilitation hospital have better outcomes and return home or place of residence at a much higher incidence…currently, such services are extremely limited in Prince George's County and are badly needed for the people who reside here." (Board Certified Neurologist, Bowie)

> "One of the biggest barriers that we face is access to post hospital care and rehabilitation…many times patients are forced to choose less intensive arenas to

carry out the vital rehabilitation that is needed to reintegrate them back into society…The importance of a quality inpatient acute rehabilitation facility for the community surrounding our hospital cannot be overemphasized." (Stroke Program Coordinator, University of Maryland Prince George's Hospital Center)

"I know firsthand of the quality inpatient rehabilitation services they provide. This is a top tier company." (Board Certified Physical Medicine and Rehabilitation Specialist)

9. Encompass Health will strengthen prevention activities and community education programs in the area of safety and falls prevention.

The Encompass Health Safe Patient Mobility Program addresses the high risk of falls in the elderly population through the following activities:

- Hospital policies that include assessment of all patients upon admission and reassessment through the stay using the Morse Fall Scale, a nationally accepted fall assessment tool.
- Specialized training for staff in fall precautions and fall prevention.
- Color-coded armbands for patients at high risk for falls.
- National Fall Task Force that monitors the fall rate in each hospital and explores innovative ways to reduce falls.
- Patient and family education on how to reduce falls in the home.
- Annual celebration of National Patient Safety Awareness Week, which includes patient, family and community awareness of safety issues, including falls.
- Bed Safety program designed to reduce risk of falls in patient rooms.

(G) New Rehabilitation Special Hospitals: Premises and Volume Projections

The following section presents the overarching premises for establishing a new hospital and the detailed assumptions for volume projections based on Year 2021 as Year 1 of operation.

Overarching Premises

The Project is premised on 7 fundamental principles and market dynamics:

1. Encompass Health will provide the distinct resources of an IRF and will meet community needs.

Currently, there is no IRF operating in this service area and after the reconfiguration at Laurel Regional, there will be only 10 (ten) rehabilitation beds at UM PGRMC. Already this region is underutilizing acute rehabilitation services and relying heavily on the SNF setting for post-stroke and other needs for rehabilitation. This is inconsistent with clinical practice guidelines issued for

stroke care and denies access to the highest quality, highest caliber rehabilitation services offered to other regions of Maryland. EHRHSM will assure this region of 1.4 million residents equitable access to a high quality, state-of-the-art rehabilitation program.

2. Outmigration to District of Columbia facilities should be reduced.

Encompass Health will reduce the outmigration to District of Columbia facilities. The new hospital will provide local access, promote effective use of rehabilitation services, and provide a lower cost service site relative to District of Columbia facilities.

3. Demographic growth in Southern Maryland and Anne Arundel County will support an additional program in Maryland.

The service area population already accounts for 63 occupied rehabilitation beds (even at a low utilization rate) and the over-65 population of this region is growing at approximately 5% per year. The service area can support an additional program without having an adverse impact on existing, out-of-region providers.

4. Quality of care improvements can be achieved by shifting volume from skilled nursing facilities to a more rehabilitation intensive, specialty supported, state-of-the-art rehabilitation hospital setting.

The heavy reliance on skilled nursing facilities has resulted in post-acute stays of more than 30 days for patients who could be treated more intensively/aggressively in an IRF for an inpatient stay of less than 15 days. Use of an IRF may also reduce the originating acute care stay because the IRF can admit patients sooner and provide continued specialty attention/medical management. In sum, patients will experience dramatically shorter inpatient stays and achieve better functional outcomes. Patient satisfaction will increase, return to work/routine activities will be supported, and longer-term disability will be minimized. Use of an IRF in place of the SNF for stroke patients is consistent with clinical practice guidelines published by the American Stroke Association and endorsed by the American Heart Association for stroke patients.

5. An IRF in Prince George's County will support population health management and support success of the new UM Capital Regional under the total cost of care model.

The new UM Capital Regional PGRMC has been premised on the goal of achieving a 30% market share in Prince George's County as outmigration is reduced, and acute rehabilitation services will be critical to promote continuity of care and effective care management. In addition, a lower cost alternative to District of Columbia hospitals will be important to reduce Medicare spending under the Waiver. Finally, improved functional outcomes will support longer-term independence and reductions in the total cost of care for Prince George's County residents.

6. Encompass facilities will accommodate a broader population than do SNFs and will improve performance under the Waiver.

Experience from Encompass Health hospitals across the country provides evidence that Encompass Health hospitals:

- Offer a hospital level of clinical care for appropriate patients - thereby improving clinical functional outcomes for qualified patients.
- Accommodate direct admissions for rehabilitation - appropriate patents from physician offices, the community and from the acute care hospital emergency rooms - thereby assisting with less acute care hospital admissions.
- Admit patients who are more medically complex and still require specialty attention and medical management - thereby assisting with reducing acute care hospital lengths of stay.

7. Encompass can expect to achieve at least 50% market share in its service area.

Evidence demonstrates that IRFs - - recognized for their distinctive resources and level of care - - capture more than 50% market share in the Maryland and District of Columbia markets where they operate.

Market Share for IRFs

Adult Acute Rehab Discharges (18+)
Market Share by Hospital & County of Residence
CY 2016

	Montgomery County		Eastern Shore Counties		District of Columbia	
Hospital	#	%	#	%	#	%
Maryland Hospitals						
UM Rehabilitation & Orthopaedic Institute	32	2.1%	66	4.3%	4	0.3%
Laurel Regional Hospital	21	1.4%	1	0.1%	5	0.4%
Johns Hopkins Hospital	23	1.5%	13	0.8%	15	1.3%
Sinai Hospital	10	0.7%	6	0.4%	1	0.1%
MedStar Good Samaritan Hospital	7	0.5%	7	0.5%	1	0.1%
Meritus Medical Center	-	0.0%	-	0.0%	1	0.1%
UM Shore Medical Center at Easton	1	0.1%	339	22.1%	-	0.0%
MedStar Union Memorial Hospital	-	0.0%	-	0.0%	-	0.0%
Western Maryland Regional Medical Center	-	0.0%	2	0.1%	-	0.0%
Levindale	1	0.1%	1	0.1%	-	0.0%
Adventist Rehabilitation Hospital of MD	1,193	**78.2%**	9	0.6%	79	6.7%
HealthSouth Chesapeake Rehab Hospital	1	0.1%	1,076	**70.3%**	1	0.1%
Subtotal: Maryland Hospitals	1,289	84.5%	1,520	99.3%	107	9.0%
Washington, DC Hospitals						
George Washington University	15	1.0%	2	0.1%	226	19.0%
MedStar National Rehabilitation Hospital	221	14.5%	9	0.6%	854	**71.9%**
Subtotal: Washington, DC Hospitals	236	15.5%	11	0.7%	1,080	91.0%
Total	**1,525**	**100.0%**	**1,531**	**100.0%**	**1,187**	**100.0%**

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2016 Final
[2] DC hospitals: DCHA Database; CY2016 Final
Notes:
Acute Rehab: Based on State Health Plan definition
Adult: Age 18+ years

Based on these overarching premises, volume projections were prepared for Year 2023, representing Year 3 target performance year.

Detailed Assumptions: Based on CY2016 volume

Discharges

Existing Market Base

(A) Volume currently served by Laurel Regional
Encompass will serve 90% of the volume currently served at Laurel Regional
Total Laurel volume = 259 discharges
90% of volume to be served by Encompass — 233 discharges
Service area volume = 128 discharges
Out of area volume = 105 discharges

(B) Service are volume currently out-migrating to NRH/GWU in the District of Columbia
Encompass will serve 40% of this volume; this represents a conservative target with the assumption that a substantial percentage of MedStar-affiliated patients in the service area will continue to be directed to NRH
Service area volume out-migrating to NRH/GWU = 853 discharges
40% of volume will be served by Encompass — 341 discharges

(C) Population growth associated with the service area (with no change in use rates)
Assuming no use rate increase, an additional 298 discharges will be generated
Total incremental discharges = 298 discharges
75% of volume will be served by Encompass — 223 discharges

Use Rate Increase

(A) Shift of service area volume from SNFs to Encompass hospital — 418 discharges
- Stroke volume x 30% shift
- Traumatic brain injury and spinal cord injury x 5-10% shift
- All other high potential rehabilitation diagnoses x 2-3% shift

(B) Demographic growth of population estimated above @ 5% annually
By Year 2023 — 154 discharges

(C) Organ transplants, service area = 98
x 10% rehabilitation candidates — 10 discharges

New Markets

(A) Direct admissions: Assume 5% of total discharges
Slightly lower than Encompass's national experience — 75 discharges

(B) Out-of-area admissions
Assume 10% of total discharges, less Laurel's out of area — 46 discharges

GRAND TOTAL, DISCHARGES	**1,500 discharges**
Average length of stay	13.5 days
Average daily census	55 occupied beds
Occupancy	92.5%

Synthesis: Volume Projections, Year 2023

	Base 2016 Actual	Projection: Year 2023	
Existing market base			
CY2016 Laurel volume	259		
x 90% share		233*	
CY2016 service area volume at NRH/GWW	853		
x 40% share		341	797 = 692 service area + 105 out of area
Population growth:			
Discharges from 1,661 to 1,959 non-TBI discharges = + 298 discharges	298		
x 75% share		223	
Shift of SNF discharges, 4 counties + 50% Anne Arundel County			
Current: Stroke transfers to SNFs	1,079		
x 30% share		324	
Current: TBI/SCI transfers to SNFs	841		
x 5-10% share		63	418 = Shift of current nursing home volume
Current: All other CMS13 transfers to SNFs	1,238		
x 2-3% share		31	
2023 population growth, age 65+ @ 5%/year:			
Incremental discharges by 2023		154	154 = Projected demographic growth by Year 2023
Organ transplants in service area x 10% rehab candidates	96	10	131 = New volume to the market
Additional out of area: Assume 10% of total (w/Laurel's 105 out of area)		46	
Direct admissions: Assume 5% of total		75	
Total, CY2023 Discharges		1,500 discharges	
Average length of stay, CY2023		13.5 days	
Average length of stay, TBI/SCI		18.2 days	
Average length of stay, other		13.0 days	
Average daily census, CY2023		55 occupied beds	
Occupancy		92.5% occupancy	

* Includes 128 in service area + 105 out of service area

Average length of stay

The average length of stay is recognized to be significantly different for TBI/SCI patients and all other patients. Based on the source of volume delineated above, and the market share projected, the following mix of patients was documented:

TBI/SCI patients	138 patients	(9.2%)
All other rehabilitation patients	1,362 patients	(90.8%)
Total	1,500 patients	100.0%

This projected mix of patients is consistent with the Statewide mix of patients and service area mix of patients (8-9% of TBI/SCI discharges).

The average length of stay for service area patients and the average length of stay for Encompass patients was documented. Encompass expects that through its care protocols and care management resources, its patients will demonstrate a reduction in the current length of stay for

service area patients. The following depicts the projected Encompass length of stay compared to national averages, and the midpoint projected for the new hospital:

Average length of stay

	Current service area	Encompass, National	Midpoint Projected
TBI/SCI in rehabilitation units	19.6 days	13.4 days	16.5 days
All other rehabilitation patients	13.7 days	12.7 days	13.2 days
Total projected, new hospital			13.5 days

Payor mix

The projected payor mix is based on the source and volume of discharges delineated under the volume assumptions.

- Payor mix for volume tied to Laurel Regional, NRH, and GWU is based on the actual payor mix of service area discharges now served in rehabilitation units at these three service sites.
- Payor mix tied to population growth is based on the current payor mix of the service area's rehabilitation volume.
- Payor mix tied to the shift of volume from SNFs is assumed to be 100% Medicare, as projected volume was based off of Medicare claims file.[9]
- Payor mix tied to population growth of this cohort is assumed to be 100% Medicare, consistent with the statement above.
- Payor mix of organ transplants is based on the actual payor mix of 98 solid organ transplant cases from the service area.
- Payor mix of out-of-area volume is based on the actual payor mix of Statewide rehabilitation volume in the Maryland/DC market.
- Payor mix of direct admissions is assumed to be 100% Medicare based on national experience of Encompass facilities (the large majority of these admissions are elderly who have suffered a fall).

[9] Note: Encompass did not assume a shift of non-Medicare volume from SNFs; therefore, volume projections are conservative.

The composite of these assumptions produced the following projected payor mix for CY2023:

Projected Payor Mix at Encompass Bowie
CY 2023

	# Discharges	% Discharges
Medicare	1,164	78%
Commercial/Managed	243	16%
Medicaid	61	4%
All Other	32	2%
Total Discharges	1,500	100%

It is important to acknowledge that the projected payor mix is significantly different than the current payor mix of rehabilitation discharges from the service area. The current payor mix shows a dramatically lower percentage of Medicare patients relative to most rehabilitation programs across the country and reflects the fact that acute rehabilitation is underutilized in both Southern Maryland and Anne Arundel County. Not surprisingly, then, the percentage of Medicare patients is very low; a high percentage of Medicare patients are discharged to SNFs or to home with less intensive, less aggressive rehabilitation services.

Projected market share

Based on the assumption that the rehabilitation use rate will increase to the State of Maryland average use rate, the total projected service area volume is projected to be 2,780 discharges by Year 2023. Assuming that Encompass achieves the projected 1,500 discharges, this would equate to a service area market share of 48%.

As noted earlier, the three IRFs in Maryland and the District of Columbia (NRH, Adventist, and HealthSouth Chesapeake) each command > 50% market share in their regions.

Projected Market Share in Service Area
CY2023

Source of volume	Service Area	Out of Area	Total Volume
Laurel Regional	128	105	233
NRH/GWU	341		341
Population growth, service area	223		223
Shift from SNFs	418		418
Population growth tied to above	154		154
Organ transplants	10		10
Direct admissions	75		75
Additional out of area	____	46	46
TOTAL	1,349	151	1,500
Total projected market	2,780		
Market share, service area	48.5%		

Achieving volume targets: Referral base and strong program support

Community-based clinicians and hospital-based clinicians in Southern Maryland have described the current access barriers to rehabilitation care and have expressed strong support for the proposed rehabilitation hospital (see Exhibit 11). More specifically, area clinicians and the Stroke Program Coordinator at Prince George's Hospital Center have emphasized the need for intensive post-acute rehabilitation and the capabilities of an IRF. These Letters of Support are but one set of indicators of the referral base for the proposed hospital.

Volume projections: Reasonableness Tests

Encompass prepared two high level analyses to test the reasonableness of its volume targets.

Reasonableness Test A: Medicare Claims Data and Volume of "Ultra-Rehabilitation" Patients

A review of Medicare claims data documents the number of Medicare cases identified as "high potential rehabilitation discharges" who are now admitted to SNFs for care. In this analysis, the population of high potential rehabilitation candidates was further refined to quantify how many of these SNF patients actually received rehabilitation services in the SNF based on the number of patients identified as "ultra-rehabilitation" patients. To qualify for an Ultra-High (RU) Rehabilitation RUG, a resident must receive at least 720 minutes of therapy each week, among other criteria. This definition produces a meaningful count of patients who would be best served in an intensive rehabilitation setting with state-of-the-art rehabilitation resources and expertise. The analysis documented the following caseload for service area patients only:

Service Area Patients[10] with High Potential Rehabilitation Diagnoses Served in SNFs with "Ultra-Rehabilitation" Services CY2016

Stroke	545
Neurological disorders	265
Hip fracture	259
Amputation	175
Joint replacement	53
Multi-trauma	29
Brain injury	290
Spinal cord injury	67
Total, High Potential, w/Ultra-Rehabilitation in SNFs	1,683

Assuming conservatively that 20% of this "ultra-rehabilitation" patient population (documented to require intensive rehabilitation) were to shift to an intensive rehabilitation service setting designed explicitly for this level of care, this volume would equate to 340 cases. This represents a shift only from the "ultra-rehabilitation" patient population; a substantial number of other SNF patients with high potential rehabilitation diagnoses are also expected to shift from the SNF setting and benefit from the IRF setting. This analysis, then, supports the Encompass Health's estimated shift from SNFs (418 discharges).

Reasonableness Test B: Medicare Patients: "Conversion Rate" to Rehabilitation

Based on Encompass Health's extensive national experience, a proprietary review is conducted to identify the number of Medicare patients who would be appropriate candidates for inpatient rehabilitation as compared with the number of patients who actually received inpatient rehabilitation services. This review can be referred to as a "*conversion rate to rehab*" from the acute care hospital, and represents a conversion rate for Medicare patients, only.[11]

Currently, the service area confirms a very low utilization rate by Medicare patients. Medicare claims data shows that only 5% of Southern Maryland's Medicare patients with a high potential rehabilitation diagnosis converted to a rehabilitation setting; this includes hospital-based rehabilitation units (e.g., JHH; Sinai) or specialty hospitals (Adventist). In CY2016, only 3% of Anne Arundel County Medicare patients with these diagnoses converted to a rehabilitation setting. This is in contrast to an approximate national conversion rate of 16% for Medicare patients across the nation in Encompass Health markets where Encompass works with joint venture partners, and 13% in Encompass markets nationally (as documented by Encompass Health).

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[10] Based on residents with Southern Maryland or Anne Arundel County address; only 50% of Anne Arundel County residents estimated based on service area definition.

[11] Note: Encompass facilities, on average, serve 85%. Medicare patients and 15% non-Medicare patients.

Assuming that the conversion rate for Medicare volume from Southern Maryland and half of Anne Arundel County for these eight diagnostic groups were instead at the national conversion rate in Encompass Health markets, one could expect an incremental volume of more than 200 Medicare discharges in the acute rehabilitation setting from these 8 diagnostic groups, alone (or, by Year 2023, closer to 300 discharges). These diagnostic groups have historically accounted for only 62% of Encompass Health's discharges. This assessment, then, provides further support to the Encompass Health projection of new market volume (in addition to the existing Laurel Regional and NRH/GWU volume).

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

1. Hospital-based acute rehabilitation unit - General.

First, Encompass Health does not operate acute care hospitals and many acute care hospitals do not have the space or are unwilling to sacrifice core-program space to house an inpatient rehabilitation program that is not a key program or initiative for the acute care hospital. Rehabilitation hospitals have different physical plant regulations than acute care hospitals. Some of these differences are related to required room and bathroom size to accommodate rehabilitation patients and requirements for such items as additional sinks in patient rooms and a large, convenient or adjacent area for gym space. Federal regulations have strict guidelines

related to HIH hospitals. These CMS requirements regulate the separateness of the physical space, how patients and their families and staff access the segregated space and certain other Medicare conditions of participation. Many times it is more costly than one might think to "retrofit" an acute floor to a rehabilitation unit.

In addition, a rehabilitation unit will not provide the distinct strengths and the highly valued features of an Encompass Health rehabilitation hospital with (i) easy access to a one story building with adequate surface parking and ease of entry for caregivers as they are able to directly access the rehabilitation hospital by simply walking in (as opposed to having to navigate within an acute care hospital to find the rehabilitation unit devoted solely to rehabilitation care) and (2) space for the new technology, the educational programs, the family-focused services, and the specialty-focused teams that Encompass Health delivers. These features are core to the value and quality that Encompass Health hospitals provide.

2. Utilize Laurel Regional Hospital ("Laurel") for an expanded acute rehabilitation unit.

Two additional challenges made this plan not feasible.

(a) Laurel is not centrally located in Prince George's County and the Southern Maryland Planning Region to effectively serve the targeted population.

(b) Laurel is being converted into a freestanding medical facility (FMF). It will no longer be feasible to operate inpatient services at Laurel long-term.

3. Utilize space in the new Capital Regional University of Maryland Prince George's Regional Medical Center ("PGRMC") for a new hospital-based acute rehabilitation unit.

In the course of the CON review process, facility plans for PGRMC were downsized and virtually all of the space in the new facility is now programmed and "spoken for" and therefore the opportunity to incorporate a new rehabilitation unit does not exist.

4. Invest in a freestanding hospital to provide the specialty resources, high-quality clinical outcomes, experienced management, capital investment, cost efficiencies, and independent provider status to respond to population need

Given the unique challenges explained above, a freestanding hospital was the best option to provide the most conveniently located, accessible care that would provide the greatest benefit to appropriate patients and their families. Moreover, national data attests to the fact that freestanding rehabilitation hospitals have lower costs relative to hospital-based units.

FY2018 Average Cost and Average Payment per Discharge
By Provider Setting

	Average Estimated Total Cost per Discharge	Average Estimated Total Payment per Discharge
Encompass Health	**$12,903**	**$19,776**
Other Freestanding	**$17,363**	**$20,749**
Hospital-Based Units	**$20,798**	**$21,153**
Total, All Rehabilitation Inpatient	**$17,753**	**$20,665**

Source: Encompass Health analysis based on CMS Cost Reports and Rate Filings

Based on this assessment of alternatives, the proposed plan to establish EHRHSM clearly represents the most cost-effective option for meeting community needs and offers the highest opportunity potential for high caliber, state-of-the-art, patient-focused care.

10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

See Exhibit 11 for letters demonstrating community support. Available cash will be used to fund the Project. See Exhibit 12.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[12];

b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access); and

c) On costs to the health care delivery system.

1. Volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project.

The Project is premised on the assumption that patient volume will be generated from four major sources:

a. Patient volume previously served at Laurel Regional.

b. Patient volume redirected from District of Columbia acute rehabilitation programs.

c. Patient volume generated by demographic growth of the service area.

d. Shift of patient volume from SNFs to serve patients who qualify for intensive rehabilitation.

[12] Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.

The only existing acute inpatient rehabilitation providers expected to be impacted by the proposed project are the two acute rehabilitation programs in the District of Columbia: NRH and GWU. Encompass Health does not anticipate a meaningful impact on any acute rehabilitation providers in Maryland. The volume projections documented in Section __ confirm that the proposed program is not expected to be built through volume shifts from existing acute rehabilitation programs in Maryland; none of the 1,500 projected discharges are projected to be drawn from existing acute rehabilitation providers in Maryland. This point is further clarified by the following summary presentation:

Projected Volume for Encompass Health, Southern Maryland
Impact on Existing Facilities
Projected Year 2023

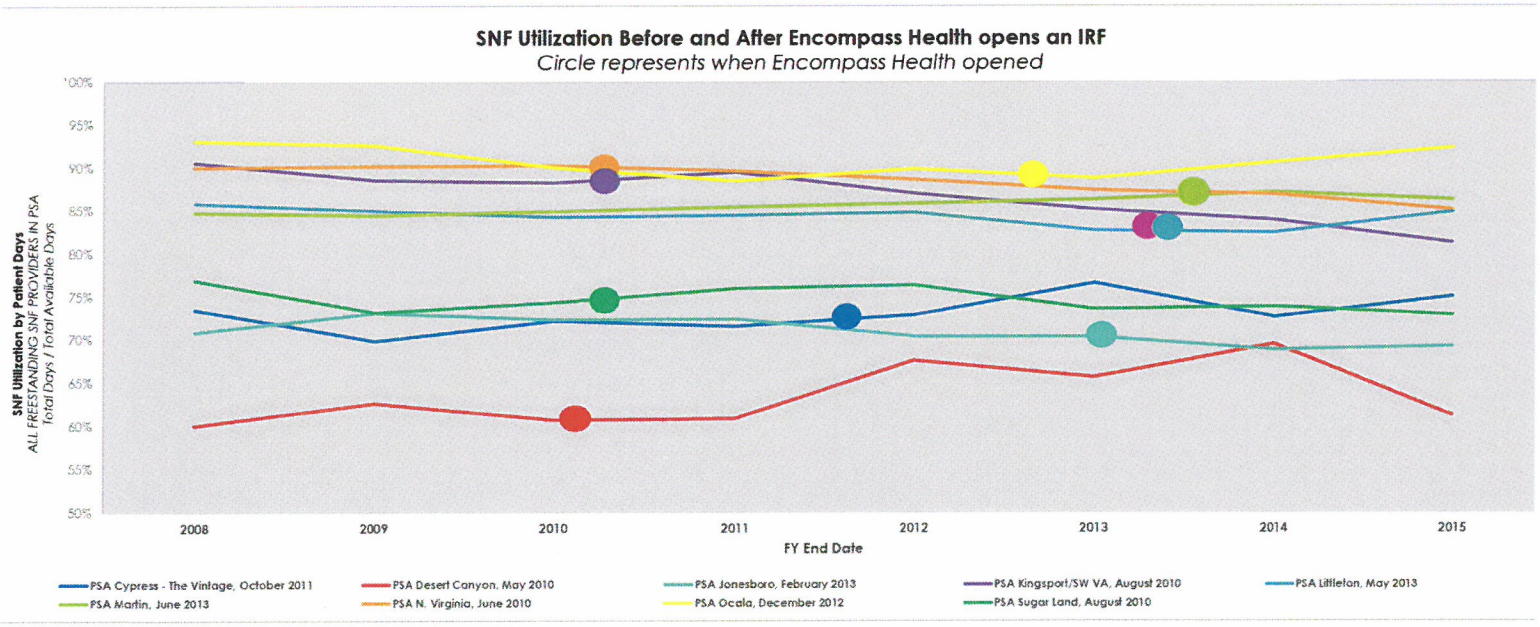
			Projected Loss			Projected Gain/Retain			
Category	Referral source	CY2016 Discharges	Laurel Regional	National Rehab/GWU	SNFs	Shift/Gain: Encompass	Retain/Gain: Other acute providers	Retain/Gain: Nursing homes	CY2023 Discharges
Acute rehab	Laurel Regional	259	(259)			233	26		
	National Rehab/GWU	2,470		(341)		341	2,129		
	All other acute hospitals	9,750					9,750		
	Demographic growth, 2016-2023					223	75		
	Total, Acute Hospitals	**12,479**	**(259)**	**(341)**	**-**	**797**	**11,980**	**-**	12,777
SNFs	Volume at SNFs: High Pot'l Rehab	3,158			(418)	418		2,740	
	Demographic growth					154		1,115	
	Total, SNFs	**3,158**			**(418)**	572	-	**3,855**	4,427
New volume	Direct admissions					75			
	Organ transplants					10			
	Out of area volume					46			
	Total, New Volume to the Market	-				131	-	-	131
	Grand Total	**15,637**				**1,500**	**11,980**	**3,855**	**17,335**

As acknowledged, EHRHSM does intend to redirect approximately 340 discharges from NRH/GWU. But this volume represents only 15% of total discharges across these two facilities. Moreover, this presentation does not show the opportunities that NRH/GWU have for backfilling this volume through demographic growth in the Washington metropolitan area (including the high growth region of northern Virginia) and through shifts of SNF volume in its own local service area.

EHRHSM does project a volume shift from SNFs to its new rehabilitation hospital. This will occur as referral patterns by clinicians/discharge planners change, redirecting more patients who are clinically appropriate patients requiring a hospital level of care to EHRHSM. This is consistent with clinical practice guidelines issued for the post-acute management of stroke patients and the goals for quality care improvements. In contrast to SNFs, the Project will provide more intensive and more specialized rehabilitation services, supported by state-of-the-art equipment and specialized therapeutic settings. As an acute rehabilitation hospital, supported by more physician and nursing staff, EHRHSM will be able to admit patients from the hospital

sooner and initiate rehabilitation earlier; taken together, this promotes greater progress and improved functional status upon discharge. Finally, the new facility is geared toward early discharge to the community by actively engaging/training family members and by effectively coordinating community-based services and care management to support successful transitions to home. Therefore, although EHRHSM will redirect volume from SNFs, the goal is to provide more patients with earlier, more intensive rehabilitation, support improved outcomes, and promote successful care transitions with reduced risk of readmission to the acute hospital.

Furthermore, although the projected volume shift from SNFs amounts to approximately 400 discharges from area SNFs, no single SNF will be significantly affected, as SNF placements from area hospitals are currently dispersed across more than 10 SNFs[13]. In CY2015, SNFs in Southern Maryland reported an average occupancy rate of 91%[14], and with the demographic growth of the over-65 population area SNFs are not likely to experience a significant decline in admissions even as more stroke patients and other high opportunity rehabilitation candidates are referred to EHRHSM. In fact, Encompass hospitals in markets across the country support this premise. The graph below depicts occupancy rates of area SNFs before and after the entry of Encompass into sample markets; the graph documents that occupancy rates at area SNFs generally do not suffer a significant decline in occupancy rates as an Encompass IRF begins operating in their local market.



[13] Medicare Claims File, CY2016. Findings based on examination of Southern Maryland and Anne Arundel County residents with high potential rehabilitation diagnosis at discharge from the acute care hospital and discharge destination within seven days of discharge.

[14] Maryland Health Care Commission. Annual Long-Term Care Survey, CY2015.

2. On access to health care services for the service area population that will be served by the project.

EHRHSM does not expect that the proposed project and the projected volume shift will result in any reduction in the availability or accessibility of services. Instead, the new facility will produce a new and needed service.

3. On costs to the health care delivery system and successful performance under the Waiver.

Clearly, the pressures to minimize the total costs of care have intensified as Maryland enters Phase II of the Demonstration Project. Hospitals will be operating under total costs of care contracts, physicians will increasingly be participating in risk-based models (either for single episodes or ACO-like models) and risk-based contracts are anticipated for the dual eligible population. Maryland providers have begun to craft acute/post-acute partnerships for value-based payment models. Cost-effective rehabilitation providers will be critical to successful performance and cost savings.

An Encompass Health partner in Southern Maryland will be invaluable to supporting successful performance under the Waiver. Its distinct level of care, its evidence-based protocols, its high-quality outcomes, its measurement systems and real-time reporting, and its data-driven operations make EHRHSM a cost-effective, quality-minded and discharge-oriented provider with the experience to operate under value-based contracts.

Hospitals seeking to manage successfully under total costs of care contracts will find an experienced partner for episode management. Clinicians seeking to maintain continuity of care will be able to find a local service setting for recovery and rehabilitation and will able to maintain that continuity of care with patients. Patients and families seeking shorter institutional stays and care coordination services will find experienced providers who are committed to these same goals.

The following Section provides evidence to show that an IRF in Southern Maryland, and an Encompass Health hospital in particular, can reduce Medicare spending and/or promote the longer-term goals for population health management and quality improvement.

(a) Use of an Encompass Health hospital - in place of an SNF can dramatically reduce the total number of inpatient days for patients, provide state-of-the-art rehabilitation resources, and still maintain or lower inpatient episode spending for high potential rehabilitation patients.

Evidence: A review of Medicare FFS claims (2016) for Maryland residents transferred for acute rehabilitation within seven days of hospital discharge to either HealthSouth Chesapeake or to SNFs ***with*** significant rehabilitation services demonstrates that Encompass facilities can accept

patients more quickly for transfer, discharge patients after half the number of days in rehabilitation and result in comparable or lower costs for the episode of care[15]. This is evident despite the huge difference in resources provided in the IRF relative to the SNF setting:

Maryland Medicare FFS Patients
Discharges with High Potential Rehabilitation Diagnoses & Admitted to IRF vs. SNF
Utilization Comparison
CY2016

	HealthSouth Chesapeake	SNF w/ultra-rehabilitation
STROKE COHORT		
# Discharges	141 discharges	2,057 discharges
ALOS for Originating Hospital Stay	4.6 days	7.9 days
ALOS for Rehabilitation/SNF stay	15.0 days	41.1 days
Total Inpatient Episode, Days	19.6 days	48.9 days
Total Inpatient Episode, $$	$33,543	$34,281
TBI/SCI PATIENT COHORTS		
# Discharges	43 discharges	1,530 discharges
ALOS for Originating Hospital Stay	5.2 days	9.2 days
ALOS for Rehabilitation/SNF stay	14.9 days	35.0 days
Total Inpatient Episode, Days	20.1 days	44.1 days
Total Inpatient Episode, $$	$39,654	$37,555
OVERALL, 8 HIGH REHABILITATION POTENTIAL COHORTS		
# Discharges	225 discharges	6,918 discharges
ALOS for Originating Hospital Stay	4.8 days	7.4 days
ALOS for Rehabilitation/SNF stay	14.8 days	37.8 days
Total Inpatient Episode, Days	19.6 days	45.2 days
Total Inpatient Episode, $$	$34,595	$34,152

Source: CMS Standard Analytic File (2016)

(b) Use of an IRF in place of an SNF can reduce the 30-day readmission rate for high potential rehabilitation patients who are now served at SNFs.

Evidence: Medicare FFS claims for the same populations as examined above were documented for the 30-day period following the initial discharge date to document the 30-day readmission rate of patients served at IRFs and patients served at SNFs with ultra-rehabilitation services. This provides further evidence of the impact that use of an IRF will have on improving Maryland performance under the waiver.

The data below documents 30-day readmission rates for patients across all three IRFs in Maryland and Washington, DC relative to the readmission rate for Maryland patients at SNFs:

[15] This is evident despite per diem costs at SNFs generally being below $450/day.

Maryland Medicare FFS Patients
Discharges with High Potential Rehabilitation Diagnoses Admitted for Rehabilitation Stay
30 Day Readmission Rates from Date of Original Discharge
CY2016

	IRFs, MD/DC	SNF w/ultra-rehabilitation
STROKE COHORT		
# Discharges	141 discharges	2,057 discharges
30 Day Readmission Rate	20.6%	22.8%
TBI/SCI PATIENT COHORTS		
# Discharges	43 discharges	1,530 discharges
30 Day Readmission Rate	14.0%	23.9%
OVERALL, 8 HIGH REHABILITATION POTENTIAL COHORTS		
# Discharges	225 discharges	6,918 discharges
30 Day Readmission Rate	18.2%	19.9%

Source: CMS Standard Analytic File (2016)

(c) Medicare spending will be lower for inpatient rehabilitation services at Encompass Southern Maryland relative to rehabilitation services at MedStar National Rehabilitation Hospital.

Evidence: A review of Medicare FFS claims (2016) for Maryland residents discharged with a stroke diagnosis, and admitted to either HealthSouth Chesapeake or NRH, documents that the rehabilitation stay was nearly 20% higher cost at NRH relative to the stay at HealthSouth Chesapeake for nearly identical average lengths of stay.

Maryland Medicare FFS Patients
Discharged with Stroke Diagnosis and Admitted for Rehabilitation Stay
Utilization Comparison
CY2016

	MedStar NRH	HealthSouth Ches
# Stroke Discharges, Medicare FFS	132	141
ALOS at Rehabilitation Hospital	15.3 days	15.0 days
Average Charge at Rehabilitation Hospital	$23,895	$19,671
Average Per Diem	$ 1,562	$ 1,311
% Differential, per diem		*(19%)*

Source: CMS Standard Analytic File (2016)

(d) Use of an IRF has been correlated with improved functional outcomes and reduced morbidity rates. Higher utilization of acute rehabilitation services for the Southern Maryland population can be expected to yield longer-term savings to the per capita Medicare spending in Southern Maryland and Anne Arundel County.

Evidence: A longitudinal study of Medicare patients, prepared by researchers using a 20 percent Medicare sample and using matched cohorts, assessed long-term patient outcomes of patients served in IRFs as compared with patients served in SNFs. Results of this longitudinal analysis demonstrated that over a 2-year study period, clinically comparable patient populations showed the following:

- IRF patients experienced significantly fewer hospital readmissions per year than SNF patients for five (5) of the 13 conditions examined.
- IRF patients experienced five percent fewer emergency room visits per year than SNF patients.
- IRF patients experienced an eight-percentage point lower mortality rate during the two-year study period[16].

Evidence: A study prepared by Encompass Health, Blue Health Intelligence and a national accounting firm showed that use of Encompass Health's IRFs was considerably more cost effective than the average SNF as measured by the total cost of care and as measured by hospital readmissions. The study examined utilization patterns of stroke patients from 90 days prior to stroke through stroke incident through 90 days after completion of the rehabilitation stay (Claims data, 2010-2013). Utilization patterns and cost of care were compared for stroke patients utilizing SNFs ad stroke patients utilizing IRFs[17]. Findings included:

- Stroke patients at SNFs were nearly twice as likely to have a hospital readmission when receiving care at an SNF as compared with stroke patients at an IRF.
- IRF patients had a lower readmission rate after discharge relative to SNF patients. Approximately 10% more SNFs patients were readmitted to the hospital than were IRF patients.
- IRF patients had the lowest readmission costs in each of the three 30-day segments of the 90-day period following a stroke.
- IRF patients had the lower total costs of care in each of the 30-day segments of the 90-day period following a stroke.

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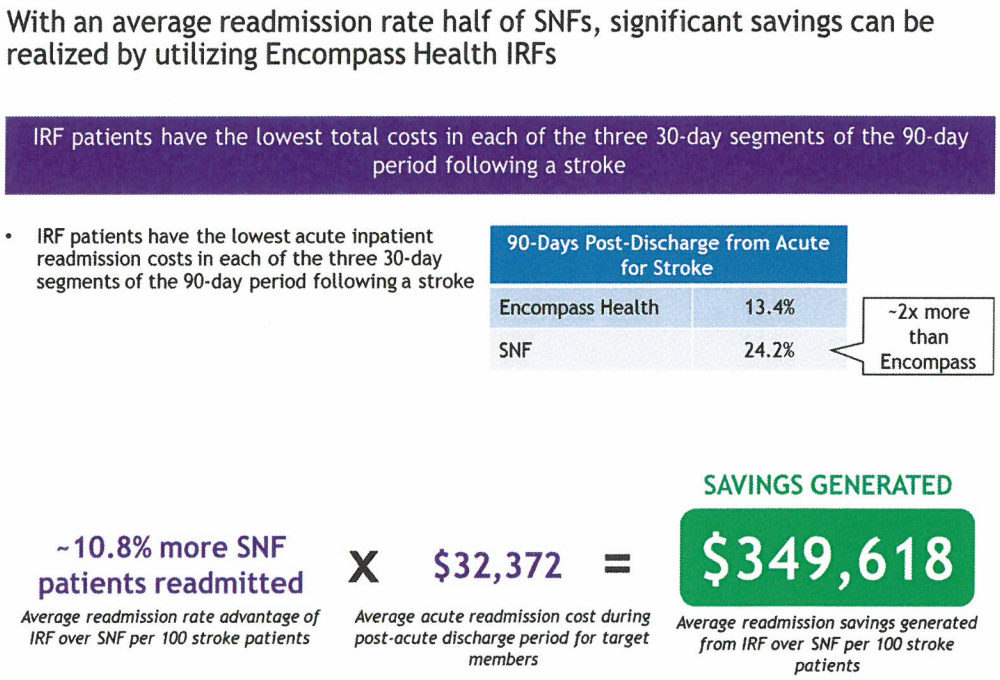
[16] Dobson & DaVanzo Associates. "Assessment of Patient Outcomes of Rehabilitative Care Provided I IRFs," (2014).

[17] Blue Health Study of Stroke Patients. Prepared by Encompass Health, Blue Health Intelligence and a national accounting firm (Claims data, 2010-2013).

Based on these findings and an estimated cost per readmission, the study estimated that approximately $350,000 of savings could be generated for every 100 stroke patients served at an IRF.



(e) The role of Encompass Health in the market will provide deep expertise in the regulatory and financial issues tied to acute rehabilitation and is already equipped with the measurement and reporting tools necessary to support compliance during a very dynamic period of regulatory and reporting changes.

Evidence: Encompass Health is actively involved in the development and monitoring of changes being issued by CMS for financial reporting and quality measurement. This expertise will be invaluable going forward as a significant number of changes are adopted and new sets of quality reporting requirements are imposed. In addition to its regulatory expertise, Encompass Health is equipped with information technology systems and national benchmarking software to support ongoing operations improvement and boost efficiencies. This will continue to support cost savings in Maryland.

The evidence compiled demonstrates the opportunity to leverage the IRF for both improved quality of care and readmission reduction:

- The effect on length of stay is dramatic. The IRF permits earlier discharge from the acute care facility and the IRF demonstrates significantly shorter post-acute stays in the rehabilitation settings.
- Use of the IRF correlates with lower 30-day readmission rates for Maryland residents defined by high potential rehabilitation discharge diagnoses.
- A longitudinal study of stroke patients documents that savings from readmission reduction continues through a 90-day period.

RESPONSES TO PART IV

COMAR 10.24.09 - Specialized Health Care Services - Acute Inpatient Rehabilitation Services

.04 Standards.

A. General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as

reported in the most recent HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Encompass Health operates its hospitals in a manner that promotes health for a broad cross-section of the community. Encompass Health's wholly-owned hospitals provide charity care to qualifying patients based on the following percentages of the Federal Poverty Limits:

Income Level	Reduction of Charges
0-200% Federal Poverty Limit	100%
201-300% Federal Poverty Limit	75%
301-400% Federal Poverty Limit	50%

The Encompass Health Charity Care Policy (see Exhibit 12) includes the requirements set forth above as set forth on Exhibit 13:

(2) Quality of Care.

A provider of acute inpatient rehabilitation services shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

EHRHSM will seek to be licensed by the Department of Health and Mental Hygiene as a special hospital, rehabilitation.

(ii) Accredited by the Commission for Accreditation of Rehabilitation Facilities.

EHRHSM will be accredited by the Commission for Accreditation of Rehabilitation Facilities as Comprehensive Integrated Inpatient Rehabilitation.

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

EHRHSM will be in compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

Not applicable.

(c) **An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or on inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally**.

The following section discusses quality performance on 4 levels:

Level 1	Inpatient Rehabilitation Facilities (IRFs): Distinctions in level of care and quality performance relative to SNFs.
Level 2	Encompass Health: Scope of operations, clinical advances through technology, clinical management initiatives, continuous quality improvement, quality performance indicators.
Level 3	Encompass Health: Experience in population health management and value-based contracting.
Level 4	HealthSouth/Encompass Health in Maryland: Improving waiver performance through high quality performance and lower costs of care.

Quality Performance, Level 1: IRFs - Fundamental distinctions and quality strengths

Before discussing the high-quality performance of Encompass Health hospitals, it is critical to first establish how inpatient rehabilitation hospitals (IRFs) differ from alternative service settings, such as skilled nursing facilities (SNFs) where rehabilitation services may be provided. These differences are critical to understanding how IRFs produce higher quality outcomes for patients.

IRFs are qualitatively different from SNFs that provide rehabilitation services: IRFs have highly regulated admission criteria, provide higher intensity medical and nursing services, have more rehabilitation professionals with specialty training/certification, utilize a multi-disciplinary approach to care involving a rehabilitation physician, nurses, therapists, case managers and others to maximize functional outcomes and provide more state-of-the art technology for rehabilitation care. These resources permit specialty rehabilitation hospitals to accommodate more complex patients, initiate rehabilitation sooner, and promote progress early on in the recovery process. IRFs also have the facilities for simulated environments and more equipment for therapy to match individualized care plans, as well as more formalized programs for family engagement and education. Together, these resources result in shorter inpatient stays for rehabilitation patients in IRFs relative to SNF stays reflecting the more intensive rehabilitation care and the early focus on adapting to the home/community settings.

The fundamental core differentiators between IRFs and SNFs are described below.

IRF is a Different Level of Care: Fundamental Distinctions

Inpatient Rehabilitation Hospital		Nursing Home	
Average length of stay	= 12.7 days	Average length of stay	= 38.5 days
Discharge to community	= 76.0%	Discharge to community	= 38.8%
Requirements:		Requirements:	
IRFs must also satisfy regulatory/policy requirements for hospitals, including Medicare hospital conditions of participation.		No similar requirement; Nursing homes are regulated as nursing homes only	
All patients must be admitted by a rehab physician.		No similar requirement	
Rehab physicians must re-confirm each admission w/n 24 hours.		No similar requirement	
All patients, regardless of diagnoses/condition, must demonstrate need and receive at least three hours of daily intensive therapy.		No similar requirement	
All patients must see a rehabilitation physician "in person" at least three times weekly.		No similar requirement; some SNF patients may go a week or longer without seeing a physician, and often a non-rehabilitation physician.	
IRFs are required to provide 24 hour, 7 days per week nursing care; many nurses are RNs and rehab nurses.		No similar requirement	
IRFs are required to use a coordinated interdisciplinary team approach led by a rehab physician; includes a rehab nurse, a case manager, and a licensed therapist from each therapy discipline who must meet weekly to evaluate/discuss each patient's case.		No similar requirement; Nursing homes are not required to provide care on a interdisciplinary basis and are not required to hold regular meetings for each patient.	
IRFs are required to follow stringent admission/coverage policies and must carefully document justification for each admission; further restricted in number/type of patients (60% Rule).		Nursing homes have comparatively few policies governing the number or types of patients they treat.	

Source: The Medicare Payment Advisory Commission, Medicare Payment Policy, March 2017 - pages 208, 216, 217, 271, and 275.

1. Level of nursing care and frequency of physician visits

IRFs are required to provide nursing care 24 hours per day while SNFs do not have this requirement. IRFs are required to provide face-to-face rehabilitation physician visits three days per week while SNFs are required to provide physician visits only one-day per month, and not necessarily by a rehabilitation physician. In addition, patients at Encompass Health hospitals are usually seen on a daily basis for management of their complex medical needs. Patients at Encompass Health hospitals may receive IV medications, get dialysis, see respiratory therapists and obtain specialist consultations as needed. Encompass Health also provides in-house pharmacies with full time pharmacist staffing. Together, these services permit the rehabilitation hospital to admit patients with more complex acute medical problems and/or continuing medical management requirements. Thus, IRFs can admit patients from the acute care hospital sooner and initiate rehabilitation services as early as possible after an acute hospitalization while continuing to manage these medical needs. The higher level of nursing care and the more

frequent physician visits are also critical elements to minimizing ER visits and readmissions from IRFs.

2. *Eligibility for admission*

As depicted in the chart above, to qualify for an IRF admission, patients must meet very strict admission requirements, including the need for two therapy modalities and the ability to tolerate a minimum of three hours of therapy per day. IRFs can admit an appropriate patient from any location provided the patient has the need for intensive rehabilitation services in an inpatient setting. Although the vast majority of IRF patients are admitted from acute care units, approximately 2% of patients admitted to Encompass Health hospitals come from SNFs and approximately 7% are admitted from physician offices and the community.

A major difference and value-added of the IRF is that a three-day hospital stay is not required to qualify for transfer to an IRF, as is required for SNF admission; IRFs can admit acute care patients after a one- or two-day hospital stay. This minimizes acute care length of stay and functions to initiate rehabilitation services as soon after an acute episode as possible. In fact, Encompass Health has reported a number of cases when patients have been admitted directly from the ICU. Early initiation of intensive rehabilitation after a critical illness has been shown to improve long term functional outcome and reduce morbidity and mortality.

3. *Diagnostic mix and requirements to serve*

CMS requires that at least 60 percent of the patients admitted to IRFs have one of the 13 diagnoses listed below (the "60 percent rule"). By way of illustration, statistics are provided documenting the diagnostic mix of Encompass hospitals nationally:

Encompass Health: Inpatient Rehabilitation Hospitals
Diagnostic Mix of Patients, 2017

Rehabilitation Impairment Category	Percentage of Discharges
Neurological conditions	21.6%
Stroke	18.0%
Brain dysfunction	10.1%
Other disabling impairments	10.0%
Other orthopedic	9.3%
Fracture of lower extremity	7.9%
Major multipe trauma	5.3%
Cardiac	4.3%
Replacement of lower extremity joint	4.1%
Spinal cord dysfunction	4.0%
All other	2.8%
Amputation	2.6%
Total	100.0%

Source: Encompass Health (2018)

In contrast, no particular diagnosis is required for admission to a SNF so long as the criteria for nursing care needs are satisfied.

4. Intensity of rehabilitation therapy

IRFs provide physical therapy, occupational therapy, speech-language therapy, and orthotics/prosthetics, and admit those patients who require two or more types of therapy. IRFs provide rehabilitation therapy for a minimum of three hours per day for at least five days per week (or, at least 15 hours within seven consecutive days). The IRF must initiate therapy within 36 hours from midnight of the day of admission and must implement an overall plan of care within four days of admission. In most cases, patients admitted to Encompass Health rehabilitation hospitals begin therapy on the day of or the day after admission (if the patient arrives late in the day).

In skilled nursing facilities, the decision about how much therapy to provide is largely determined by individual facilities, and there is a great deal of variance in the number of therapy hours, and the quality of therapy, across facilities. It is also important to note that there is a payment differential for SNFs and IRFs. IRFs are paid based on a discharge methodology while SNFs are paid on a daily per diem basis. While the IRF payment is somewhat fixed over different lengths of stay, a SNF will benefit financially for longer lengths of stay. Further, SNFs are paid more by Medicare as more minutes of therapy are provided to each patient.

The different incentives associated with rehabilitation intensity appear to impact length of stay. A review of patient cohorts with rehabilitation services provided at SNFs vs. IRFs in Maryland and in the District of Columbia documented that the average length of stay at SNFs is more than twice as long compared to IRFs (+ an additional 20 days) for comparable diagnostic groups of Medicare patients, as described herein.

5. *Interdisciplinary team approach*

IRFs are required to provide an interdisciplinary approach to assure that each patient receives the optimal therapy components and discharge planning, and that nursing staff reinforces the therapies provided. An interdisciplinary team is required to meet weekly to evaluate each patient's case, re-establish goals for the patient, and adjust therapeutic plans, as needed. The interdisciplinary team must include a:

- Rehabilitation physician
- Registered nurse with specialized training or experience in rehabilitation
- Social worker or case manager, and a
- Licensed or certified therapist for each therapy discipline involved in treating the patient

The interdisciplinary team is required to complete a plan of care document within the first few days of arrival and is required to meet at least on a weekly basis to modify the plan to meet the patient goals prior to discharge.

6. *Specialty Medical Director*

IRFs are required to contract with a Medical Director with training and experience in rehabilitation medicine, and this clinician must be available on a full-time basis. The majority of Encompass Health's Medical Directors are board certified in Physical Medicine and Rehabilitation. Encompass Health has a robust onboarding for new Medical Directors and provides ongoing education for Medical Directors with CME-sponsored conferences and didactic lectures. This presence is a critical distinguishing factor: The Medical Director impacts the quality of medical and nursing care and assures compliance with all Joint Commission and CARF requirements as part of the senior management team at the hospital. While SNFs typically have a family physician or internist as Medical Director, a SNF Medical Director is required to be present only once monthly and his/her focus is more largely on long-term care services rather than on rehabilitation care.

7. *Leading edge technologies and customized facilities*

Encompass Health invests in leading-edge rehabilitation technology, including state-of-the-art therapy equipment for patients, a paperless documentation system for therapists, and an electronic clinical information system including a rehabilitation-specific electronic medical record. The Encompass Health hospitals are specially designed to accommodate large equipment and simulated settings to practice activities of daily living, work settings, and life skills. (See Exhibit 14) In addition, Encompass Health hospitals are designed to accommodate participation of family members in both education sessions and therapy sessions. SNFs may not have the dedicated space to accommodate these advanced technologies and do not generally design programs for family-patient training sessions. Encompass Health's rehabilitation philosophy entails including the family and patient in goal setting and education to ensure the best possible outcome and discharge to the community with a lowered risk of readmission to the acute hospital.

8. *Monitoring of rehabilitation progress and outcomes*

All IRFs are required to use the Functional Independence Measure (FIM) ® to measure and evaluate outcomes and treatment efficiency. FIM® Gain is a measure of functional improvement from admission to discharge and indicates the degree of practical improvement toward the patient's rehabilitation goals. This tool includes 18 cognitive and functional measures including walking, climbing stairs, transfers, bowel and bladder function, and dressing. FIM® evaluations are administered at the beginning of the inpatient rehabilitation program, again at designated intervals, and then at discharge. Encompass Health also utilizes the Uniform Data System for Medical Rehabilitation (UDSMR®), the rehabilitation industry's most widely recognized outcomes measurement tool, to monitor overall patient outcomes. This system measures the effectiveness of rehabilitation programs by evaluating and tracking a patient's functional status at admission, discharge, and post-discharge to document the level of disability and to assess the effectiveness of rehabilitation. UDSMR® also allows Encompass Health to benchmark its rehabilitation hospitals against regional and national performance data. In contrast, SNFs have not been required to track functional status nor measure progress toward functional independence in this detail.[18]

In addition, IRFs are required by CMS to also use the CARE tool. As a part of the Medicare Post-Acute Care Payment Reform Demonstration (PAC-PRD), a standardized patient assessment tool was developed for use at acute hospital discharge, at post-acute care admission, and at discharge. This tool was named the Continuity Assessment Record and Evaluation (CARE) Item Set. The CARE Item Set measures the health and functional status of Medicare beneficiaries at

[18] Clearly, the requirements for functional status measurement is evolving for SNFs. As Medicare payment terms align more closely with ADLs and as value-based contracting is more broadly applied, SNFs will be obligated to measure/monitor progress along functional status measures.

acute discharge, and measures changes in severity and other outcomes for Medicare post-acute care patients.

The CARE Item Set is designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings including IRFs and standardize the items used in each of the existing assessment tools while posing minimal administrative burden to providers. The CARE Item Set targets a range of measures that document variations in a patient's level of care needs including factors related to treatment and staffing patterns such as predictors of physician, nursing, and therapy intensity. The CARE Item Set is designed to measure outcomes in physical and medical treatments while controlling for factors that affect outcomes, such as cognitive impairments and social and environmental factors.

Notwithstanding the foregoing, SNFs have not demonstrated the effectiveness of rehabilitation services in their service settings. In fact, a recent report issued by the Medicare Payment Advisory Commission ("Report to the Congress," 2017) stated the following:

> ***"No improvement in patients' functional status*** **- Most beneficiaries receive rehabilitation therapy, and the amount of therapy furnished to them has steadily increased over time. Yet patients vary considerably in their expected improvement during the SNF stay...The average risk-adjusted rates of functional change -- rate of improvement in one, two, or three mobility ADLs (bed mobility, transfer and ambulation) and the rate of no decline in mobility -- were essentially unchanged between 2011 and 2015. Even though the program paid for more therapy during this period, the average functional status of beneficiaries did not improve."[19]**

9. Utilization patterns at IRFs: Distinctions

IRFs are intensely focused on improving functional outcomes and independence and being able to discharge to the community as quickly as possible so that the patient returns home to family, friends, social activities and possibly even work. The sooner a patient can return to the community, rather than another care setting, the better it is for the patient and the less costly it is for the health care system, in most cases.

National statistics document that 76% of IRF patients are discharged to the community, in contrast to 39% of patients discharged to the community from skilled nursing facilities. Length of stay figures further validate this distinction showing that SNFs that are more focused on long-

[19] The Medicare Payment Advisory Commission Report to Congress (2017)

term care. The average length of stay at a SNF is documented nationally to be 38.5 days while the average length of stay at IRFs is 12.7 days.[20]

A more refined and balanced assessment was prepared for Maryland patients, specifically, by examining only those patients at SNFs who were coded with "ultra-rehabilitation" services at SNFs, defined as receiving 720 hours per week of rehabilitation services in the SNF.

This comparison showed that the length of stay differential continues to be demonstrated:

Average Length of Stay at SNFs vs. IRFs
Maryland Medicare FFS Residents with High Potential Rehabilitation Diagnoses (HPRDs)
CY2016

	ALOS
Medicare FFS patients at SNFs, HPRDs, with ultra-rehabilitation services	37.8 days
Medicare FFS patients at SNFs, HPRDs, routine services	33.3 days
Medicare FFS patients at Freestanding IRFs in Maryland	14.6 days

Source: CMS Standard Analytic File (CY2016)
Notes: Cohort-specific comparisons based on Medicare FFS claims, CY2016
Maryland adult residents, only, discharged with one of eight High Potential Rehabilitation Diagnoses

Clinical practice guidelines issued by professional associations recommend use of IRFs over SNFs for stroke patients - Two leading professional associations have concluded that IRFs are the preferred rehabilitation setting for stroke patients relative to SNFs and have formally issued clinical practice guidelines identifying the IRF setting as the preferred setting over SNFs for stroke care. In 2016, the American Stroke Association issued "Guidelines for Adult Stroke Rehabilitation and Recovery," guidelines endorsed by the American Heart Association. These Guidelines were also endorsed by the American Academy of Physical Medicine and Rehabilitation and affirmed by the American Society of Neurorehabilitation as an educational tool for neurologists. Statements from these Guidelines are excerpted below:

"Whenever possible, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility. While in an inpatient rehabilitation facility, patients participate in at least three hours of rehabilitation a day from physical therapists, occupational therapists, and speech therapists. Nurses are continuously available and doctors typically visit daily."[21]

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[20] The Medicare Payment Advisory Commission, Medicare Payment Policy (March 2017)
[21] American Heart Association. "Guidelines for Adult Stroke Rehabilitation and Recovery," June 2016. Downloaded from http://stroke/ahajornals.org

"If the hospital suggests sending your loved one to a skilled nursing facility after a stroke, advocate for the patient to go to an inpatient rehabilitation facility instead."[22]

"The studies that have compared outcomes in hospitalized stroke patients first discharged to an IRF, a SNF, or a nursing home have generally shown that IRF patients have higher rates of return to community living and greater functional recovery, whereas patients discharged to a SNF or a nursing home have higher rehospitalization rates and substantially poorer survival."[23]

Quality Performance, Level 2: Scope of operations, clinical advances, and quality performance indicators for Encompass Health

Encompass Health is one of the nation's largest providers of post-acute healthcare services that include inpatient and home-based operations supported by care management/care navigation services. Encompass Health's operations also include clinical research and professional training, and Encompass Health has developed a proprietary electronic clinical information system designed explicitly for rehabilitation care and evidence-based protocols.

Encompass Health has built the expertise to care manage patients across the continuum of post-acute services and is committed to serve patients in the most cost-effective setting. In addition to its network of 127 rehabilitation hospitals, Encompass operates the 4th largest network of Medicare-certified skilled home health services which operate in 200 locations. Encompass Health is firmly committed to the integration of inpatient services with community-based services, and this is reflected in its investments and its program design: Approximately 60% of its IRFs also have a home health operation within a 30-mile radius.

Performance indicators attest to the fact that Encompass Health is a low cost and high-quality performer. As indicated above, Encompass Health utilizes Uniform Data System for Medical Rehabilitation (UDSMR®), the rehabilitation industry's most widely recognized outcomes measurement tool, to monitor overall patient outcomes. Key indicators include the following (see pages following for detail):
IRF quality indicators: Relative to national providers reporting through UDSMR®, Encompass Health reports

- Consistently higher rates of discharge to the community
- Lower discharge rate to the acute care setting
- Lower rate of discharge to skilled nursing facilities
- Lower than average cost per discharge, relative to hospital-based units and freestanding facilities

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[22] Ibid (verify same source)
[23] Ibid (verify same source)

- Higher than expected functional improvement gains

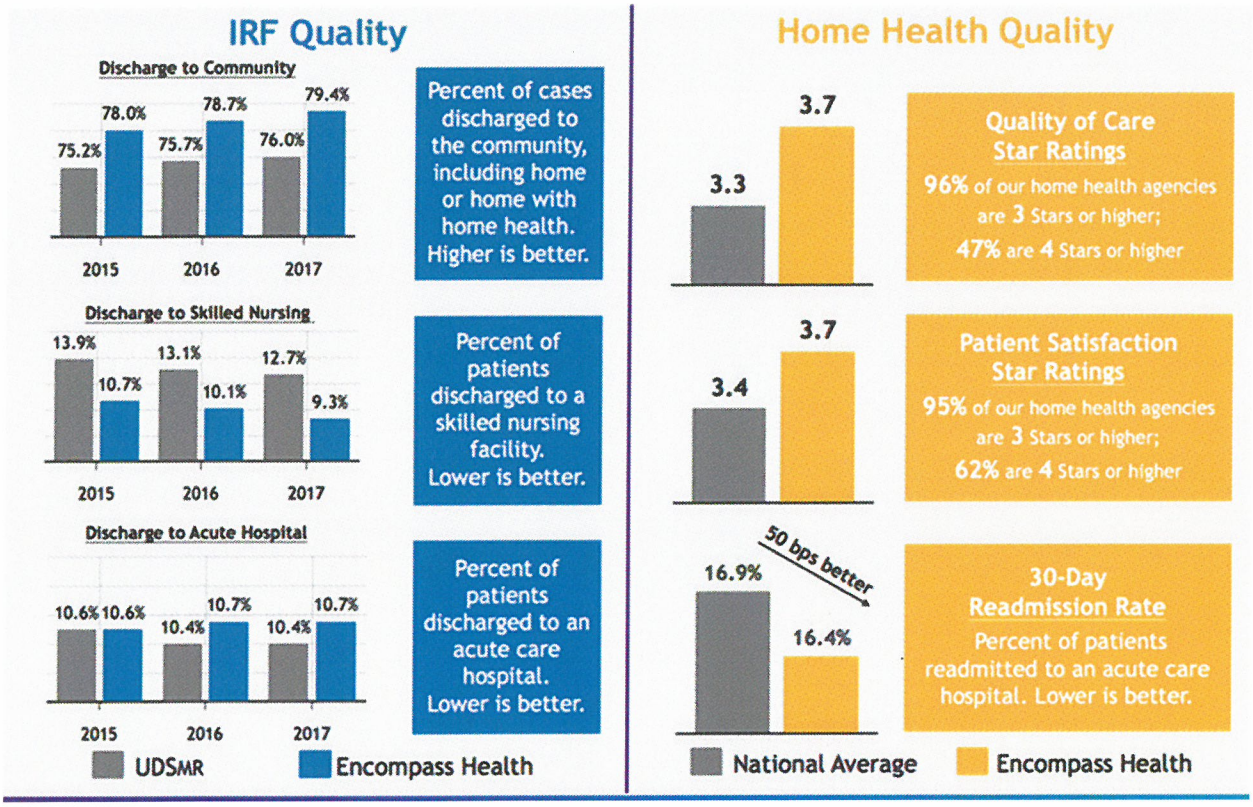
Home health quality indicators: Relative to providers nationally, Encompass Health reports

- Higher than average quality of care star ratings and patient satisfaction scores
- Lower 30-day readmission rates for patients served
- Lower cost per visit

These factors are highlighted to emphasize the following:

- Encompass Health brings a track record of high quality performance that consistently exceeds national averages across the continuum of post-acute care and will demand continued high-quality performance for all patients it serves
- Encompass Health brings expertise in proprietary, advanced rehabilitation-specific technology to promote high-quality clinical management and will work with acute care providers in the service area to help reduce the overall total cost of care
- Encompass Health's national scale and operating leverage supports low cost operations across the continuum
- Encompass Health's use of evidence-based medicine supports high quality outcomes and a reduction in preventable readmissions
- Performance targets and incentives at Encompass Health align with the goals of Maryland's Demonstration Model. Performance measures and incentives are designed around reducing readmissions and reducing the costs of care. Encompass Health will be a valuable partner in Maryland's efforts to achieve performance targets under the total cost of care model

Leading Positions in Quality of Care



Source: Uniform Data System for Medical Rehabilitation (UDSMR), UB Foundation Activities, Inc.
Notes:
(1) Data is gathered from approximately 70% of the industry including Encompass Health sites
(2) Data is adjusted by applying Encompass Health IRF case mix to non-Encompass Health UDS IRFs.

Leading Position in Cost Effectiveness | Inpatient Rehabilitation

	#	Avg. Beds per IRF	Avg. Medicare Discharges per IRF	Case Mix Index[b]	Avg. Est. Total Cost per Discharge for FY 2018	Avg. Est. Total Payment per Discharge for FY 2018
Encompass Health[a] =	123	67	955	1.26	$12,903	$19,776
Free-Standing = (Non-Encompass Health)	153	57	577	1.26	$17,363	$20,749
Hospital Units =	864	24	229	1.20	$20,798	$21,153
Total	1,140	33	354	1.23	$17,753	$20,665

Medicare pays Encompass Health less per discharge, on average, and Encompass Health treats a higher acuity patient.

The Company differentiates itself by:

- *"Best Practices" clinical protocols*
- *Supply chain efficiencies*
- *Sophisticated management information systems*
- *Economies of scale*

The average estimated total payment per discharge, as stated, does not reflect a 2% reduction for sequestration.

Sources: (1) Medicare Cost Reports (2) CMS Rate Setting Files
Notes: (a) Excludes Encompass Health hospitals opened most recently (b) CMI from Rate Setting File adjusted for short-stay transfer cases (c) Company's CMI for Year 2016 was 1.36; industry CMI was 1.33 as measured by UDSMR

Leading Position in Cost Effectiveness | Home Health

	2017 Episodes	Average Revenue per Episode	Average Visits per Episode	Average Revenue per Visit	Cost per Visit
Encompass Health	211,743	$2,998	17.9	$161	$75
Public Peer Average	283,366	$2,835	17.4*	$148*	$81*
Comparison to Peer Average		5.7%	2.9%	8.8%	(7.4)%

Public peer average represents 2017 data from publicly traded home health providers.
* One publicly traded company (Kindred) does not report visit counts.

Average revenue per episode is 5.7% higher than the peer average due to higher acuity patient mix.

Cost per visit is 7.4% lower due to market density and operational efficiency:
- *Caregiver optimization*
- *Optimization of HCHB*
- *Employee culture of excellence*
- *~75% of visits conducted by full-time staff*
- *Daily monitoring of productivity*

Source: Medicare Cost Reports

Encompass Health's success is built on the quality of care provided to each and every patient. Encompass Health has a network of national and regional leaders comprised of expert physicians, nurses, and therapists who provide oversight and consultation to its hospital staff in clinical and quality activities. Its national Clinical Leadership Council meets monthly with the Chief Medical Officer to review benchmarking data and develop innovative programs and services. The Quality and Clinical Excellence programs focus on all 4 major areas of clinical performance:

- Clinical outcomes
- Patient-centered care
- Culture of safety
- Technology and innovation

The various clinical leadership boards -- nursing, quality, pharmacy, health information systems, and case management -- along with the Physician Advisory Board, regularly produce materials and educational programs to help hospitals adopt best practices. For example, the Nursing

Leadership Board developed a tremendously successful training program to prepare eligible nurses to earn the designation of CRRN; the Pharmacy Leadership Board developed a highly regarded white paper and pocket guide to anticoagulation and a procedural guide for handling medication reconciliation; and the Quality Leadership Board developed the Quality Metric Report to facilitate data collection to improve their performance in areas ranging from infection prevention and control to patient safety.

Outcomes Management System

Perhaps the most important characteristic of successful healthcare is the ability to demonstrate superior levels of care and quality. Encompass Health's quality scores exceed industry benchmarks demonstrating a superior level of quality care. As explained above, Encompass Health utilizes the Uniform Data System for Medical Rehabilitation (UDSMR®), the rehabilitation industry's most widely recognized outcomes measurement tool, to monitor overall patient outcomes. UDSMR® also allows Encompass Health to benchmark its rehabilitation hospitals against regional and national performance data. As demonstrated in the following graphs, Encompass Health hospitals achieve superior results when compared to other rehabilitation providers.

Encompass Health Inpatient Discharges
CY2017

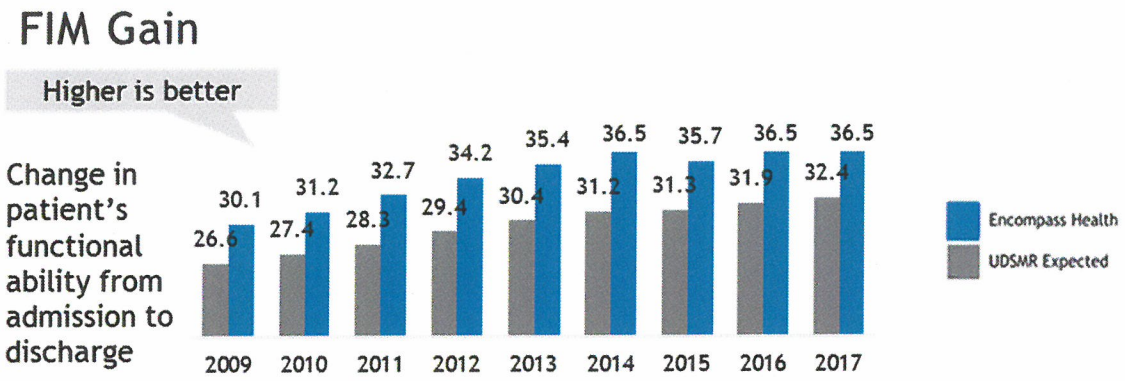
	UDS Expected	Actual
Average Length of Stay	13.3 days	12.7 days
FIM Score at Admission	56.4	54.7
FIM Score at Discharge	88.8	91.1
FIM Gain	32.4	36.5

Source: Uniform Data System for Medical Rehabilitation (UDSMR), UB Foundation Activities Inc.
Note: Reflects performance of all Encompass Health hospitals

Each of these measures is described below:

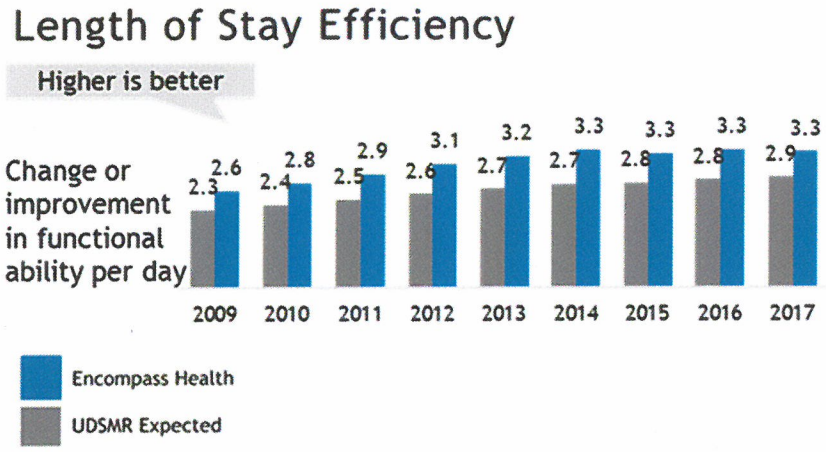
FIM® Gain

FIM® Gain is a measure of functional improvement from admission to discharge and indicates the degree of practical improvement toward the patient's rehabilitation goals. As explained above, this tool includes 18 cognitive and functional measures including walking, climbing stairs, transfers, bowel and bladder function and dressing. As indicated by the chart below, Encompass Health's FIM® Gain exceeded the UDSMR® expected FIM® Gain for each of the last nine years.



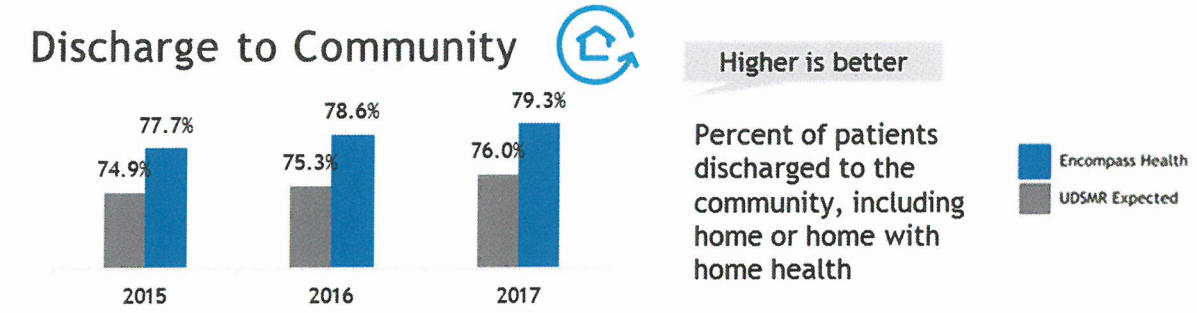
Length of Stay Efficiency

Length of stay efficiency is the measure of change or improvement in functional ability per day. As the following chart demonstrates, patients at Encompass Health hospitals exceed the expected rate of improvement per day (as measured by FIM Gain per patient day).



Percent of Patients Discharged to the Community

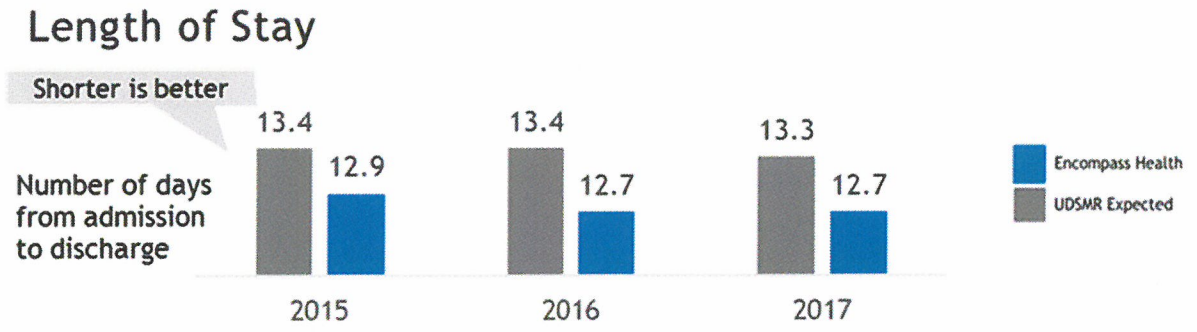
As the following chart demonstrates, Encompass Health also discharges a greater percentage of its patients to the community than the UDSMR® expected discharge rate.



Discharge to the community means that the patient returns home - to family, friends, social activities and possibly even work. The sooner a patient can return to the community, as opposed to another care setting, the better it is for the patient. Discharge to the community also is less costly for the health care system.

Length of Stay

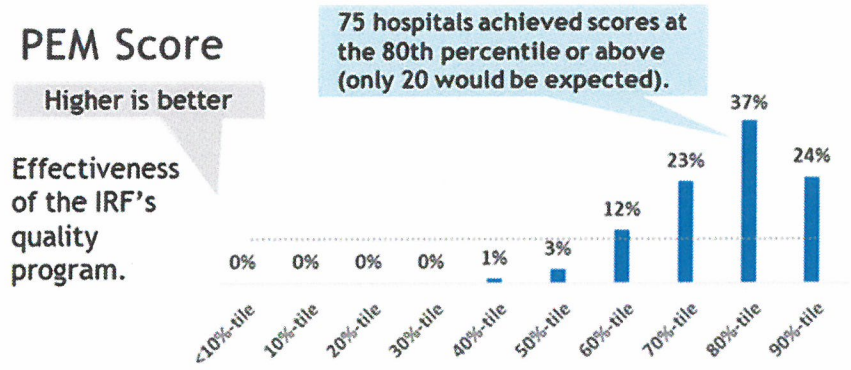
Length of stay is the number of days a patient resides in a hospital from admission to discharge. As the following chart demonstrates, Encompass Health's patients have an average length of stay that is shorter than the UDSMR® expected length of stay, meaning that patients return home or to a less intensive care setting faster than the UDSMR® expected length of stay.



PEM Score

Performance Evaluation Model (PEM) score, reported annually, is a summary statistic of the overall quality of an inpatient rehabilitation hospital. PEM is defined as a case-mix adjusted and severity-adjusted metric tool that provides rehabilitation providers with a composite performance score and percentile ranking drawn from nearly three-quarters of all inpatient rehabilitation hospitals in the country. A higher PEM score demonstrates superior results.

The following chart shows where Encompass Health's hospitals rank in the PEM score distribution. As demonstrated below, Encompass Health operates significantly more hospitals in the higher deciles of the PEM distribution than would be expected from a purely statistical analysis.



***Note: PEM Score** - Year End 2017, PEM scores use discharge FIM, FIM gain, LOS efficiency, discharge to community and acute care transfers*

Quality Care Management

Encompass Health has developed a proprietary tool called TeamWorks, designed to identify "best practices" and then to standardize best practices across all of the Encompass Health hospitals related to patient selection, the admission process, post-admission procedures, coordination of care, and discharge planning.

Since its inception, TeamWorks projects (or, process improvement projects) have been completed in the following areas:

- Care Management
- Patient Experience
- Sales and Marketing
- Nutrition and Dietary
- Fleet Management
- Business Office Standardization
- Supply Chain

The Care Management Program focuses on promoting effective communication and coordination across care settings to ensure a smooth transition from hospital to community and a seamless integration of services. An underlying focus in the Encompass Health Care Management Program is the importance of engaging patients and their caregivers in the discharge planning process to help make the transition from hospital to the next level of care safe and effective. A case manager is assigned to all patients on admission to provide care coordination while the patient is in the hospital, as well as to initiate discharge planning and begin coordination and collaboration of services with the individuals and service providers responsible for providing care to the patient post-discharge.

During the hospital stay, the Encompass Health team spends a significant amount of time educating patients and caregivers through the offering of customized one-on-one education and training sessions and a wide range of written educational materials. Weekly team meetings led by a rehabilitation physician with participation from the clinical team assigned to the patient are held to discuss patients' progress toward the discharge goals and solutions to any barriers to discharge. Patients and caregivers are kept abreast of the patient's progress by the case manager, and patient and family conferences are held with the physician and team when needed to discuss caregiver concerns and issues.

Integration of services from the hospital to community depends on knowing what services are needed and available and developing good working relationships with the community resources. Encompass Health case managers work closely with community service organizations, such as home health agencies, assisted living facilities, transportation services, meal services, local Area Agency on Aging, and other organizations that can provide housing, financial, social, and spiritual services to patients once they leave the hospital. To achieve a smooth transition from hospital to home or another post-acute setting also requires the successful transfer of health information from clinicians to the patient and family and community providers to reduce adverse events and prevent readmissions.

At the time of discharge, case managers assist with making sure that necessary medical follow-up appointments are scheduled with the patient's primary care physician or specialists, and the rehabilitation physician sends necessary medical information regarding the patient's rehabilitation stay to the community physician who will be following the patient. If home health services are needed post-discharge, case management collaborates with the home health agency to make sure that services are initiated as soon as possible.

In markets where the company has both Encompass Health Rehabilitation Hospitals and Encompass Home Health Services, Encompass Health is available to provide a seamless coordination of care for the transition home. This transition is facilitated by a Clinical Transition Coordinator who meets with the patient/family prior to discharge, participates in the weekly Team Conference and interacts with the Physician and Clinical Team to assure a safe, timely discharge process. In addition, Encompass will make a home visit on the day of discharge to further assure a smooth transition home for the patient and family. In markets where the company does not have Encompass Home Health, Encompass Health works in a similar coordinated fashion with the home care agency identified for follow-up care.

For patients discharged to the community, follow-up phone calls are made by the case manager to assure that the discharge arrangements have been implemented as planned, medical follow-up appointments have been scheduled and any questions that patient or caregiver may have regarding the discharge instructions are answered.

Another example of a TeamWorks program focuses on the admissions process; all too frequently, the referral/assessment/transfer process is slowed down by delays in telephone calls, information exchange, and discharge procedures. Encompass Health has developed operational improvements to respond quickly to physician referrals and expedite transfers smoothly and quickly. TeamWorks includes proprietary software, a custom-configured CRM, and mobile devices to speed up these processes and improve customer service. A "Patient Hub" receives referral requests and patient information for pre-screening, and Encompass Health Rehabilitation Liaisons communicate using iPhones, iPads and/or laptops which has facilitated communications and expedited clinical decision making in response to referring case managers and physicians.

The Pre-Admission Assessment completely automates and facilitates the referral processes; the pre-admission screening includes crucial elements that need review and approval of a physician in advance of a patient's admission, and the CRM system accepts electronic referrals and/or CCDs via the Patient Hub. The system also facilitates billing. The system has expedited the admissions process and has helped to decrease acute care lengths of stay.

Routine quality measurement/quality reporting - All Encompass Health hospitals comply with the IRF Quality Reporting Program (QRP) that includes 13 reporting measures such as CAUTI (catheter associated urinary tract infections), all-cause unplanned readmission rates, falls with major injury, and five functional outcome measures. In addition, Encompass Health hospitals report data on the CMS HealthCompare website.

Compliance expertise, regulatory expertise, and a "voice" in Washington - Encompass Health leadership actively participates in initiatives at the federal level; several Encompass Health clinical leaders have participated in CMS' Technical Expert Panels and other committees to represent Encompass and the inpatient rehabilitation industry. The Encompass Health management is familiar with all CMS compliance requirements associated with rehabilitation services and is knowledgeable about current and emerging regulatory requirements. Encompass Health rapidly translates new requirements into technology design that supports compliance following regulatory changes.

This expertise is extremely valuable. By way of illustration, in the past four years IRFs have been required to report on 17 new quality guidelines ("QRPs"); failure to meet/achieve specified guidelines reduces Medicare reimbursement to the facility. In response to these new requirements, Encompass Health has steadily invested in the technology to help its hospitals report QRP data accurately and on a timely basis. The result has been that all **Encompass Health hospitals have complied with the IRF QRP requirements, with virtually no QRP-related penalties imposed on any of its 127 rehabilitation hospitals.** This must be recognized in contrast to the many facilities across the country that have suffered multimillion dollar penalties for violations/lack of compliance and breakdowns that may be tied to weaknesses in

education/training/system support. Encompass Health's experience and sophistication in this realm are invaluable to assure both high quality patient care and compliance.

Certifications and Centers of Excellence

Encompass Health's rehabilitation hospitals provide the medical, nursing, therapy and ancillary services required to comply with local, state and federal regulations, as well as accreditation standards. All of Encompass hospitals are accredited by The Joint Commission. In specific markets, some hospitals also are accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF"). EHRHSM will seek accreditation by both The Joint Commission and CARF.

Encompass Health hospitals hold more than 200 disease-specific care certifications from The Joint Commission. Approximately 100 Encompass Health hospitals have disease-specific care certifications from The Joint Commission in stroke rehabilitation programs. Other Joint Commission disease-specific certifications earned by Encompass Health include certified programs for brain injury rehabilitation, cardiac rehabilitation, diabetes mellitus, oncology rehabilitation, pulmonary rehabilitation, spine injury, and Parkinson's rehabilitation.

Stroke Centers of Excellence

In addition to the external stroke-specific certifications awarded by The Joint Commission, Encompass Health operates its own internal recognition program for stroke excellence. The Stroke Center of Excellence recognition program attests to the accomplishments of Encompass Health hospitals that have exceeded established benchmarks in clinical programming and patient outcomes for the treatment of stroke.

Encompass Health stroke treatment teams are led by a board-certified physician with specialized training in stroke care, and the team consists of specially trained clinicians in the areas of physical, occupational, and speech therapies, in addition to nursing. Treatment teams meet weekly to develop individualized courses of treatment for patients which could include a combination of the following specialty programs: cognitive retraining, behavior management, comprehensive spasticity management, neuropsychological testing and treatment, augmentative communication, driving education, and gait and balance training. Encompass Health's stroke rehabilitation teams meet with the patient and family to obtain input for the plan of care. Structured family education series provide caregivers disease-specific information on prevention, medication management and coping strategies.

Encompass Health stroke rehabilitation programs provide discharge planning and continuing education initiatives to stroke patients in the form of vocational and community re-entry

education, transitional living, home evaluations and therapeutic home visits. Stroke support groups are also available to patients for follow-up care every other month.

Approximately 80% of stroke survivors who receive comprehensive rehabilitation return to their homes, work, or active retirement.[24]

The Stroke Rehabilitation Program at Encompass Health will be supportive to Maryland residents, and the Program will be valuable to Maryland's performance under the Waiver and under other Federal quality measurement programs.

- The Stroke Rehabilitation Program will align with the HSCRC's Complex and Chronic Care Improvement Program (CCIP). Under this program, clinicians must closely manage program enrollees and provide cost-effective care across settings. Encompass Health is a highly experienced provider and will support high quality outcomes and cost-effective service delivery for stroke patients enrolled in this program.
- The Stroke Rehabilitation Program will support high quality performance on the new quality measures required by federal regulations for post-acute providers across the country, quality measures that focus more intently on functional status. Evidence indicates that IRF's, relative to SNFs, produce better outcomes on functional status and morbidity measures; therefore, Encompass Health services will improve quality of care and Maryland's overall performance in the post-acute arena.
- Encompass Health will help manage smooth transitions and follow-up with home care service providers. This, too, can be expected to improve quality of care and improve the patient experience.

Culture of Safety

- Encompass Health Hospitals train all medical staff and employees in the significance of patient safety and implements a number of programs to ensure the safety of all of its patents. Some examples are described below.
- Encompass Health utilizes a Patient Safety Task Force that is comprised of a multidisciplinary group that meets monthly by phone to focus on patient safety initiatives.
- The Encompass Health Safe Patient Mobility Program addresses the high risk of falls in the elderly population. Activities include:

[24] National Rehabilitation Caucus

- Hospital policies that include assessment of all patients upon admission and reassessment throughout the stay, using the Morse Fall scale, a nationally accepted fall assessment tool.
- Specialized training for staff in fall precautions and fall prevention.
- Color-coded armbands for patients at high risk for falls.
- National Fall Task Force that monitors the fall rate in each hospital and explores innovative ways to reduce falls.
- Patient and family education on how to reduce falls in the home.
- Annual celebration of National Patient Safety Awareness Week, which includes patient, family, and community awareness of safety issues, including falls.
- Bed Safety program designed to reduce risk of falls in patient rooms.

- *Sepsis Early Warning System* - The Sepsis/SIRS early warning system allows clinicians to identify patients at risk of developing sepsis or systemic inflammatory response syndrome (SIRS) by alerting clinicians to changes in the patient's clinical status, thereby allowing them to get urgent evaluation and treatment to reduce the morbidity/mortality associated with these diagnoses.
- *Medication Reconciliation Improvement Project* - Developed by Encompass Health, this program supports the accuracy of admission medication order entry and strengthens discharge education reconciliation to ensure that patients understand and are educated about their medications prior to discharge. Encompass Health's medication reconciliation program includes fostering patient/family education on medications by pharmacists, nurses and physicians prior to discharge and ensuring that patients have access to their medications after discharge by streamlining the discharge process.
- *Violence prevention* - Encompass Health believes it is important for all hospitals to have a plan to reduce the likelihood of violent or disruptive behavior. All of its hospitals have a site-specific program that addresses training, response and prevention of such episodes. A task force was recently created to develop a company-wide violence prevention plan, with the goal of providing the necessary training and resources to prevent violence. In addition, all episodes of violence or threatened violence are reported into the adverse event reporting system and automatically forwarded to the Home Office Risk department for review.
- *Employee safety program ("STOP" = Stop, Think, Organize, Position)* - Encompass Health hospitals value the health and safety of their employees and recognize that moving and handling patients in this environment may put employees at risk for life-altering, work-related injuries. All Encompass Health

hospitals have adopted the STOP injury prevention program to managing ongoing training and operational requirements to reduce workplace injuries.

Advancing clinical care through best practices, care coordination, and technology supports

One of the most significant drivers of the operational excellence of Encompass Health is the proprietary and innovative rehabilitation-specific technology. Encompass Health has devoted substantial effort and expertise to leverage technology to improve patient-centered care and operating efficiencies and to position the company to collect, analyze, and share information on a timely basis. The Encompass Health Information Technology Group is an enterprise-class technology organization, which is a multi-disciplined, talented organization that has the ability to design and build proprietary systems or deploy enterprise systems where proprietary systems are not necessary.

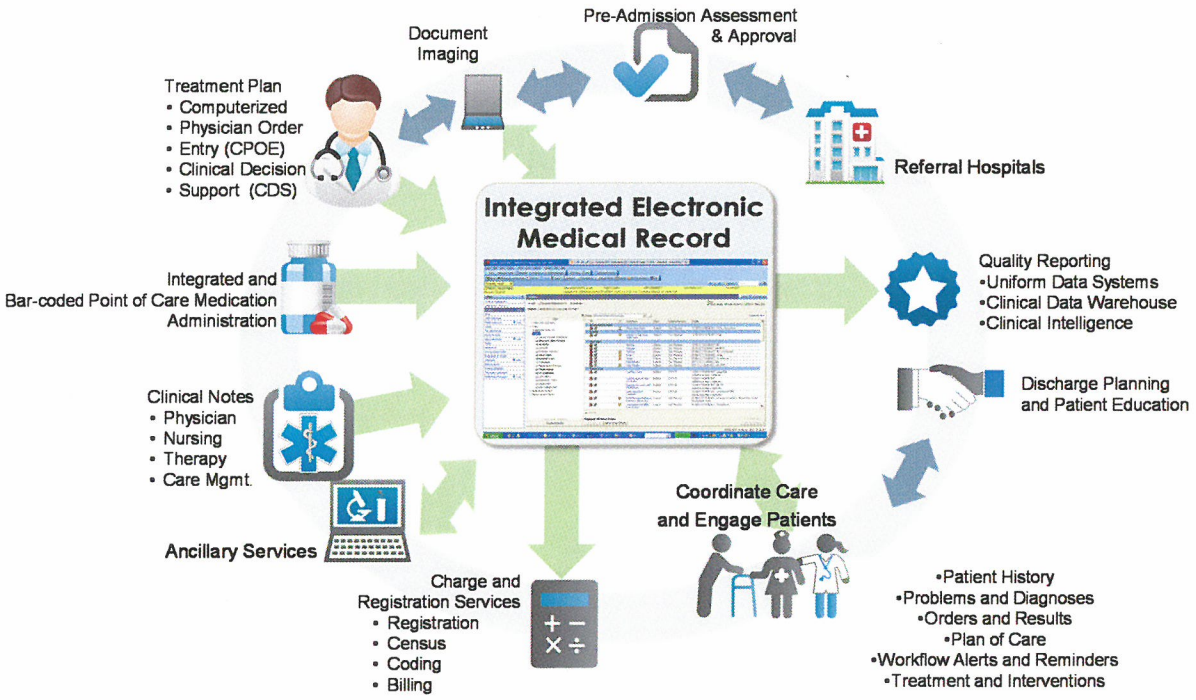
Encompass Health's commitment to technology includes a rehabilitation-specific, electronic clinical information system called Advancing Clinical Excellence through Information Technology (ACE IT), the internally-developed performance management reporting system (BEACON), and the sales and marketing technologies (electronic pre-admission assessment application and Customer Relationship Management system (CRM)) as described in the TeamWorks section above. Encompass Health is also investing in Cerner's HealtheIntent platform to better enable care coordination and post-acute network management, enhance patient care with predictive analytics, and prepare for alternative payment models. Selected tools are described below:

The ACE IT system is based on Cerner Millennium technology and is an inpatient rehabilitation-specific EMR and Clinical Information System. The system automates the preponderance of all clinical functions and clinical data acquisition in Encompass Health hospitals. Encompass Health has invested more than $200 million in the development and installation of ACE IT across the country. It has been implemented in 125 of Encompass Health hospitals, and is currently being implemented in Puerto Rico, delayed due to Hurricane Maria, at which time Encompass Health will have achieved 100% penetration.

ACE IT capabilities and characteristics include:

- Clinical Data Repository
- Workflow Management
- Inpatient Rehabilitation-Specific Clinical Documentation
- Orders Management
- Computerized Provider Order Entry (CPOE)
- Clinical Decision Support
- Pharmacy and Medication Management
- Scheduling

- Document Imaging
- Clinical Reporting and Dashboards
- CMS Quality Reporting Capture (Wound Care, CAUTI, etc.)
- Internal and External Interfacing (Lab, ADT, Charge, Order, Results, Automated Dispensing, etc.)
- Dictation to Structured Documentation Tool (Dragon)



A key function of ACE IT is also to support compliance with the complex and ever-changing requirements imposed by CMS on rehabilitation programs; the ACE IT system facilitates compliance with key reporting requirements for rehabilitation facilities:

- A pre-admission screening requiring physician approval by a physician specializing in rehabilitation; specific elements must be approved in advance of a patient's admission.
- A post-admission physician evaluation (PAPE) to identify any relevant changes that may have occurred since the pre-admission screening; a documented history and physical exam as well as a review of the patient's prior and current medical and functional conditions and comorbidities.
- An individualized plan of care required within four days of admission, reviewed and approved by the rehabilitation physician.
- The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) included in the medical record; this Instrument includes functional independence measurements collected at all key points from admission through discharge.

- Documentation to demonstrate the IRFs interdisciplinary approach to care, evidenced through weekly collaborative team meetings focused on the required items.

ACE IT supports continuous quality improvement at Encompass Health hospitals; Encompass Health makes system improvement on a routine basis, including user-suggested process improvements and enterprise-scale clinical improvement activities. Since the inception of ACE IT, Encompass has implemented 3,500 improvements and these improvements become immediately available to all Encompass Health hospitals.

Integration with State-specific HIEs - One of the overarching goals in development of the ACE IT system was to contribute to population health initiatives and improve care coordination. Encompass Health participates in State-operated HIEs in several states to facilitate communication and electronic transfer of information. For example, a hospital in Missouri is fully integrated with the Tiger Institute HIE for clinical encounter summaries and information exchanges. Similarly, Encompass Health expects to integrate with CRISP in Maryland to enable real-time reporting systems, support care coordination, and leverage all of the tools that have been built in Maryland.

ACE IT has been recognized by the industry as a superior tool. ACE IT has earned the HIMSS Analytics Stage 6 designation and is the only post-acute provider to have earned this recognition on an enterprise scale.

BEACON - BEACON is the Encompass Health proprietary management reporting system that operates in all Encompass Health hospitals. The BEACON system is a performance management system that was developed in-house at Encompass and integrates clinical and financial information to produce real-time reports. It is built on data warehousing technology that accepts feeds from all major Encompass Health systems including ACE IT, UDS, Sysco, Cardinal, PeopleSoft, and Press Ganey. Beacon organizes data into online reports that can be queried by each BEACON user to provide near real-time information.

BEACON can be used to measure actual outcomes against defined key indicators. In addition, when an industry-wide or federally mandated core measure is not available, Encompass Health uses BEACON metrics (which have been internally developed based on our experience across 127 hospitals) to measure the effectiveness and efficiency of the programs; within a user-defined role, users can potentially drill down from an enterprise level to individual hospital, employee or patient levels. Using the BEACON system, hospital leadership and regional teams can quickly and efficiently monitor the effectiveness of programs at any particular hospital and rapidly make adjustments when appropriate. The following is a sample listing of BEACON applications:

- Volume analyses: Admissions, discharges, daily census
- AR management

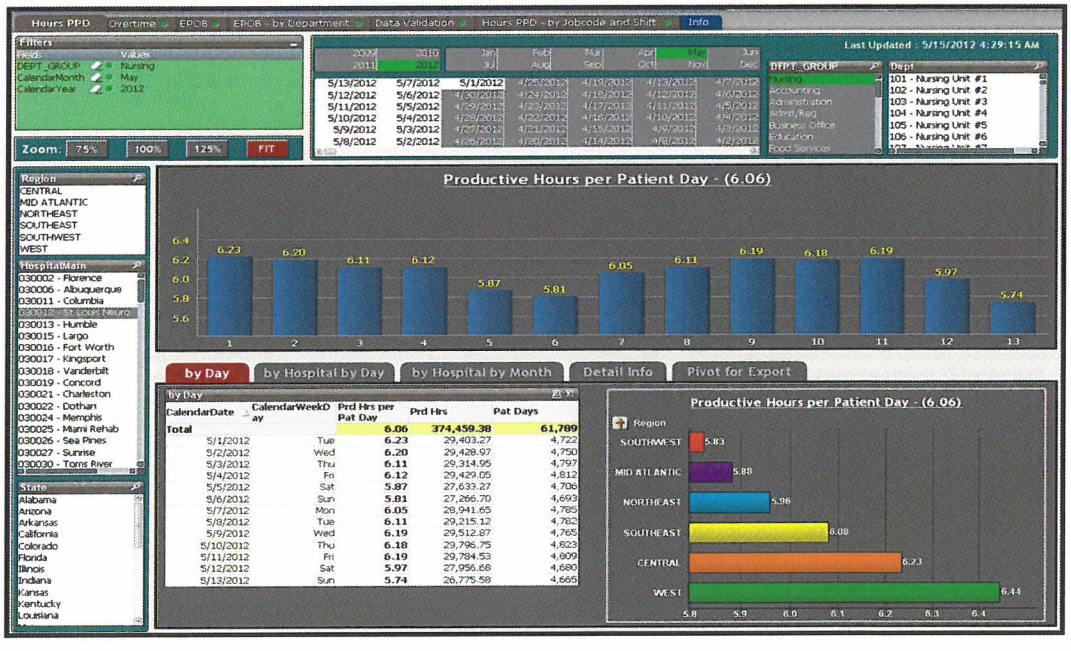
- Care management
- Compliance dashboard
- Hospital survey results
- Labor productivity analyses
- Managed care
- Patient claim denials
- Quality reporting, including patient satisfaction indicators
- CNS rule implementation analysis
- HIPAA risk assessment
- Sales and marketing
- Therapy analysis
- Therapy effectiveness
- Various supply chain and HR metrics
- Physician outcomes

Beacon Management Reporting System

Proprietary Operation Management Tool

- ✓ Provides regional and hospital leadership near real-time data to run the business
- ✓ Benchmarking – side-by-side hospital comparison to promote best practices
- ✓ Quality
  - Key care indicators
  - Patient satisfaction
- ✓ Volume metrics – admissions, discharges, and daily census
- ✓ Labor productivity
- ✓ Other variable expenses
- ✓ Accounts Receivable


Dashboard
Census
Admissions
Discharges
CMS Compliance
In-House
Referrals
Non-Admits
Current Selections
Daily
MTD
YTD
Patient Days Daily Trend
ADC MTD - 4,601.1
4571
4592
4648
4666
4559
4543
4625
4624
4614
4672
4652
4531
4512
4607
MTD Occupancy
70.79%
MTD CMS Compliant Discharges
67.51%
MTD Referral to Admit
61.92%
MTD Volume Analysis
Region
As Of Period
CENTRAL
MID ATLANTIC
NORTHEAST
SOUTHEAST
SOUTHWEST
WEST
Region
Hospital
State
PatientClass


Hours PPD
Overtime
EPOB
EPOB - by Department
Data Validation
Hours PPD - by Jobcode and Shift
Info
Filters
Last Updated : 5/15/2012 4:29:15 AM
Productive Hours per Patient Day - (6.06)
6.23
6.20
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5.87
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6.19
6.18
6.19
5.97
5.74
by Day
by Hospital by Day
by Hospital by Month
Detail Info
Pivot for Export
Productive Hours per Patient Day - (6.06)
SOUTHWEST
MID ATLANTIC
NORTHEAST
SOUTHEAST
CENTRAL
WEST
5.83
5.88
5.96
6.08
6.23
6.44

ADDITIONAL PROPRIETARY PROGRAMS DEVELOPED BY ENCOMPASS HEALTH

ReACT program - Developed together with Cerner, this is a predictive model based on an algorithm that dynamically predicts the risk of an **a**cute **c**are **t**ransfer and provides clinical decision support to the caregiver. Algorithms were developed based on more than 80,000 patients across 60 Encompass Health hospitals. Encompass physicians, CEOs, clinical leadership and Cerner statisticians collaborated on developing algorithms, and the program is now operating in all of Encompass Health's 125 ACE-IT equipped hospitals.

The Post-Acute Innovation Center - Encompass Health recognized that the tools currently available for post-acute care management have been very limited; to date, these tools have been developed either by providers with limited clinical expertise or providers that have not made the necessary technology investments to advance efficient, patient-focused care. In 2017, Encompass Health formed the Post-Acute Innovation Center in collaboration with the Cerner Corporation to develop advanced analytics and predictive models for more effective and efficient care management across post-acute settings. It will integrate the tremendous experience and the immense database of Encompass Health with Cerner's leading-edge health information technology solutions and data analytics. The Innovation Center will produce clinical decision support tools that will promote more cost efficient and high-quality patient care across the diverse post-acute service settings. (See Exhibit 13)

COMPLIANCE

Compliance Program

Encompass Health has a strong Compliance Program, based on five elements:

- Development of effective regulatory compliance policies and financial and management controls for all Encompass Health operations.
- Dissemination of policies to employees and contractors, and the development of appropriate training mechanisms to ensure that policies are clearly understood and capable of being carried out effectively.
- Provision of opportunities for employees and contractors to ask questions or report suspected violations of Encompass Health policies, regulatory obligations, or public financial reporting obligations without fear of retaliation, and the prompt investigation of all credible reports of such violations.
- Regular audit of Encompass Health functions and assessment of the effectiveness of internal controls to determine compliance with applicable regulatory obligations and the integrity of public financial reports.

- Accountability for violation of Encompass Health policies or regulatory obligations (including those in supervisory positions who condone or unreasonably fail to prevent improper conduct).

Professional development

Encompass Health directly operates programs to train new professionals, provide continuing education, encourage expanded professional roles, and nurture a satisfying workplace. Encompass Health was recognized by Modern Healthcare in the 2017 ranking of "Best Places to Work in HealthCare:" The following programs illustrate the investments that Encompass Health makes in professional development:

- Training and Education for Employees - In 2017, Encompass Health offered more than 90 live, on-site courses for nurses, therapists and case managers through its Clinical Excellence University. Courses are developed and taught by Encompass subject matter experts and are designed around primary diagnoses. In addition, Encompass Health employees have free access to on-line. Discipline-specific continuing education through HealthStream, CE Center, MedBridge and the ACMA and employees have free access to MedLine 21 full-text, rehabilitation-related journals.
- Medical Directors and Rehabilitation Physicians - Encompass Health provides educational opportunities for onboarding physicians and existing medical staff in the areas of quality, compliance, regulatory issues and documentation. Medical Directors from across the country gather annually for professional networking and a continuing medical education national conference, with programs led by Encompass Health clinicians and by nationally recognized subject matter experts. More routinely, the Chief Medical Officer at Encompass Health conducts monthly national medical director WebEx calls to discuss topics of interest and provide updates of IT systems/new initiatives. More broadly, Encompass Health offers its group of 700+ rehabilitation physicians the opportunity to obtain CME credits through online lectures through its association with Washington University.
- Nursing - Encompass Health encourages its nurses to become Certified Rehabilitation Nurses (CRRN) and assists with the training and preparation to achieve this designation.
- Assistance and rewards are provided to nurses who become a CRRN.
- Case Management - Encompass Health requires that all new case managers are certified, and sponsors "case management boot camps" across Encompass Health regions to help staff meet certification requirements. In addition, Encompass Health provides an incentive bonus to those employees who complete supplemental professional development programs. Lastly, Encompass Health operates a "Preceptor Program" for Directors of Case management, assigning a

case management preceptor to orient and support the "onboarding" of new Directors of Case Management.

Staffing and Clinical Training Programs

To attract the quality staff required for its various rehabilitation programs, Encompass Health has developed and initiated a number of innovative approaches to recruit and retain staff throughout its hospitals, including:

1. Encompass Health Nursing and Therapy Student Loan Program
2. Encompass Health Clinical Career Ladder for Rehabilitation Clinicians
3. Encompass Health's Proprietary Certified Registered Rehabilitation Nurse ("CRRN®") Training Program
4. Clinical Preceptor Programs
5. Leadership Development and Coaching
6. Nurse Leadership Academy
7. Associate Administrator in Training Program

In addition to these programs, hospitals use other recruitment strategies including:

1. Encompass Health's internet career portal
2. Social media
3. National and regional clinical organization career conferences
4. Newspaper and journal advertisements (locally, state-wide, and nationally)
5. Internet job boards and databases
6. College career fairs
7. National recruitment programs through Encompass Health's national recruitment network
8. Companywide employee referral incentives for current staff to refer qualified applicants

Across the country, Encompass Health develops relationships/training programs with local universities and colleges, community colleges and other training agencies to create and support a local workforce and retain trained professionals. In the Maryland/Washington, DC region, Encompass has already established affiliations and working relationships with 13 colleges and universities (See Exhibit 18). Encompass Health in Southern Maryland expects to expand the number of educational relationships to help meet the needs of EHRHSM and other local providers.

Clinical research - Encompass Health is currently engaged in a number of research initiatives and sponsors research through an annual scholarship awarded to therapists who are chosen based

on the merits of their research proposals. Encompass has a research committee that approves research proposals submitted by its clinicians after obtaining IRB approval. This allows clinicians to participate in ongoing research invaluable to the field of rehabilitation.

Level 3: The Encompass Health Experience in Population Health Management and Value-Based Contracting

Encompass Health has tremendous experience with bundled payments and other risk-based contracting, and is equipped for episode management, 60-day care management models, and community-based prevention initiatives.

Encompass Health brings experience as a participant in bundled payment initiatives, ACOs, and value-based contracts, and is uniquely equipped to perform successfully under these initiatives through evidence-based protocols, electronic information exchange, real-time cost/quality performance monitoring, and supportive transitioning of patients to the community. For example:

- Encompass Health is actively participating as a risk-bearing participant in the Comprehensive Care for Joint Replacement Model with 25 IRFs and 29 home health agencies (HHAs) in proposed mandatory markets The CJR program as a whole operates in 67 markets but only 34 are mandatory and Encompass Health operates in 25 of the mandatory markets
- Encompass Health operates 11 IRFs and 13 HHAs in proposed voluntary markets

BPCI

- Encompass Health is an awardee in Medicare's Bundled Payments for Care Improvement (BPCI), initiative. A total of eight Encompass Health hospitals are participating in BPCI Model 3, 60-day, post-acute initiatives in episode types that include stroke, simple pneumonia, sepsis, double-lower extremity joint replacement, and upper extremity joint replacement.
- BPCI Model 3 provides the opportunity to continue analyzing data which will help identify additional opportunities to expand participation in bundling initiatives and risk-sharing arrangements going forward.
- It is important to note that only nine (9) IRFs are participating in the program, and Encompass Health makes up eight (8) of the nine (9) IRFs participants. The 9th IRF participant is located in Florida.
- Currently, 72 Encompass Health home health agency ("HHA") locations are participating in more than 141 bundles, Encompass Health selected multiple types of bundles, including lower extremity joint replacement, simple pneumonia, sepsis, congestive heart failure and

COPD. Early results have been positive and valuable data is being obtained which will help identify opportunities to expand participation in the future.

- **Detail on BPCI IRF Participation**

The Company's Participation in BPCI Model 3

Inpatient Rehabilitation			
BPCI Bundle	Participating IRFs	Bundle Length (in days)	% of the Company's Total Discharges
Stroke	3	60	0.12%
Simple Pneumonia	1	60	0.02%
Sepsis	1	60	0.01%
Double-lower extremity joint replacement	2	60	<0.01%
Upper extremity joint replacement	1	60	<0.01%
Total	**8**		**0.16%**

Home Health			
BPCI Bundle	Bundled Arrangements	Bundle Length (in days)	% of the Company's Total Episodes
Major joint replacement of the lower extremity	26	90	0.80%
Spinal fusion (non-cervical)	9	60/90	0.06%
Sepsis	14	90	0.06%
Revision of the hip or knee	14	90	0.05%
Simple pneumonia and respiratory infections	8	90	0.04%
Major joint replacement of the upper extremity	8	60/90	0.04%
Other respiratory	19	90	0.04%
Urinary tract infection	6	90	0.04%
Congestive heart failure	32	90	0.02%
Chronic obstructive pulmonary disease	17	90	0.01%
All other episode types	51	30/60/90	0.12%
Total	**204***		**1.29%**

Note: Data based on 2016 discharges/episodes

* Represents a total of 79 locations participating in 204 bundled payment arrangements throughout 2016
As of December 31, 2017, 72 locations were participating in 128 active bundled payment arrangements.

Collaborator and Preferred Provider Agreements

- Exclusive hip fracture preferred provider for an acute care hospital in Texas.
- In active discussions with other acute hospitals to serve as a risk-sharing collaborator.

ACOs and NGACOs

- Encompass Home Health is Premier ACO's exclusive home health provider - Premier ACO includes approximately 20,000 covered lives in north Texas and southern Oklahoma.
- Encompass is exploring ACO participation in several other markets.
- Encompass Health IRFs and HHAs are a preferred provider for a number of Medicare Shared Savings Providers and Next Generation ACOs.

Value-Based Purchasing

- 39 HHAs participating in CMS' Value Based Purchasing model.

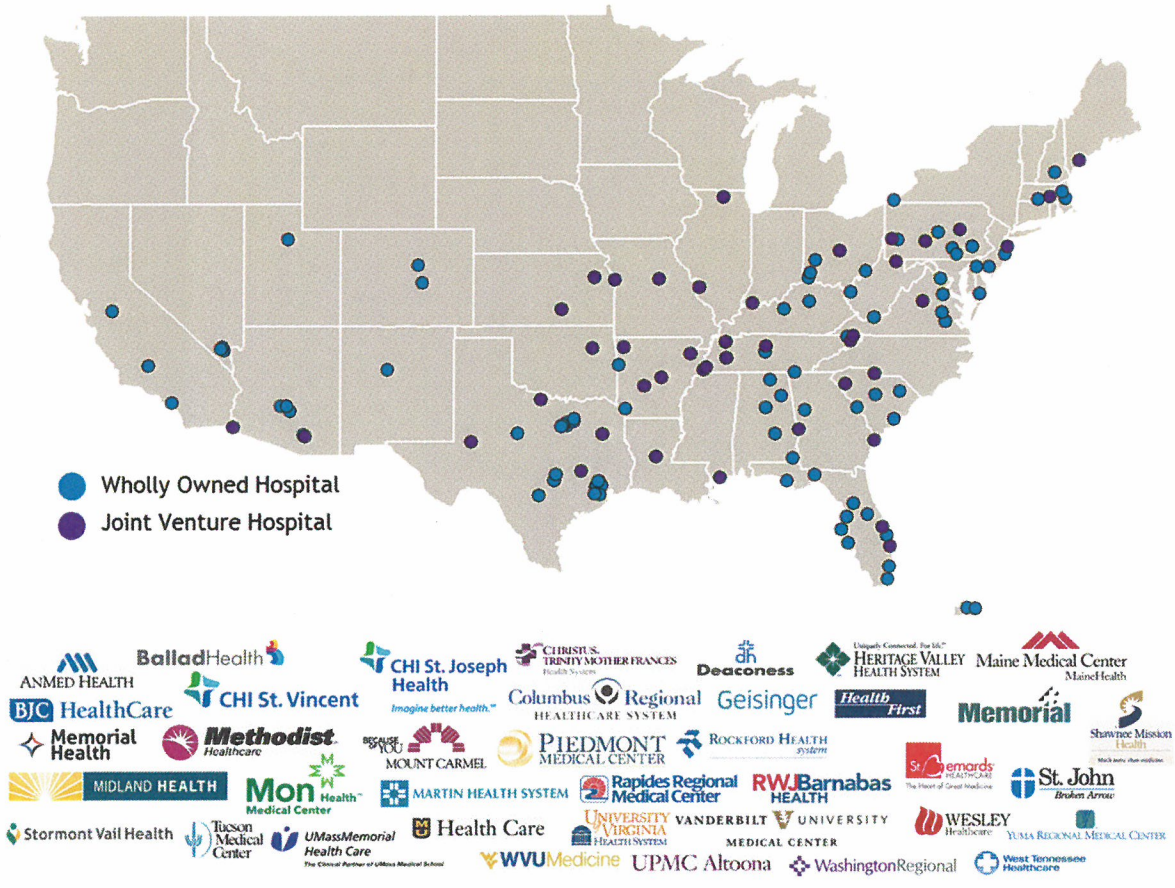
Custom Bundling

- Proposing an Encompass Health -specific bundled pilot to CMS to take risk for quality outcomes.
- In active discussions with managed care plans to develop bundled payment programs.

Encompass Health will bring immense experience to the Maryland market for high quality post-acute care and care management across the continuum. Under Maryland's total cost of care targets, Encompass Health will serve as a valuable partner to all health systems/acute care hospitals/physicians in the Region who are invested in population health management. Encompass Health has built a track record of successful working partnerships with hospitals and health systems. The table below identifies these partnerships, designed around both facility joint ventures and contracting initiatives.

Encompass Health Inpatient Rehabilitation Hospitals

(approximately 93% not-for-profit joint venture partners, as noted by logos below)



Level 4: Encompass Health in Maryland: Reducing the total costs of care and providing the highest quality services to patients

HealthSouth Chesapeake Rehabilitation Hospital, located on the Eastern Shore, has demonstrated how an IRF can support health systems and cost-effective care

Support to acute care hospitals - In Year 2017, HealthSouth Rehabilitation Hospital ("HealthSouth Chesapeake") received referrals from 19 acute care hospitals. More than half of these patients were from Peninsula Regional Medical Center where a trauma center operates, and another 18 hospitals have referred to HealthSouth Chesapeake attesting to the IRF's distinct capabilities and high-quality outcomes.

Length of stay reduction for high potential rehabilitation patients - HealthSouth Chesapeake effectively accelerates the initiation of rehabilitation services and minimizes the total inpatient stay for rehabilitation patients. An analysis was prepared to compare utilization patterns of Medicare FFS patients from the three Eastern Shore counties local to HealthSouth Chesapeake (Wicomico, Worcester, and Somerset) receiving rehabilitation care at HealthSouth Chesapeake with those patients from this region receiving rehabilitation care at SNFs.

This analysis demonstrated that the rehabilitation length of stay at HealthSouth Chesapeake was dramatically shorter relative to the post-acute length of stay at SNFs even as the diagnostic mix and patient severity were comparable: Comparable Medicare patients showed an average length of stay for rehabilitation of 14.6 days at HealthSouth Chesapeake as compared with an average length of stay of 38 days at SNFs for patients receiving "ultra-rehabilitation" services.

In addition, the acute care lengths of stay (prior to the rehabilitation stay) were considerably shorter for patients discharged to HealthSouth Chesapeake: This reflects the fact that Encompass Health hospitals can admit patients earlier, even as continuing medical management is required. This permits earlier initiation of rehabilitation services.

In total, patients discharged from this three County Eastern Shore region to HealthSouth Chesapeake reported a total facility stay (acute + rehabilitation stay) of 19 days; in contrast, patients discharged to SNFs had a total facility stay (acute + rehabilitation stay) of 45 days. **Therefore, on average, the total number of inpatient days for patients served at HealthSouth was more than 25 days shorter for HealthSouth patients (see below).**

While the total episode costs were slightly higher for HealthSouth Chesapeake patients[25], this does not portray the improvements on functional gains, nor account for the quicker return to work[26]/routine activities and the longer-term functional independence attained. HealthSouth Chesapeake also demonstrates a lower 30-day readmission rate for its Eastern Shore patients relative to a comparable population served at SNFs (see below).

Readmission reduction - HealthSouth Chesapeake documents a significantly lower 30-day readmission rate relative to comparable patients discharged to an SNF. HealthSouth Chesapeake is supporting the goal of readmission reduction for the region (see data below). Thus, higher utilization of an IRF in Maryland can be expected to reduce the readmission rate for the patient population now served at SNFs.

Residents of 3 Eastern Shore counties: Wicomico, Worcester, Somerset
Medicare FFS patients, CY2016

Including all High Potential Rehabilitation Discharges (8 cohorts)

	HealthSouth Chesapeake	SNF cases, ultra-rehabilitation
# Discharges	205 patients	186 patients
Acute ALOS	4.7 days	7.3 days
Rehabilitation ALOS	14.6 days	38.1 days
Episode ALOS	19.3 days	45.3 days
Inpatient episode costs of care	$34,038	$32,810
30-day readmission rate	**17.2 %**	**22.6 %**

Source:
Medicare FFS payments: CMS Standard Analytic File, CY2016
Notes:
Ultra-rehabilitation: Defined as patient who had the majority of their units in the HIPPS codes for "ultra-high therapy;" this definition is associated with at least 720 hours per week of rehabilitation services
Patient cohorts: High potential rehabilitation patients defined by ICD10 codes aligned with CMS13 definitions for IRFs

Other key performance indicators - Finally, HealthSouth Chesapeake has demonstrated high quality performance on core measures for the IRF. HealthSouth Chesapeake, then, stands as a "local" illustration of some of the contributions that an Encompass Health rehabilitation hospital can make to Maryland residents.

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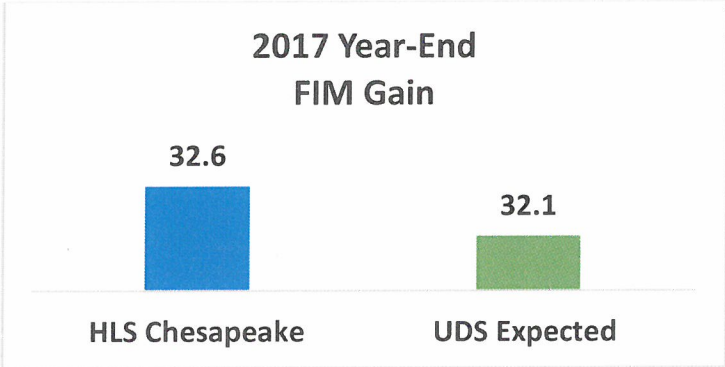
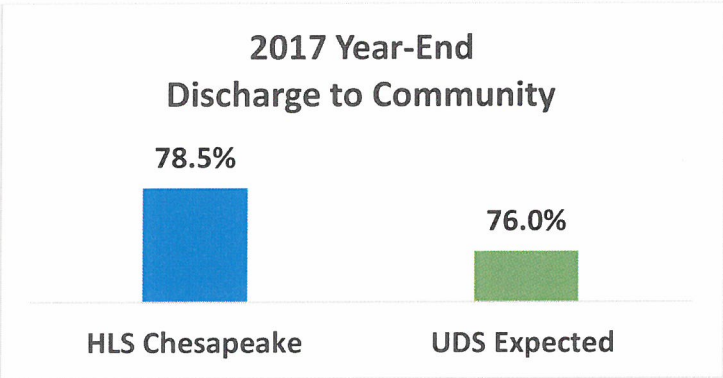
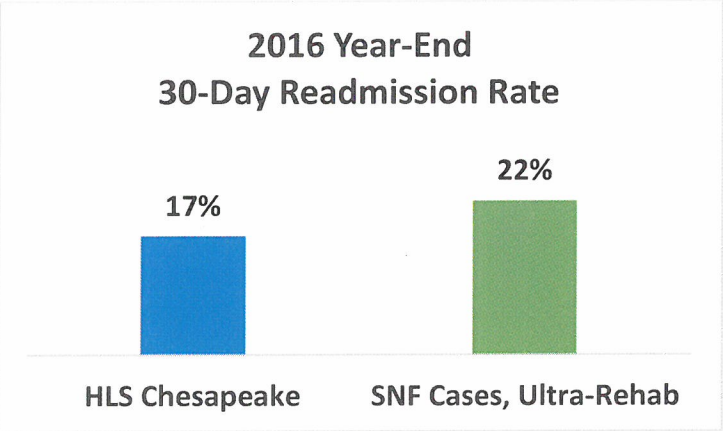
[25] Tied to higher per diems of a rehabilitation hospital relative to per diems at a SNF High Potential Rehabilitation Patients Served in Post-Acute Settings.

[26] Associated more largely with the non-Medicare patient population.

Performance indicators include the following:







Sources: (1) FIM, Discharge Location: Encompass Health Care (2) 30-Day Readmission Rate: CMS Analytic File

B. Project Review Standards

B. (1) Access

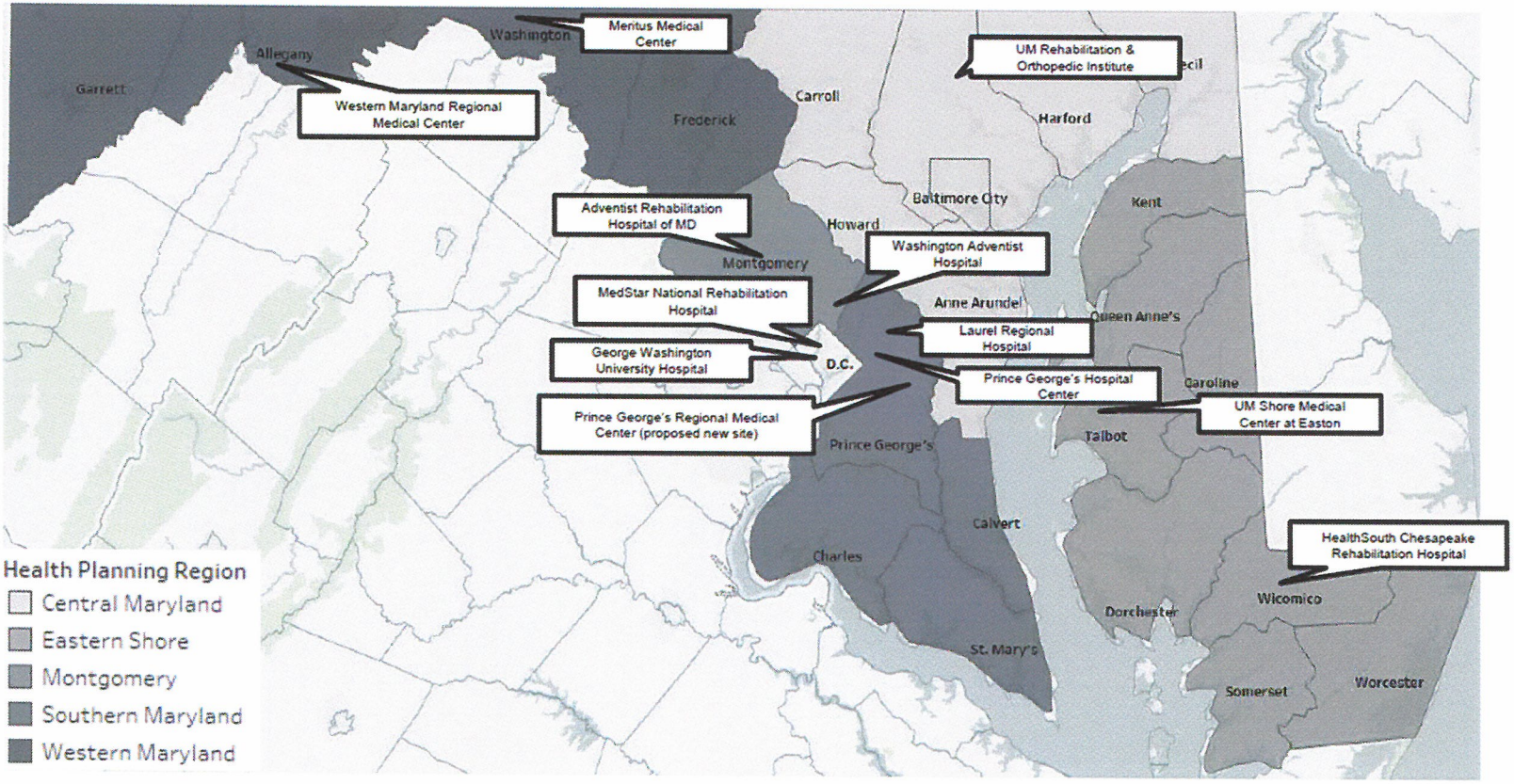
An applicant shall present evidence to demonstrate that barriers to access exist for the population in the service area for the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers.

Acute rehabilitation services for adults are currently provided by 13 providers in Maryland and two providers in the District of Columbia. The two maps on the pages following depict the geographic distribution of programs and highlight the inequitable distribution of rehabilitation programs across the State of Maryland.

Acute Rehabilitation Programs Outside of Baltimore City

Maryland & Washington D.C.

By Health Planning Region



* Prince George's Regional Medical Center is the CON-approved replacement hospital for PGHC

**Baltimore City shown separately on next slide

Acute Rehabilitation Programs

Baltimore City, Maryland

Current barriers to access are identified below:

(a) Maldistribution of beds - Acute rehabilitation beds for adults are not distributed equitably or responsively across Health Planning Regions in Maryland.

The Southern Maryland Health Planning Region accounts for approximately 1.2 million residents. Prince George's County is the second most populous County in the State of Maryland, and the four counties of Southern Maryland are among the fastest growing counties in Maryland. The 18 communities of Anne Arundel County, included in the term "South Maryland Region" add an additional 175,000 residents. In CY2016, the adult population of this combined region (the service area) accounted for a total of 63 occupied beds.

Despite this large population base and the 63-bed census attributed to its population, only one acute rehabilitation program currently operates locally, a 28-bed hospital-based unit at Laurel Regional. The table below documents licensed beds by Health Planning Region, and by provider, and highlights the inequitable distribution of rehabilitation beds across the State of Maryland.

Adult Rehabilitation Programs: Licensed Beds by Health Planning Region

Health Planning Region	Provider	# Licensed Rehabilitation Beds
Central Maryland	UM Rehabilitation & Orthopaedic Institute	98[1]
Central Maryland	MedStar Good Samaritan Hospital	51
Central Maryland	Johns Hopkins Bayview Medical Center	9
Central Maryland	Sinai Hospital	57
Central Maryland	Johns Hopkins Hospital	18
Central Maryland	Levindale	20
Central Maryland	MedStar Union Memorial Hospital	18
Eastern Shore	HealthSouth Chesapeake Rehabilitation Hospital	59
Eastern Shore	UM Shore Medical Center at Easton	20
Western Maryland	Meritus Medical Center	20
Western Maryland	Western Maryland Regional Medical Center	13
Montgomery	Adventist Rehabilitation Hospital of MD	87
Washington, DC	MedStar National Rehabilitation Hospital	157
Washington, DC	George Washington University	16
Southern Maryland	Laurel Regional Hospital	28

[1] Includes 82 licensed rehabilitation beds and 16 dually licensed chronic/rehabilitation beds

Source: Maryland Health Care Commission. "Annual Report on Selected Maryland Acute Care and specialty Hospital Services," Center for Health Care Facilities Planning and Development (2016)

The maldistribution of beds is demonstrated most clearly by the population-to-bed ratio, calculated based on the number of licensed acute rehabilitation beds to adult population in each Health Planning Region. The ratio in Southern Maryland is strikingly low relative to other Health Planning Regions in the State. The figures below highlight that the Southern Maryland Region is under-bedded for rehabilitation care, creating access barriers and leading to the markedly low utilization of acute rehabilitation care by residents of both Southern Maryland and Anne Arundel County.

 # Adult Population per Rehabilitation Bed in Maryland

By Health Planning Region

CY 2016

Health Planning Region	Adult Population Age 18+	# Licensed Rehab Beds	Adult Population: Bed Ratio
Eastern Shore	279,236	79	3,535:1
Central Maryland	2,219,888	255	8,705:1
Montgomery	812,040	87	9,334:1
Western Maryland	397,975	33	12,060:1
Southern Maryland	980,122	28	35,004:1
Total	**4,689,261**	**482**	**9,729:1**

Sources:

[1] Licensed Beds: Maryland Health Care Commission, 2017

[2] Population: Nielson-Claritas

Notes:

UMROI includes 82 licensed rehabilitation beds and excludes 16 dually licensed chronic/rehabilitation beds

(b) Limited options and anticipated program changes - Currently, there is only one 28-bed acute rehabilitation program operating in Southern Maryland (at Laurel Regional), and bed capacity is expected to be reduced; with the reconfiguration of Laurel Regional, 18 beds are expected to be temporarily delicensed and only 10 acute rehabilitation beds relocated.

This limited capacity for rehabilitation care is in sharp contrast to other Health Planning Regions where multiple options are available for acute rehabilitation care. Residents of all other Health Planning Regions outside of Southern Maryland are provided with multiple options for rehabilitation services in reasonable driving distance; residents of Southern Maryland have been provided with only one local program option at Laurel Regional. Going forward, rehabilitation bed capacity will be further reduced. With the reconfiguration of Laurel Regional, 18 of the 28 rehabilitation beds at Laurel Regional will be temporarily delicensed and only 10 beds will be transferred to UM Prince George's Hospital Center.

(c) Travel time: Costs and family hardship - More than 90% of rehabilitation patients from this region travel out-of-area for services, imposing travel time, out-of-pocket costs, and added hardships for Southern Maryland patients/families.

In CY2016, nearly 1,500 adult patients travelled outside the service area for rehabilitation care; more than 800 of these patients (853 patients) travelled to facilities in the District of Columbia and nearly 400 patients (371 patients) travelled to Adventist Rehabilitation Hospital. This utilization pattern is evidence of the demand for a specialty rehabilitation hospital (IRF) in reasonable driving distance to Southern Maryland residents.

Adult Rehabilitation Discharges: Market Share by Rehabilitation Program[27]
Encompass Service Area
CY2016

Encompass Health Service Area Acute Rehab Discharges Market Share by County, By Hospital, Age 18+
CY 2016

	Prince George's		Calvert		Charles		Saint Mary's		Anne Arundel - South		HealthSouth Service Area	
Hospital	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
Maryland Hospitals												
UM Rehabilitation & Orthopaedic Institute	85	7.0%	9	12.7%	13	9.4%	4	4.9%	41	34.2%	152	9.3%
Laurel Regional Hospital	130	10.7%	2	2.8%	5	3.6%	2	2.4%	4	3.3%	143	8.8%
Johns Hopkins Hospital	21	1.7%	7	9.9%	6	4.3%	2	2.4%	12	10.0%	48	2.9%
Sinai Hospital	15	1.2%	2	2.8%	3	2.2%	2	2.4%	1	0.8%	23	1.4%
MedStar Good Samaritan Hospital	9	0.7%	-	0.0%	1	0.7%	-	0.0%	5	4.2%	15	0.9%
Johns Hopkins Bayview Medical Center	10	0.8%	3	4.2%	-	0.0%	1	1.2%	9	7.5%	23	1.4%
Adventist Rehabilitation Hospital of MD	337	27.6%	8	11.3%	11	7.9%	4	4.9%	11	9.2%	371	22.7%
HealthSouth Chesapeake Rehab Hospital	3	0.2%	-	0.0%	-	0.0%	-	0.0%	1	0.8%	4	0.2%
Subtotal: Maryland Hospitals	610	50.0%	31	43.7%	39	28.1%	15	18.3%	84	70.0%	779	47.7%
Washington, DC Hospitals												
George Washington University	44	3.6%	8	11.3%	11	7.9%	1	1.2%	1	0.8%	65	4.0%
MedStar National Rehabilitation Hospital	566	46.4%	32	45.1%	89	64.0%	66	80.5%	35	29.2%	788	48.3%
Subtotal: Washington, DC Hospitals	610	50.0%	40	56.3%	100	71.9%	67	81.7%	36	30.0%	853	52.3%
Total: HealthSouth Service Area	**1,220**	**100.0%**	**71**	**100.0%**	**139**	**100.0%**	**82**	**100.0%**	**120**	**100.0%**	**1,632**	**100.0%**

Sources:
[1] Source: HSCRC Abstract Inpatient Database; CY2016 Final
[2] Source: DCHA Database; CY2016 Final
Notes:
[a] Adult: Age 18+
[b] MedStar NRH, Adventist Rehab, HealthSouth Chesapeake includes all cases
[c] SHP definition is: Nature of Admission =8, Daily Service Code = 8

For residents of Calvert, Charles, St. Mary's and Southern Anne Arundel County, drive time to MedStar National Rehabilitation Hospital (NRH) is 60-100 minutes' drive time for residents; this

27 While the choice of a rehabilitation provider may sometimes be tied to subspecialty programs for traumatic brain injury and spinal cord injury patients, this volume represents less than 5% of volume from the service area; utilization patterns and long travel times do *not* change appreciably when these cohorts are excluded.

imposes travel costs and time off from work for family members who want to visit regularly and be actively engaged in the rehabilitation process. Drive times are particularly onerous given the average length of stay of two weeks for acute rehabilitation patients. Clinicians report that there are many families who choose to sacrifice the rehabilitation component because the "commuting" arrangement to visit family members is simply unworkable.

(d) Travel time: Discouraging family engagement - Long drive times burden families/visitors and limit the opportunities for family education/family engagement in the recovery process; this makes care transitions more difficult and may slow down patient progress upon the patient's return home.

Rehabilitation programs typically are designed to engage family members in the recovery process. IRFs provide a great deal of family education and training, to help equip family members to "take over" and manage the ongoing process toward meeting goals. In fact, Encompass Health hospitals are designed with accommodations for a family member to stay overnight before discharge and manage the support role before discharge. But family engagement becomes much more challenging if family members are struggling to get to the hospital and spend time with the patient/therapists in the course of the recovery process.

(e) Underutilization of acute rehabilitation services - The access barriers identified above have resulted in underutilization of rehabilitation services by Southern Maryland and Anne Arundel County residents.

Hundreds of patients who might benefit from an IRF are discouraged from using rehabilitation services due to the commuting time entailed. Use rates for Southern Maryland residents are markedly lower relative to all other counties of Maryland, reflecting the combination of access barriers:

- There is no specialty rehabilitation hospital (IRF) in Southern Maryland, a first-choice service setting for many patients and clinicians.
- The program in Laurel -- the only program in the Health Planning Region -- operates with limited physical capacity.
- Use of an out-of-area program imposes hardships and added costs; families are often reluctant to assume the responsibilities/hardships entailed by this arrangement.
- Clinicians and social workers may not be strongly promoting rehabilitation care at an IRF; providers in Southern Maryland may not have had enough experience with IRFs to appreciate the superior outcomes in terms of clinical outcomes and costs of care savings.

Underutilization is clearly evident by the use rates documented below:

Adult Rehabilitation Discharges per 1,000 by County & Age Group
Based on SHP definition of acute rehabilitation
CY 2016

	Discharges				Population				Use Rate per 1,000			
County	**0-17**	**18-64**	**65+**	**18+**	**0-17**	**18-64**	**65+**	**18+**	**0-17**	**18-64**	**65+**	**18+**
Caroline	1	26	65	91	7,886	20,330	5,419	25,749	0.13	1.28	11.99	3.53
Dorchester	-	40	111	151	6,706	18,495	6,473	24,968	-	2.16	17.15	6.05
Kent	-	14	12	26	4,366	14,141	5,980	20,121	-	0.99	2.01	1.29
Queen Annes	-	23	42	65	9,710	26,672	7,797	34,469	-	0.86	5.39	1.89
Talbot	-	38	173	211	6,812	20,218	10,136	30,354	-	1.88	17.07	6.95
Somerset	-	18	66	84	4,217	15,950	3,760	19,710	-	1.13	17.55	4.26
Wicomico	-	130	449	579	22,275	63,537	15,035	78,572	-	2.05	29.86	7.37
Worcester	1	63	264	327	9,685	31,201	14,092	45,293	0.10	2.02	18.73	7.22
Subtotal: Eastern Shore	2	352	1,182	1,534	71,657	210,544	68,692	279,236	0.03	1.67	17.21	5.49
Charles	8	85	54	139	36,599	98,312	17,854	116,166	0.22	0.86	3.02	1.20
Calvert	2	49	42	91	21,464	58,742	12,748	71,490	0.09	0.83	3.29	1.27
Prince Georges	16	661	559	1,220	206,094	595,173	110,357	705,530	0.08	1.11	5.07	1.73
Saint Marys	3	50	32	82	28,417	72,552	14,384	86,936	0.11	0.69	2.22	0.94
Subtotal: Southern Maryland	29	845	687	1,532	292,574	824,779	155,343	980,122	0.10	1.02	4.42	1.56
Montgomery	23	594	944	1,538	246,181	661,182	150,858	812,040	0.09	0.90	6.26	1.89
Subtotal: Montgomery	23	594	944	1,538	246,181	661,182	150,858	812,040	0.09	0.90	6.26	1.89
Baltimore City	3	878	856	1,734	144,969	431,808	88,133	519,941	0.02	2.03	9.71	3.33
Baltimore	1	650	939	1,589	169,899	494,731	131,970	626,701	0.01	1.31	7.12	2.54
Carroll	1	76	119	195	35,068	102,814	26,796	129,610	0.03	0.74	4.44	1.50
Cecil	-	23	14	37	23,638	64,176	15,029	79,205	-	0.36	0.93	0.47
Harford	-	162	173	335	56,319	156,841	38,009	194,850	-	1.03	4.55	1.72
Howard	-	173	201	374	74,885	204,839	40,647	245,486	-	0.84	4.95	1.52
Anne Arundel	1	308	208	516	125,370	346,116	77,979	424,095	0.01	0.89	2.67	1.22
Subtotal: Central Maryland	6	2,270	2,510	4,780	630,148	1,801,325	418,563	2,219,888	0.01	1.26	6.00	2.15
Allegany	-	34	185	219	13,006	46,453	14,817	61,270	-	0.73	12.49	3.57
Frederick	4	121	115	236	60,409	163,014	34,846	197,860	0.07	0.74	3.30	1.19
Garrett	-	3	16	19	5,274	16,330	5,724	22,054	-	0.18	2.80	0.86
Washington	2	127	224	351	32,618	92,581	24,210	116,791	0.06	1.37	9.25	3.01
Subtotal: Western Maryland	6	285	540	825	111,307	318,378	79,597	397,975	0.05	0.90	6.78	2.07
Total: Maryland	**66**	**4,346**	**5,863**	**10,209**	**1,351,867**	**3,816,208**	**873,053**	**4,689,261**	**0.05**	**1.14**	**6.72**	**2.18**

Sources:
[1] Maryland hospitals: HSCRC Abstract Inpatient Database; CY2016 Final
[2] DC hospitals: DCHA Database; CY2016 Final
[3] Population Data: Nielson-Claritas Population Data; CY2016
Notes:
[a] Acute Rehab: Based on State Health Plan definition (see Technical Notes)

This underutilization has serious implications for quality of care. Comparative effectiveness studies have documented the superior clinical and functional outcomes achieved by IRFs as compared with SNFs for specific patient cohorts. Based on national studies, the American Heart Association and the American Stroke Association have issued clinical practice guidelines that explicitly recommend intensive rehabilitation and multidisciplinary teams for post-stroke patients, giving preference in their guidelines for IRF settings rather than SNF-based care. In Southern Maryland, these clinical recommendations are not being widely implemented: The

majority of patients in the High Potential Rehabilitation cohorts are discharged to home or to SNFs with/without significant rehabilitation services.

(f) Disruption in continuity of care - The dependence on out of area providers can result in "breaks" to continuity of care and less effective care management.

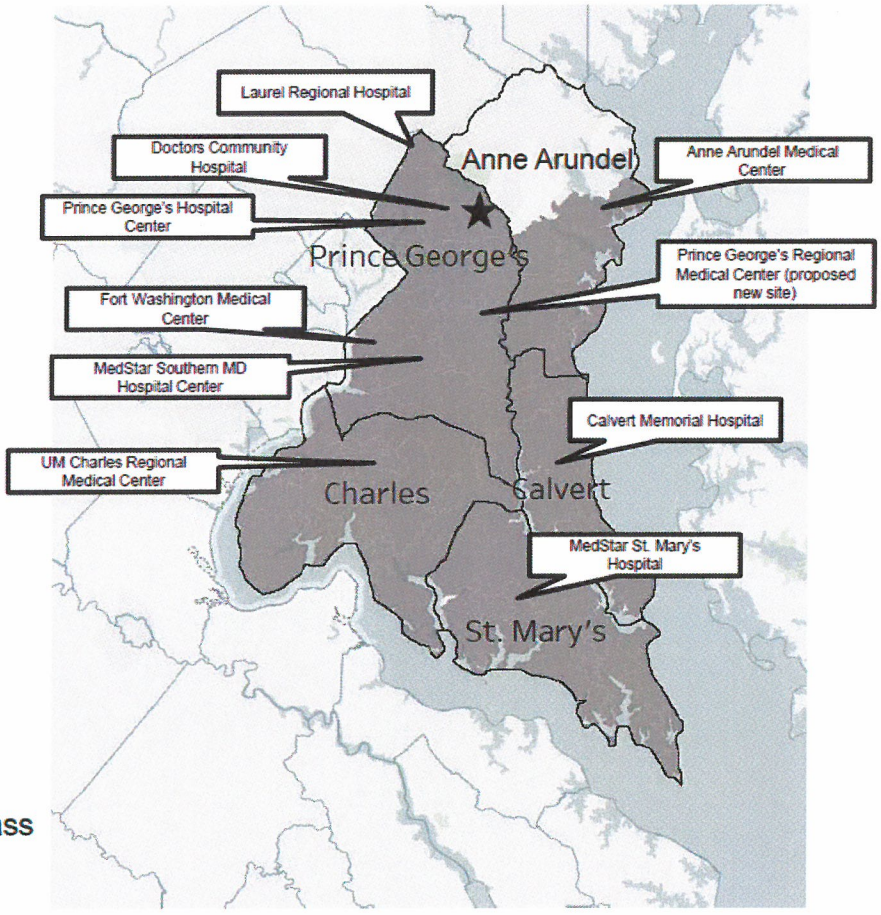
The use of out of area providers typically means a disruption in medical management or, at best, a more challenging task for discharge planners/case managers to arrange community-based services post-discharge. Discharge planners are typically less familiar with local resources and arranging community-based services for post-discharge typically takes more time.

Conclusion: Southern Maryland is under-resourced and underserved for rehabilitation care. The limited options in the local area, the access barriers associated with commuting time, and the fragmented care across institutions have discouraged the use of rehabilitation services. This has denied residents access to the expertise, the technology, the multidisciplinary model and the extended care management of a specialty rehabilitation hospital despite evidence-based guidelines that recommend referral to an IRF. As the over-65 population grows by more than 5% annually, and the need for return to functional independence becomes a more pervasive issue, this service gap is and will continue to be a dominant issue.

How will the applicant address access barriers?

EHRHSM will be well-positioned geographically and programmatically to improve access to rehabilitation services, promote effective use of acute rehabilitation services, support continuity of care, and provide Southern Maryland residents with more options for high quality rehabilitation services.

Encompass Health Southern Maryland
Service Area for Acute Rehabilitation



★ New proposed location of Encompass Health

1. The proposed facility will increase bed capacity and its Bowie location will be near densely populated communities in Prince George's County and southern Anne Arundel County; the proposed facility will reduce travel time for the service area population

The Project will increase bed capacity and will reduce current travel times for service area residents; in particular, residents of Calvert County and Anne Arundel County will experience significant reductions in travel time. A table showing reduced travel time is presented below:

Current Travel Time to Nearest Acute Rehabilitation Program, By County and Effect of New Hospital (excluding Laurel Regional)

From \ TO	Average Travel Time and Distance									
	Anne Arundel County		Calvert County		Charles County		Prince George's County		St.Mary's County	
	Travel Time	Distance (mi)	Travel Time	Distance (mi)	Travel Time	Distance (mi)	Travel Time	Distance (mi)	Travel Time	Distance (mi)
MedStar National Rehabilitation Hospital	56	32	82	51	71	41	38	15	106	70
George Washington University Hospital	54	34	76	52	98	41	39	18	103	69
Adventist Rehabilitation Hospital of Maryland	77	51	106	73	104	65	59	33	134	91
University of Maryland Rehabilitation and Orthopaedic Inst	68	44	107	72	113	75	68	41	140	96
Johns Hopkins Hospital	74	45	114	71	118	72	73	39	145	94
Johns Hopkins Bayview Medical Center	70	40	110	68	120	75	72	40	143	94
Sinai Hospital and Levindale	82	48	123	76	128	78	83	44	154	100
MedStar Good Samaritan	86	46	124	74	133	81	87	46	158	100
MedStar Union Memorial	76	42	126	70	122	74	78	40	149	95
HealthSouth Chesapeake	128	105	164	134	177	145	138	118	201	160
UM Shore Medical Center	79	55	114	84	126	95	86	68	150	110
Meritus Medical Center	125	98	162	120	158	112	115	80	187	138
Encompass Health	29	20	59	42	69	45	27	18	93	65

2. The proposed facility will be located approximately 9.5 miles from Largo where the new UM Capital Region Prince George's Regional Medical Center will operate.

EHRSM in Bowie will be well-positioned to meet the need for post-acute services where volume is expected to grow most dramatically. The new University of Maryland Capital Regional Medical Center in Largo is projected to serve more than 30% of Prince George's County inpatients; this represents a dramatic growth in the number of acute care patients who will be served in Prince George's County, with an accompanying increase in local demand for rehabilitation services.

3. Encompass Health will increase access by admitting more appropriate patients who deserve a hospital level of rehabilitative care, many who also have complex medical needs. These are patients who previously have not been admitted by area SNFs or by the unit at Laurel.

The capacity to admit patients with complex conditions and continuing medical management need will also function to help decrease length of stay in the acute care facility, a feature that will further encourage utilization of EHRHSM as a post-acute provider.

4. EHRHSM will be accredited by both The Joint Commission and CARF and also will seek accreditation for disease-specific programs. Several of these programs will align with disease management programs now operating across hospitals in Southern Maryland and will support Maryland's goals for chronic disease management.

By way of illustration, Encompass Health hospitals operate certified stroke programs supported by state-of-the-art equipment and professionals who have completed specialty program training in stroke care. Encompass Health's Stroke Centers of Excellence will increase access to care by collaborating with physicians in the Southern Maryland Region, building awareness of these disease-specific programs, and sharing the evidence/clinical practice guidelines that support the use of IRFs for specific clinical cohorts.

5. *Encompass Health will become a presence at all area hospitals through its team of Rehabilitation Liaisons to provide timely evaluation and smooth transfer of patients.*

Encompass Health's Rehabilitation Liaisons conduct screenings, discussions with healthcare personnel and meetings with families of patients to assess clinical needs and arrange timely transfer. Often, this process occurs within hours of patient identification as described above in the Quality Care Management section. Lengths of stay in the acute hospital will be minimized by the close working relationship with hospitals and by this efficient system for transfer.

6. *Encompass Health will increase access by accommodating direct admissions.*

Across the country, approximately 7% of Encompass Health's admissions are now admissions from physician offices and from the community and 2% from SNFs. Patients can be provided intensive rehabilitation in a setting designed explicitly for restoring patients' strength and mobility. The opportunity for direct admissions will increase access to intensive rehabilitation and reduce the cost of inpatient stays at Southern Maryland hospitals.

7. *Encompass Health will increase access through working partnerships with area hospitals and ACOs, and through participation in Medicare Advantage contracts.*

Encompass Health will serve as a highly experienced and well-equipped partner for care management of the Southern Maryland population. If there is opportunity in the market to do so, Encompass Health will evaluate the opportunity to contract with area hospitals and ACOs under bundled payment/episode payment models and will work collaboratively with acute care hospitals and physicians to reduce readmissions and reduce the total costs of care under the Waiver. Encompass brings extensive experience in working with both acute care teams and community-based teams:

- Eight (8) Encompass Health hospitals across the country currently participate as risk-bearing participants in Medicare's Bundled Payment for Care Improvement Initiative and 72 of Encompass Health's home health agencies are participating in bundled payment initiatives. Encompass's home care agencies across the country are also actively participating in ACO's.

- At this time, Encompass Health contracts with Medicare Advantage plans in every state where it operates. Encompass Health expects to contract directly with Medicare Advantage plans in Maryland and Washington, DC.

8. Area hospitals/area clinicians have expressed support for the proposed facility to improve quality of care and cost-effective service delivery.

As demonstrated by the support letters provided as Exhibit 11: area hospitals/area clinicians have expressed support for the proposed facility to improve quality of care and cost-effective service delivery. For example:

> *"Patients who are cared for in an acute inpatient rehabilitation hospital improve their functional capabilities much faster and more comprehensively compared to those in a skilled nursing facility...it is well known that those cared for in an acute inpatient rehabilitation hospital have better outcomes and return home or place of residence at a much higher incidence...currently, such services are extremely limited in Prince George's County and are badly needed for the people who reside here." (Board Certified Neurologist, Bowie)*

> *"This is a top tier company...I know firsthand of the quality inpatient rehabilitation services they provide." (Board Certified Physical Medicine and Rehabilitation Specialist)*

> *"One of the biggest barriers that we face is access to post hospital care and rehabilitation...many times patients are forced to choose less intensive arenas to carry out the vital rehabilitation that is needed to reintegrate them back into society...The importance of a quality inpatient acute rehabilitation facility for the community surrounding our hospital cannot be overemphasized." (Stroke Program Coordinator, University of Maryland Prince George's Hospital Center)*

B.(2) Need

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

The basis for defining need for the proposed project ties to need in the Southern Maryland Planning Region and need in Southern Anne Arundel County (representing a contiguous health planning region) (referred to herein as the "Southern Maryland Region").

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affects its need projection.

Currently, more than 90% of service area residents travel out of area for acute rehabilitation services. More than half of these patients travel as far as the District of Columbia for care. A major goal of the proposed project is to reduce outmigration in order to relieve travel hardships for families, support greater continuity of care across clinicians, and reduce Medicare spending. Volume projections assume that approximately 400 discharges now served at District of Columbia rehabilitation programs will be served locally. Volume projections for the new EHRHSM do not assume any redirection of volume from existing hospital-based programs in Maryland (see Section: Need, Volume Projections).

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPT, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

The Maryland Health Care Commission's Need Projection for Acute Rehabilitation Beds was published in the Maryland Register on October 17, 2014. In this projection, the 2017 bed need for Southern Maryland was projected to range from a bed surplus of 9 beds to a bed need for 66

beds. This range reflects a methodology that calculates a minimum bed need and a maximum bed need using two sets of inputs:

Minimum: The *regional* use rate and outmigration factors, as compared with
Maximum: The *State* use rate and outmigration factors

The large differential produced by these two approaches reflects the large differential in Southern Maryland's utilization patterns: Southern Maryland has a markedly low use rate and a very high outmigration factor. It is only when one applies the more appropriate State of Maryland use rate and the more appropriate outmigration factor that the methodology demonstrates the large need for additional rehabilitation capacity.

Encompass Health maintains that the *maximum* bed need projection is the only relevant criteria to be adopted based on the following:

Premise A: Reducing the outmigration rate should be the goal for the State of Maryland. Applying the "maximum" assumptions reflects the goal to reduce outmigration, improve access, and improve quality of care.

- Bed need should be evaluated in context of reducing outmigration, consistent with the goal of improving access
- Bed need should be evaluated in context of increasing utilization, consistent with clinical practice guidelines and evidence-based care
- Only the maximum model reflects these goals; only the maximum model indicates goals for improved access and quality improvement.

Premise B: With a new Encompass Health hospital in Southern Maryland, the outmigration rate will decline considerably.

- Encompass Health projects approximately 50% market share for acute rehabilitation in its defined service area by offering the specialized resources/facilities of an IRF; this will reduce the outmigration rate considerably. This forecast is conservative relative to the experience of other IRFs in Maryland: Adventist Rehabilitation and HealthSouth Chesapeake currently hold nearly 70% market share in their respective Health Planning Regions.
- Only the "maximum" model assumes a major decline in outmigration

Premise C: With a new Encompass Health facility in Southern Maryland, the in-migration rate can be expected to increase.

- An Encompass Health hospital in Southern Maryland can be expected to attract patients from out-of-area; it is reasonable to assume that the in-migration rate will increase. Nationally, Encompass Health reports that 7% of patients in its facilities come from out-of-service-area.

Premise D: Given the huge demographic growth projected for the region, bed need must be projected based on CY2023 population projections, Year 3 of the new Encompass Health operation.

Conclusion: Based on these assumptions, Encompass Health proposes that the "maximum model" be applied as the relevant criteria for this application. The assessment should also consider the projection for *new patient populations* who will be served in the rehabilitation hospital, as this volume would not have been reflected in prior years' use rates.

(d) - (f)

N/A

(3) Impact

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix at other acute inpatient rehabilitation providers

The Project is premised on the assumption that patient volume will be generated from four major sources:

(1) Patient volume previously served at Laurel Regional
(2) Patient volume redirected from District of Columbia programs
(3) Patient volume generated by demographic growth of the service area
(4) Shift of patient volume from area SNFs in order to better serve patients who qualify for intensive rehabilitation

Therefore, the only existing acute inpatient rehabilitation providers expected to be impacted by the proposed project are the two acute rehabilitation programs in the District of Columbia [NRH and George Washington University Hospital ("GWU")]. Encompass Health does not anticipate a

meaningful impact on any acute rehabilitation providers in Maryland. The volume projections confirm that the proposed program is not expected to be built through volume shifts from existing rehabilitation programs in Maryland. This point is further clarified by the following summary presentation:

Projected Volume for Encompass Health, Southern Maryland
Impact on Existing Facilities
Projected Year 2023

			Projected Loss			Projected Gain/Retain			
Category	Referral source	CY2016 Discharges	Laurel Regional	National Rehab/GWU	SNFs	Shift/Gain: Encompass	Retain/Gain: Other acute providers	Retain/Gain: Nursing homes	CY2023 Discharges
Acute rehab	Laurel Regional	259	(259)			233	26		
	National Rehab/GWU	2,470		(341)		341	2,129		
	All other acute hospitals	9,750					9,750		
	Demographic growth, 2016-2023					223	75		
	Total, Acute Hospitals	**12,479**	**(259)**	**(341)**	**-**	**797**	**11,980**	**-**	12,777
SNFs	Volume at SNFs: High Pot'l Rehab	3,158			(418)	418		2,740	
	Demographic growth					154		1,115	
	Total, SNFs	**3,158**			**(418)**	572	-	**3,855**	4,427
New volume	Direct admissions					75			
	Organ transplants					10			
	Out of area volume					46			
	Total, New Volume to the Market	-				131	-	-	131
	Grand Total	**15,637**				1,500	**11,980**	**3,855**	**17,335**

As acknowledged, Encompass Health does expect to redirect approximately 340 discharges from NRH/GWU. But this volume represents only 15% of total discharges at these two facilities. Moreover, this presentation does not show the opportunities that NRH/GWU have for backfilling this volume through demographic growth in the Washington metropolitan area (including the high growth region of northern Virginia) and through shifts of SNF volume in their own local service area.

Encompass Health does not expect a meaningful change in the case mix or length of stay at NRH or GWU; Encompass Health expects that the patient volume redirected from NRH/GWU will represent a comparable case mix and length of stay profile as the broader patient mix served at these programs. Projected volume is based on the actual mix of patients in the market today.

(b) Its estimate of any reduction in the availability of accessibility of a facility or service that will likely result from the project, including access for patients are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04Q(1)(a) of this Chapter.

Encompass Health does not expect that the Project and the projected volume shift will result in any reduction in the availability or accessibility of services. Instead, the new facility will produce additional bed capacity in the State of Maryland.

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project.

Encompass Health has no basis for anticipating any reduction in the quality of care at other providers as a result of the Project.

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

The Project will operate in a large Health Planning Region of approximately 1.2 million people. EHRHSM expects that employees will largely be residents of this Region. The State of Maryland has invested heavily in the UM Prince George's Regional Medical Center and other population health initiatives with the intent to expand and upgrade the health care workforce, and the affiliation with the University of Maryland Medical System is designed explicitly to strengthen both primary care and specialty care and elevate the quality of care in Prince George's County.

It is worth noting that Encompass Health will provide a high quality professional training site for both physicians and therapists. The presence of Encompass Health in the region is likely to help train and retain high quality rehabilitation providers and attract a larger number of rehabilitation professionals to work in the State of Maryland. ERHSM plans to partner with local universities and schools to improve recruiting efforts.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

See Exhibit 8.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, **the projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels,**

geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Not applicable

(5) Safety. The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

The space needs of a rehabilitation patient are somewhat different from a general acute care patient, as some patients require extensive physical therapy space, and the use of large equipment (See Exhibit 14). Inpatient rehabilitation hospitals are designed from the ground up to meet the clinical and safety needs of rehabilitation patients. EHRHSM is designed to be architecturally barrier-free and efficient, and have square footage allowances for large equipment

EHRHSM will be fully sprinklered, designed and constructed to meet all applicable requirements of the Internal Building Code and National Fire Protection Agency. The design of all Encompass hospitals, including EHRHSM takes patient safety into consideration and includes design features that enhance and improve patient safety. Design features such as appropriate floor material and finishes, critically placed handrails, strategically placed lighting to assist in patient movement, and a centrally located nurse station for quick response and visual control are just a few features that have evolved from constant review and development of Encompass Health standards.

(6) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital CON application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with the observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provisions, as experienced by the applicant hospital

(iii) or, if a new hospital, the recent experience of other similar hospitals;

(iv) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or if a new hospital, the recent experience of other similar hospitals; and

(v) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

Please see Tab 5 - Tables J, K, and L. Tables G and H are inapplicable because this is a new facility. These tables demonstrate that the project is sustainable and achieves a positive margin by the second year of operation.

The Project is financially feasible and will not jeopardize the long-term financial viability of the hospital as explained below:

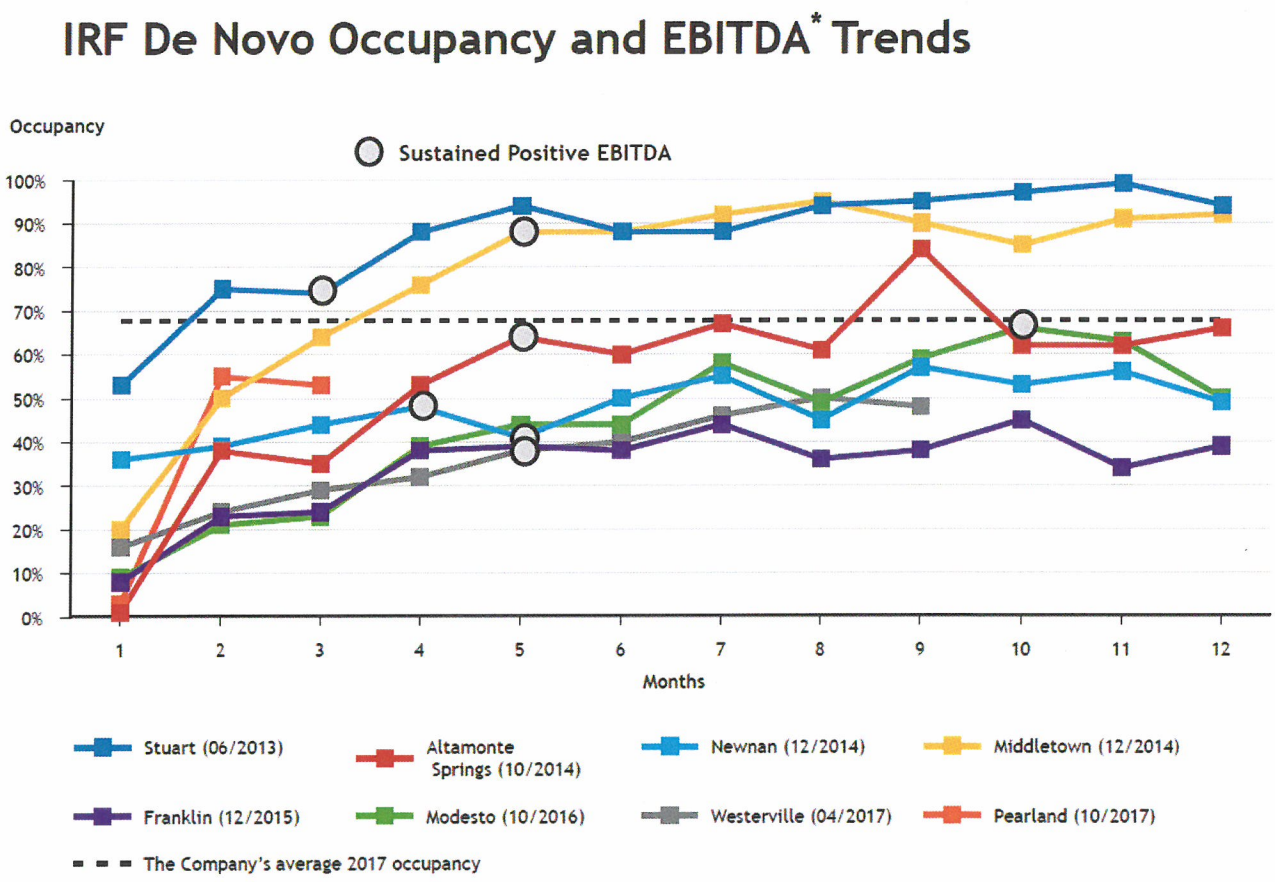
(i) Utilization projections are consistent with the observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

As demonstrated in response to COMAR 10.24.01.08G(3)(b) and 10.24.09B.(2), utilization projections are consistent with both historic trends in the Southern region and the State Health Plan need projections. Furthermore:

- In 2016, Encompass averaged 1,386 total Medicare and non-Medicare discharges per IRF in its then 118 consolidated IRFs that were open the full year.

- Also - 1544 discharges in 2017 Year end at Chesapeake – which is 59 beds.

□ By way of example, the graph below indicates Encompass Health's occupancy levels for its newer de novo hospitals for the first 12 months of operation. Encompass Health has a proven track record of a high degree of success with its de novo hospitals.



Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provisions, as experienced by the applicant hospital

(ii) or, if a new hospital, the recent experience of other similar hospitals;

Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provisions experienced by HealthSouth Chesapeake and other Encompass rehabilitation hospitals across the country.

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future

staffing levels as experienced by the applicant hospital, or if a new hospital, the recent experience of other similar hospitals; and

Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels based on the experiences of HealthSouth Chesapeake and HealthSouth Rehabilitation Hospital of Northern Virginia.

(iv) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

As demonstrated in Tab 5 the Project will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation): per Table J (uninflated) by year 1 and per Table K (inflated) by year 2.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

Not applicable

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

EHRHSM, a proposed acute inpatient rehabilitation specialty hospital, is consistent with this standard because (i) it will contain 60 beds and (ii) is projected to maintain within three years an average daily census of 55 (approximately 90% occupancy) which is consistent with the 80% minimum occupancy standard in this Chapter.

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

See Exhibit 15 for written transfer and referral agreements. Additional documentation will be provided prior to licensure.

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that offers the best balance between program effectiveness and costs to the health care system

Not applicable.