GALLAGHER EVELIUS & JONES
ATTORNEYS AT LAW

July 15, 2022

Ms. Ruby Potter
Health Care Facilities Planning & Development Administrator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299
ruby.potter@maryland.gov

Re: Encompass Health Rehabilitation Hospital of Southern Maryland, LLC
Addition of 10 Beds to Special Rehabilitation Hospital

Dear Ms. Potter:

On behalf of applicant Encompass Health Rehabilitation Hospital of Southern Maryland, LLC, we are submitting four copies of its Response to Additional Information Questions Dated June 16, 2022. A WORD version of the submission will be supplied to Commission Staff under separate email.

We hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agencies noted below.

Sincerely,

Ella R. Aiken

Alison Lutich
Alison J.B. Lutich

Enclosures
cc: Wynee Hawk, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development
Sarah Pendley, Esq., Assistant Attorney General
Alexa Bertinelli, Esq., Assistant Attorney General
Dr. Ernest Carter, Health Officer, Prince George's County Health Dept.
Dr. Diana E. Abney, Health Officer, Charles County Health Dept.
Dr. Meenakshi G. Brewster, Health Officer, St. Mary's County Health Dept.
Dr. Laurence Polsky, Health Officer, Calvert County Health Dept.
Dr. Nilesh Kalyanaraman, Health Officer, Anne Arundel County Health Dept.

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Encompass Health Rehabilitation Hospital of Southern Maryland, LLC
Addition of 10 Beds
Matter No. 22-16-2458

Responses to Additional Information Questions Dated June 16, 2022

Part I

1. Will the originally approved 60-bed hospital be open during the construction of the 10-bed unit addition? If so, what will be the impact of the ongoing construction to existing patients at the hospital located on the same wing or in close proximity to the proposed expansion?

Applicant Response

Encompass Health Rehabilitation Hospital of Southern Maryland, LLC ("Encompass Hospital") anticipates opening the 60-bed facility on June 23, 2023. The anticipated completion date of the 10-bed addition is February 15, 2025, approximately 20.5 months after CON approval. *See* Encompass Hospital June 3, 2022 CON Application (hereinafter, the "CON Application"), p. 7 for more information regarding the anticipated timing and steps needed to complete construction of the 10-bed addition. The approved 60-bed hospital will thus be open during the construction of the 10-bed unit addition.

The impact of the 10-bed addition to existing patients of the 60-bed facility will be minimal for a number of reasons, including (a) the construction process that Encompass Hospital will utilize to add the 10-bed unit; (b) the specific location of the proposed 10-bed unit in relation to the completed 60-bed facility; and (c) Encompass Health Corporation's ("Encompass Health") vast experience adding beds to existing facilities with minimal disruption to existing patients and services.

(a) Construction Process.

Encompass Hospital anticipates partnering with the Alabama-based modular construction company BLOX to standardize and expedite components of the 10-bed addition construction process, which will result in cost and time savings and minimize disruption to patients of the existing 60-bed facility. BLOX applies manufacturing and design principles to create medical modules off-site. As a result, the customized, completed, and up-to-code building module (complete with electric and plumbing) can be added to an existing structure with minimal disruption.[1] Because the majority of construction on the 10-bed unit will be completed by BLOX off-site, the addition of the unit will require only minimal on-site construction work at the 60-bed hospital campus. By reducing the amount of on-site construction work required to

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[1] See *e.g.*, https://www.bloxbuilt.com/wp-content/uploads/2019/06/Building-Blox-good-grit.pdf and https://www.bizjournals.com/birmingham/news/2021/06/25/encompass-and-blox-form-partnership.html?s=print.

add the 10-bed unit, any disruptions to patient care will be short in duration and minimal in scope.

(b) Location of the 10-Bed Addition.

The proposed 10-bed addition will be located in a new unit that will extend from the end of an existing patient corridor. *See* CON Application, Exhibit 2, schematic drawings. The customized prebuilt 10-bed unit will be brought onsite and then joined to the two rooms labeled 59 and 60 on the drawings included in CON Exhibit 2. As a result, the addition of the expanded unit will only impact the two private patient rooms where the new unit will be connected to the 60-bed hospital building. The physical connection of the 10-bed unit to the existing 60-bed facility will require only minimal renovations and time to complete. Moreover, any construction necessary in areas immediately adjacent to occupied rooms will be limited to typical patient care hours, and no work will be completed during early or late hours so as to minimize noise to patients. Encompass Hospital's approved Infection Control measures will be also be utilized during construction to mitigate risk to patients and staff resulting from the construction zone. Patient impact will therefore be limited.

(c) Prior Expansion Experience.

Encompass Health has vast experience renovating and expanding existing acute inpatient rehabilitation hospitals across the country with minimal disruption to existing patients and services, even when BLOX construction did not provide the construction services. As an example, Encompass Health recently added ten beds to its inpatient rehabilitation facility located in Salisbury, Maryland using a conventional construction model. During the construction, only two patient rooms were impacted. These rooms were out of service for approximately three weeks during completion of utility connections, but no other patient spaces were affected during the construction. The Salisbury facility implemented the same policies regarding hours for construction during this process to ensure minimal impact on patient care and experience.

2. What is the anticipated date that Encompass Health and UMMS will enter into its joint affiliation agreement becoming 50/50 owners of the Encompass Health Rehabilitation Hospital of Southern Maryland, LLC?

Applicant Response

The parties anticipate that the joint-venture affiliation will close in either the third or fourth quarter of CY2023 following the expected opening of the 60-bed hospital facility on June 23, 2023, and subsequent to determination from the Commission pursuant to COMAR § 10.24.01.03 regarding the hospital's change in its upstream ownership resulting from the joint-venture. *See* CON Application, pp. 4-5.

Charity Care

3. As a point of comparison, please provide the amount of Charity Care provided by Encompass Salisbury from 2019 to current.

Applicant Response

Rehabilitation Hospital Corporation of America, LLC d/b/a Encompass Health Rehabilitation Hospital of Salisbury ("Encompass Salisbury") has made significant progress in implementing the charity care percentage it committed to providing in connection with its October 5, 2018 CON Application, approved December 19, 2019 (the "Commission Decision *in re* Encompass Salisbury") as demonstrated in the following table.

Table 13[2]
Encompass Salisbury charity care, as a % of operating expenses
2016 through 2022 YTD

Year	Charity Care as % of Operating Expense
2016	0.004%
2017	0.007%
2018	0.069%
2019	0.66%
2020	1.49%
2021	0.46%
2022 YTD (through 6/30/2022)	0.77%

In the most recent year for which comparative data is available (2019), Encompass Salisbury outperformed Adventist Rehabilitation Hospital, a not-for-profit provider identified as a direct competitor in the Commission Decision *in re* Encompass Salisbury, and discussed by that decision in reference to Encompass Salisbury's charity care commitment. Commission Decision *in re* Encompass Salisbury, 5-6.[3]

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[2] Tables and Figures in this Response continue in numbering from the CON Application.

[3] Encompass Hospital notes that it has concerns with comparing Encompass Salisbury's charity care provision with that of Adventist Rehabilitation Hospital for several reasons, including but not limited to differences in payor mix and service area population; Encompass Hospital makes this comparison due to the Commission's focus on Adventist Rehabilitation Hospital in connection with the Commission's review and Decision. *See generally*, Commission Decision *in re* Encompass Salisbury.

Table 14
Adventist Rehabilitation Hospital charity care, as a % of operating expenses
2016 through 2019

Year	Charity Care as % of Operating Expense
2016	2.49%
2017	1.15%
2018	0.54%
2019	0.61%

Source: Maryland Hospital Community Benefit Financial Reports: FY 2016 - FY 2019

Encompass Salisbury's 2020 provision of charity care surpassed the charity care provided by the bottom quartile of Maryland hospitals in FY 2018 and FY 2019 (the last two years for which such data is available).[4]

Encompass Hospital further notes that, as a Medicaid-expansion state, Maryland's uninsured population is declining. As has been experienced in other Medicaid expansion states, the number of uninsured in Maryland has declined as residents increasingly qualify for Medicaid. Between 2013 and 2017, Maryland's uninsured population declined from 12% to 7%. Moreover, inpatient rehabilitation services such as those provided by Encompass Salisbury and the proposed Encompass Hospital 10-bed unit are highly utilized by Medicare patients, thus further reducing the anticipated number of uninsured patients. As Encompass Salisbury noted in connection with its CON review, and as found in the Decision, Encompass Health's "patients are predominantly over 65 and covered by Medicare" and "it is logical that a hospital with a primarily Medicare payor mix might be expected to show a lower level of charity care than one with a more typical payor mix." CON Decision *in re* Encompass Salisbury, p. 6. At the time of its CON Application, Encompass Salisbury had a much higher mix of Medicare patients than its direct competitor, Adventist Rehabilitation Hospital. Id.

While Encompass Salisbury has made substantial progress in performing the steps identified in its charity care plan of action pursuant to its CON Application to add ten beds (approved in December 2019) it has been limited in some ways by the effects of the COVID-19 pandemic. In particular, the pandemic limited the ability of Encompass Salisbury's representatives and the willingness of other providers to conduct in person meetings that would have enabled Encompass Salisbury to more fully complete its envisioned plan of action. Encompass Salisbury further found that many potential referral sources have been focused

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[4] The 2018 reported charity care as a percentage of total operating expenses in the 2018 Community Benefit Report demonstrates an average of 1.92% among all reporting hospitals, with the bottom quartile providing 1.1% or less. The charity care provided by Maryland hospitals was similar in FY 2019, the last year of reporting available, with an average of 1.94% in charity care as a percentage of total operating expenses, with the bottom quartile of hospitals reporting 1.06% or less. These data are discussed at greater length, with accompanying tables, in Encompass Salisbury's September 3, 2021 Report on for First Use Review and Certification.

significantly on responding to the pandemic and its impact on providers and their patient populations.

In connection with its Certificate of Need to add ten beds, Encompass Salisbury implemented a number of actions to increase its provision of charity care pursuant to a six-step plan of action. *In re Encompass Salisbury Health Rehabilitation Hospital of Salisbury*, Matter No. 18-22-2435, September 3, 2021 Request for First Use Review and Certification. These actions included providing education to patients about the availability of financial assistance; re-training its liaisons on its financial assistance policy and the importance of making patients and referral sources aware of such policy; expanding and meeting with referral sources to discuss financial assistance; and coordinating with local providers and health departments to promote awareness of Encompass Salisbury's financial assistance program. *Id.* As a direct result of these actions, Encompass Salisbury saw a significant upward trend in the amount of charity care it provided in 2020.

Encompass Salisbury has continued to focus on training, education, and outreach each year since obtaining its CON to add ten beds. Despite previous steady growth in provision of charity care, Encompass Salisbury began to experience a downward trend in its charity care expenditures as the effects of the COVID-19 pandemic on the health care system intensified at the end of 2020. This downward trend resulted from a number of pandemic-related factors, including workforce volatility and diminished access to community agencies, hospitals, and their staff. Prior to COVID-19, Encompass Salisbury's efforts to increase charity care centered on connecting with community stakeholders and referral sources through outreach. Due to the COVID-19 pandemic, however, referral source liaisons were no longer available on-site, and they primarily handled communication by phone, fax, or video conference. Interactions with liaisons also primarily focused on immediate patient discharge issues during this time, rather than larger discussions regarding charity care-eligible patients. Additionally, Encompass Salisbury's referring hospitals experienced high turnover during this period, particularly in the case manager departments. These departments play a key role in establishing and maintaining referral relationships. Encompass Salisbury believes the high turnover contributed to the decline in referrals of charity care-eligible patients.

Table 15
Charity-care eligible referrals from referring Hospitals, 2019 through present

	2019	2020	2021	2022 YTD
# of Referrals*	26	25	13	8

*Note: This data is for referrals; not all referred patients are admitted. Patients must satisfy rehab-appropriate care admissions requirements to be admitted, which further reduces the number of charity-care eligible individuals that Encompass Salisbury is able to admit, given that not all patients qualify for IRF treatment when referred.

In addition to difficulties engaging with referral source liaisons, Encompass Salisbury also faced challenges with respect to community agency collaboration. Throughout the pandemic, local health departments and other community health agencies have been largely focused on urgent public health needs and were unable to engage in meetings with Encompass Salisbury to the same degree as in pre-pandemic years. With less access to its community

partners, Encompass Salisbury was unable to fully implement its charity care community outreach efforts, which decreased its charity care provision overall.

Finally, Encompass Salisbury's own pandemic-related staffing challenges contributed to its period of decline in charity care. In addition to dealing with shortages caused by staff member infections and high levels of resignation from the industry, Encompass Salisbury had high turnover in its Rehab Liaisons from 2020 to 2022, as well as a vacancy in its Director of Business Development position from February 2021 through March 2022.

Despite these limitations, Encompass Salisbury has made considerable progress, and intends to continue making progress, especially as health measures related to the ongoing pandemic improve. Moving forward, Encompass Salisbury has identified a number of opportunities to emphasize its focus on charity care, both internally and with its community partners. Encompass Salisbury has worked diligently to fill the vacancies in its Rehab Liaison positions. Each new hire receives education and training on the charity care program during the onboarding process, during which Encompass Salisbury emphasizes its commitment to serving indigent patients. A number of Encompass Salisbury's referral partners have begun to reopen, providing the opportunity for interactive outreach and meetings on site. These steps towards returning to pre-pandemic conditions have already begun to influence Encompass Salisbury's charity care program. Through June 30, 2022, Encompass Salisbury provided more charity care in dollars to patients than it did in 2021 ($98,078 in 2022 YTD, compared to $87,802 in 2021).

Based on its improvements to date, Encompass Salisbury expects to meet its commitment to provide charity care equivalent to 2% of its annual operating expenses in the near future, after stabilizing from significant staffing turnover and shortages both internally and, anecdotally, at referral partner providers, and from other impacts of the COVID-19 pandemic.

4. Please provide a copy of the sliding-scale that will be used by the hospital for charity care purposes.

Applicant Response

Please refer to CON Application Exhibit 7, Attachment B.

Quality of Care

5. Staff conducted an analysis using data from the Medicare compare site which shows that for Encompass Salisbury the rate of potentially preventable hospital admissions during the IRF stay was 5.29% which is worse than the national rate. Please explain this discrepancy with the quality information that you provided. The data on the Medicare site was last updated April 28, 2022.

Applicant Response

The Centers for Medicare and Medicaid Services ("CMS") use two (2) rates of readmission indicators to measure the percentage of inpatient rehabilitation facility ("IRF") patients who were hospitalized again for a condition that might have been prevented:

(i) Readmissions within 30 days of discharge from the IRF, which reflects readmissions *after discharge* from the IRF.

(ii) Readmissions *during* the patient's IRF stay.

In the application, Encompass Hospital provided the readmission rate of potentially preventable hospital readmissions 30 days *after discharge* from an IRF, which is 5.87% for Encompass Salisbury compared to the national average of 6.74% for this quality metric. *See* CON Application, p. 27. For this metric, Encompass Salisbury's readmission rate is lower than the national rate. As noted by the Commission, Encompass Salisbury's 5.29% readmission rate of potentially preventable hospital readmissions *during the IRF stay* is slightly higher than the national average of 4.34% readmissions.

The general acute care hospital readmission rates are just two of many quality metrics provided by CMS on its Medicare.gov Inpatient Rehabilitation Facility (IRF) Compare website. In Table 2 of Encompass Hospital's CON Application, Encompass Hospital reported several quality metrics for which Encompass Salisbury exceeds the national averages, including readmission rates following discharge from an IRF, as well as successful return to the home and community, better ability to move around at discharge, and better ability to care for self after discharge. The CMS quality indicators reported for Encompass Salisbury illustrate the high quality health care services that the Encompass Health system offers Maryland residents.

6. Please provide a detailed explanation of why the data for Encompass Salisbury in Table 1, p. 25 is risk-adjusted, as opposed to averaged, consistent with the other data in the Table?

Applicant Response

Encompass Health provided risk-adjusted data to account for patient severity so that meaningful comparisons can be made. Risk adjustment is a statistical analysis that accounts for the differences in patient case mix that influence health care outcomes. Once data are risk-adjusted, it is reasonable to attribute material differences in patient outcomes to providers' quality of care. Thus, the use of risk-adjusted data allows for a meaningful comparison between Encompass Health facilities and other providers.

Nevertheless, the following table now includes Encompass Salisbury's risk-adjusted and its average (non-risk-adjusted) quality metrics. The table demonstrates that Encompass Salisbury's non-risk-adjusted quality metrics are higher than the risk-adjusted metrics. This difference results because patient mix and acuity are not accounted for in the unadjusted numbers. Thus, Encompass Salisbury's average non-risk-adjusted metrics appear somewhat inflated compared to the facility's risk-adjusted data. When the risk-adjustments are applied, Encompass Salisbury's quality metrics are more meaningfully compared to the national risk-adjusted average for all providers, showing that Encompass Salisbury's quality metrics are equal to or slightly higher than the national averages.

Table 16 Encompass Health's Quality Metrics Meet or Exceed National Averages 12 months ending May 6, 2022				
	Rolling 12 Months		**YTD2022**	
National Avg. or Entity	**Self-Care**	**Mobility**	**Self-Care**	**Mobility**
National Risk-Adjusted Avg., All Providers	12.3	29.0	12.2	28.9
Encompass Health National Average	14.0	34.4	14.0	34.5
Encompass Salisbury, Risk-Adjusted Avg.	12.3	30.7	12.2	31.1
Encompass Salisbury Average	13.4	36.1	13.5	37.4

Source: Uniform Data System for Medical Rehabilitation ("UDS_{MR}").
Note: The national, risk-adjusted averages are based on information from the UDS_{MR}, a data gathering and analysis organization for the rehabilitation industry which represents approximately 80% of the industry, including Encompass Health sites. Data has been adjusted by applying Encompass Health IRF case mix to non-Encompass Health UDS IRFs. Higher scores are better.

7. As a point of comparison in Figure 4, please provide the average acute rehabilitation discharge rate in the State.

Applicant Response

The 2019 statewide average acute rehabilitation discharge rate is four (4) discharges per 1,000 Medicare Beneficiaries. Three of Encompass Hospital's service area counties (Calvert, St. Mary's, and Anne Arundel) have IRF utilization rates lower than the statewide average, as shown in the figure below. For comparison, the national discharge rate of 11 IRF discharges per 1,000 Medicare Beneficiaries is also shown in the following figure.

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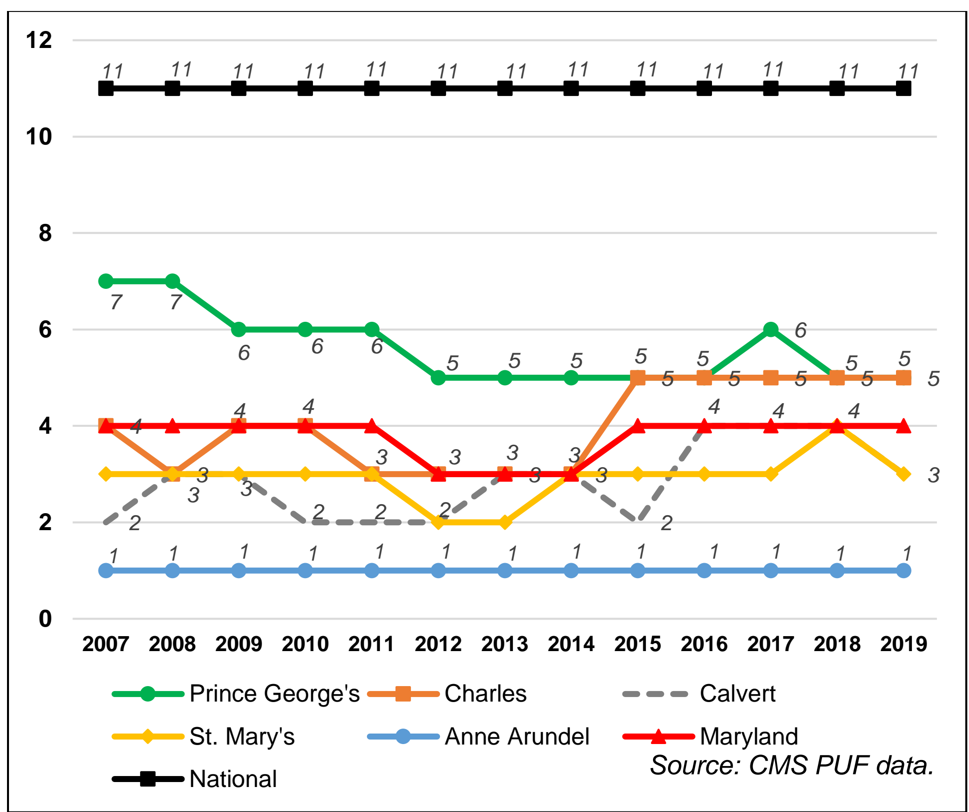
Figure 13
The Majority of Service Area Counties' Rehabilitation Discharge Rates are Below the Statewide Average Rate and Far Below the National Average Rate (Rehabilitation Discharges per 1,000 Medicare Fee-for-Service Beneficiaries)



For ease of review, the annual rehabilitation discharge rates for each service area county, the state overall, and the national average are in the following table.

Table 17
Inpatient Rehabilitation Utilization per 1,000 Medicare Beneficiaries
National, State and Service Area County Rates

County	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Prince George's	7	7	6	6	6	5	5	5	5	5	6	5	5
Charles	4	3	4	4	3	3	3	3	5	5	5	5	5
Calvert	2	3	3	2	2	2	3	3	2	4	4	4	3
St. Mary's	3	3	3	3	3	2	2	3	3	3	3	4	3
Anne Arundel	1	1	1	1	1	1	1	1	1	1	1	1	1
Maryland	4	4	4	4	4	3	3	3	4	4	4	4	4
National	11	11	11	11	11	11	11	11	11	11	11	11	11

Source: Centers for Medicare & Medicaid Services (CMS) Geographic Variation Public Use Files.

Access

8. **Your application states that residents in the HPR have access to acute care hospitals but when they are ready for discharge there are too few IRF beds available to them. What are the options or where do the current hospital discharges go for rehabilitation?**

Applicant Response

Patients who are appropriate for inpatient rehabilitation services and who would benefit from those services are too often either (i) discharged to a less intensive setting such as a skilled nursing facility ("SNF") or home health; (ii) discharged to a facility outside their local community and health planning region; or (iii) forego the needed rehabilitation and restorative care altogether.

Several physicians in the local community attest to the need for the proposed 10-bed addition to Encompass Hospital because of the difficulties these physicians experience when trying to ensure their patients receive inpatient rehabilitation services after discharge from the general acute care hospital. *See* CON Application, Exhibit 8. Not only do the physicians describe the difficulty their patients face in being discharged to inpatient rehabilitation care, but the physicians also discuss the unnecessary delays in discharge of the patients in need of rehab care while they await an available bed. For example, Dr. Renwu Chen (Board-certified Neurologist and Medical Director of University of Maryland Capital Regional Medical Center's Stroke Program) states:

> Many of our stroke patients require advanced rehabilitative care and many have expressed to me that their choices are so limited and virtually nonexistent in the Prince George's County area. Despite the hard work of our diligent case management team, patient discharges have been delayed often for several days due to lack of available and appropriate post-acute inpatient rehab resources. As a result, patients end up receiving care in other settings such as a SNF which does not provide the same level of intensive rehabilitation or go without rehab care altogether.

April Miskell, BSN, RN, SCRN (UM Capital Regional Medical Center's Stroke Program Coordinator) describes similar access problems facing residents in the Southern Maryland region who are in need of intensive inpatient rehabilitation care. In her letter, attached as part of the CON Application, Exhibit 8, Ms. Miskell states:

> Due to the hundreds of stroke patients we care for annually, as well as the patients with other neurological insults due to traumatic brain injuries, brain tumors, spinal cord injuries and the like, there are many patients who would greatly benefit from the advances made in comprehensive inpatient physical rehabilitation hospitals. … Unfortunately many of our patients are unable to access this high level of rehabilitation due to geographical constraints (too far from the patient's home and family) as no comprehensive inpatient rehab beds exist in Prince George's County. As a result, all too often many patients go to a lower level of care such as a skilled nursing unit, or get no rehab therapy at all and don't get the opportunity to experience intensive rehabilitation in a controlled inpatient setting. It is well known

and documented that comprehensive inpatient rehabilitation provides far better outcomes for physical and cognitive functioning and overall improved quality of life.

The Maryland discharge disposition data for residents in the Southern Maryland region illustrate and support the experiences of clinicians caring for patients in need of IRF services. For example, only three percent (3.0%) of service area rehab-appropriate patients[5] were discharged to an IRF in FY21. During that same period, 35.3% of service area rehab-appropriate patients were discharged to a less intensive setting, with 16.7% discharged to SNF and 18.6% discharged home with home care. Additional discharge data are consistent with the physicians' experiences cited in the letters of support, most notably the fact that more than half (53.2%) of service area rehab-appropriate patients were discharged home with no home health rehabilitation care at all.

Table 18
Discharge Disposition for Service Area Residents' Rehab-Appropriate Discharges From General Acute Care Hospitals in Maryland
FY21 (July 1, 2020 – June 30, 2021)

Discharge Disposition	Discharges	% of Total
Inpatient Rehabilitation Facility (IRF) or Rehabilitation Distinct Part Units of Another Hospital	673	3.0%
SNF with Medicare Certification in anticipation of Skilled Care	3,695	16.7%
Home under Care of an Organized Home Health Service Organization in anticipation of Covered Skilled Care	4,130	18.6%
Routine Discharge to Home or Self Care	11,801	53.2%
Another Acute Care Hospital for Inpatient Care (includes transfers to acute care units within the same hospital)	1,101	5.0%
Left Against Medical Advice or Discontinued Care (includes Administrative Discharge, Escape, Absent without Official Leave)	301	1.4%
Another Type of Health Care Institution Not Defined Elsewhere in Code List	286	1.3%
Custodial or Supportive Care Facility (Includes Intermediate Care Facilities if State Designated, Nursing Facilities that are Not Certified by Medicare or Medicaid, and Assisted Living Facilities)	127	0.6%
Medicare-Certified Long Term Care Hospital (LTCH)	34	0.2%
Nursing Facility Certified Under Medicaid but not Medicare	3	0.0%
Federal Health Care Facility (Includes VA Hospital, VA SNF, or DOD Hospitals)	8	0.0%

[5] "Rehab-appropriate patients" are those patients who were diagnosed with one of a select listing of MSDRGs that Encompass Health has identified as those diagnoses that most commonly necessitate intensive inpatient rehabilitation care.

Table 18 Discharge Disposition for Service Area Residents' Rehab-Appropriate Discharges From General Acute Care Hospitals in Maryland FY21 (July 1, 2020 – June 30, 2021)		
Discharge Disposition	**Discharges**	**% of Total**
Unknown	4	0.0%
TOTAL	**22,163**	**100.0%**
Source: Maryland HSCRC Abstract Inpatient Database, FY21 data. Note: discharges excluded from the analysis include patients who expired or were discharged to a designated cancer center, a psychiatric facility, to court/law enforcement, hospice at home, or a hospice facility.		

9. What is the typical wait time for an IRF bed within the service area?

Applicant Response

Encompass Hospital does not have data on the average wait time for an IRF bed in the service area. As discussed in more detail in response to Question #18, however, UM Capital Region Medical Center continues to experience longer than necessary average lengths of stay for inpatients who are ready for discharge but not yet able to be discharged home. The lack of access to inpatient rehabilitation facility beds in Southern Maryland and, in particular, Prince George's County, is a significant factor driving this long average length of stay. This issue will continue to persist unless additional IRF beds are added to the region, given that alternative post-acute care settings are not always an option for patients (and even when they are, they offer an inferior level of care). For example, skilled nursing facilities will not admit high acuity patients such as those with tracheotomies, those requiring transfusion, or other medically complex cases. The acute inpatient hospital must instead wait for a patient's acuity level to reduce before the patient can be discharged, despite that the patient could have been discharged to an IRF if a bed were available. At UM Capital Region Medical Center, these discharge challenges have extended average length of stay including when measured by Geometric Mean Length Of Stay (GMLOS) targets.

Need

10. The application states that inpatient rehabilitation use rates are low and continue to decline, in light of this trend how do you expect to fill the additional 10 beds that you are proposing?

Applicant Response

The historically low IRF use rates reflect the inability of patients to access needed services because there are simply too few IRF beds in the Southern Maryland Region, as noted in the Commission's decision for the 60-bed hospital. In the Decision, the Commission expressly recognized that low utilization rates in the Southern Maryland health planning region were likely impacted by a "geographic barrier to access," and that with respect to the Southern Maryland region in particular, the low utilization rates "may be tied to longer distance from an acute rehabilitation provider." As a result, the Commission concluded that "the addition of a provider in closer proximity is likely to address that barrier." *See* Decision, pp. 33-35. Declining use rates,

therefore, reflect the *lack of access and availability to IRF beds*, not the lack of need for the beds and services they uniquely provide.

The continuing decline of already low use rates in the Southern Maryland region can also be attributed to the recent loss of licensed inpatient rehabilitation beds from service in the region, and decreased access to beds in the neighboring region, Montgomery County. Since October of 2018, twenty-eight previously available inpatient rehabilitation beds in the Southern Maryland region have been delicensed. The 42-bed rehabilitation hospital operated by Adventist Rehabilitation Hospital within Washington Adventist Hospital in Takoma Park, an area within the beltway and more accessible to portions of the Southern Maryland health planning region, relocated to the more suburban White Oak in August of 2019, together with the relocation of the acute care hospital. *See In re Adventist Rehabilitation Hospital of* Maryland, Matter No. 18-15-2428, Commission Decision, March 21, 2019. The unavailability of the licensed beds and decreased access to nearby beds has exacerbated patients' challenges in accessing inpatient rehabilitation care in the region. With fewer beds available and accessible, patients have less ability to obtain post-acute care in an IRF. As discussed in more detail in Part I of the CON Application and in Encompass Hospital's response to COMAR § 10.24.09.04B(2) in the CON Application, all ten of the beds that Encompass Hospital proposes to add to its approved 60-bed facility were previously licensed beds in the region. As a result, these beds were already included in the Commission's most recently calculated bed need inventory. While utilization rates are declining due to patient access challenges, therefore, the Commission's own bed need inventory calculations support a need for additional beds in the Southern Maryland region.

The proposed additional ten beds at Encompass Hospital will be filled by patients in need of IRF services who are currently unable to receive the necessary care locally, if at all. Encompass Health has extensive experience establishing hospitals and/or adding beds to its existing hospitals to meet communities' needs.

In addition to reducing significant access barriers to care for patients in the region, which will in turn allow more patients to access the care they need in an appropriate IRF setting, Encompass Hospital will also facilitate patient utilization of its services through local outreach efforts. In particular, Encompass Hospital will work closely with local providers of healthcare, including hospitals and physicians in the community, to raise awareness of the inpatient rehabilitation services offered at Encompass Hospital. In accordance with Encompass Health's practices nationwide:

- Encompass Hospital will work closely with local hospital discharge planners to promote understanding of the level of rehabilitation services offered at the IRF, to promptly evaluate the best placement for patients who may benefit from inpatient rehabilitation services, and to provide smooth transfers of patients who are in need of intensive inpatient rehabilitative care.

- Encompass Hospital will utilize rehabilitation liaisons who are clinically trained and work closely with health care personnel and with families of patients to assess clinical needs and to coordinate a timely transfer from the acute care hospital to the inpatient rehabilitation hospital.

- Encompass Hospital's medical directors will also reach out to the community to increase the understanding of inpatient rehabilitation among referring physicians, case managers, and the general public.

Encompass Health has years of proven experience establishing relationships with area healthcare providers, including acute care hospitals and community physicians, across the country as well as in Maryland. Moreover, the proposed 10-bed addition will become part of the intended joint venture between Encompass Health Corporation and University of Maryland Medical System Corporation ("UMMS"). As a result, the facility will become part of the UM Rehabilitation Network, which is a coordinated system of inpatient and outpatient providers that will ensure patients receive the right care in the right location. *See* CON Application, pp. 8-9.

UMMS has dedicated years of strategic planning to determine how best to improve health care delivery in the Southern Maryland region. The response to Question #18 offers a detailed description of clinical expansion efforts that UMMS plans to implement at UM Capital Region Health to further develop its integrated health care model in the region. Through these efforts, UMMS will improve the quality of care provided to the Southern Maryland patient population and will reduce the inequity of care that has historically existed in the region, including within marginalized groups. By improving health care delivery locally, patients will have increased access to high quality care without needing to out-migrate to surrounding counties. As a result, larger numbers of patients will seek care locally as they move throughout the health care continuum, including post-acute inpatient rehabilitation care. By partnering with UMMS, Encompass Hospital will draw patients seeking to benefit from this strong network of integrated, local health care.

Due to its strong partnerships with community providers, its relationship with the UM Rehabilitation Network, and the well-recognized need in the Southern Maryland region for increased acute inpatient rehabilitation capacity, Encompass Hospital does not anticipate significant issues filling the additional ten beds.

11. Please provide utilization trends for the beds before they became delicensed in 2018, include the most recent three years of data available (2016-2018).

Applicant Response

Table 19
Historical Use of Laurel Regional Hospital Rehabilitation Unit, 2016-2018

Indicator	FY16	FY17	FY18
Patient Days	2,440	2,340	2,535
Avg. Daily Census	6.7	6.4	6.9

Source: UMMS internal data.
Note: 2016 was a Leap Year, thus FY16 ADC based on 366 days in that time period.

Encompass Hospital notes that the utilization of the rehabilitation beds at Laurel Regional Hospital is not indicative of need in the Southern Maryland health planning region, which the Commission has acknowledged has a net need for rehabilitation beds in its published

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need projections and in CON Decisions. Laurel Regional Hospital faced a number of challenges prior to the transfer of these beds to UM Prince George's Medical Center and the conversion of Laurel Regional Hospital to a Freestanding Medical Facility. The hospital staffed between 9 and 10 rehabilitation beds during the time period reported above. *See* Commission's Annual Reports on Selected Maryland Acute Care and Special Hospital Services, FY2016-FY2018. However, the hospital was unable to staff the beds with a dedicated acute rehabilitation team, and instead pulled staff from other units to staff beds when required. The hospital also lacked dedicated leadership on the unit, which resulted in a lack of serious effort to grow the unit. There was no liaison in place to process referrals. Rumors surrounding the likely closure of the hospital also began to circulate well before University of Maryland Medical System announced its planned acquisition. These rumors plus limitations in the physical plant and quality challenges faced by the hospital may have contributed to a reluctance in the service area population to seek care there.

Impact

12. **The Impact analysis discusses the impact on UM Rehab & Orthopedic Institute stating they discharged 119 residents residing in the Southern Maryland HPR in 2021. The chart below is from the original 60-bed hospital approval. Please update this chart with the most recent data available and discuss the impact of the potential loss of discharges to other providers.**

Encompass Hospital (Bowie) 2020 CON Decision, Table III-9
Acute Inpatient Rehabilitation Discharges Originating from Calvert, Charles, Prince George's, St. Mary's, and Anne Arundel Counties, CY 2017

Hospital	Calvert County Discharges	Charles County Discharges	Prince George's County Discharges	St. Mary's County Discharges	Anne Arundel County Discharges	Total Discharges from Selected Counties	Percent of Discharges
Maryland Hospitals							
AHC Rehabilitation	13	12	342	11	11	389	19.6%
Encompass-Salisbury			1		2	3	0.2%
Good Samaritan	1	1	8		30	40	2.0%
Johns Hopkins	4	2	16	1	49	72	3.6%
Johns Hopkins Bayview	2	3	12	2	70	89	4.5%
Laurel	1	1	101	2	52	157	7.9%
Meritus		1	1			2	0.1%
Sinai	1	1	10	2	28	42	2.1%
UM Memorial at Easton					3	3	0.2%
UM Rehab. and Ortho. Institute	6	8	48	5	215	282	14.2%
Western Maryland	1					1	0.1%
Subtotal	1,080						54.7%
District of Columbia Hospitals							
Washington	7	8	50	1	4	70	3.5%

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Hospital	Calvert County Discharges	Charles County Discharges	Prince George's County Discharges	St. Mary's County Discharges	Anne Arundel County Discharges	Total Discharges from Selected Counties	Percent of Discharges
University							
MedStar National Rehabilitation	43	94	600	55	39	831	41.8%
Subtotal	901						45.3%
Total	1,981						100%

Source: HSCRC discharge abstract data and chronic files; D.C. discharge abstract data.

Applicant Response

Encompass Hospital does not anticipate a material impact on any provider's patient volumes, average length of stay, or case mix as a result of the proposed 10-bed addition because significant access barriers, discussed above in response to Question #8, have created a gap in care for patients of the Southern Maryland region. The addition of ten beds to Encompass Hospital will provide existing patients of the region with improved access to the services they need, and will not result in significant losses of discharges from other providers in surrounding regions. The following table uses the most recent data available (July 1, 2020 – June 30, 2022) to update the distribution of patient admissions to Maryland hospitals for residents in the defined service area, which includes Calvert, Charles, Prince George's and St. Mary's County in total plus select ZIP Codes in southern Anne Arundel County. *See* CON Application, pp. 32, 48.

Table 20
Inpatient Rehabilitation Admissions for Service Area Residents, Maryland Hospitals only*
FY21 (July 1, 2020 – June 30, 2021)

Hospital	Calvert County	Charles County	Prince George's County	St. Mary's County	Anne Arundel County*	Total	% of Discharges
Adventist Rehabilitation Hospital (Rockville)	2	2	64	2	3	73	8.1%
Adventist Rehabilitation Hospital at White Oak	11	26	379	9	23	448	50.0%
Encompass Salisbury	2	0	2	0	2	6	0.7%
Johns Hopkins	6	4	41	3	25	79	8.8%
Johns Hopkins Bayview (acute)	4	5	37	4	26	76	8.5%
Lifebridge Levindale (Formerly 212005)	0	1	3	0	0	4	0.4%
Lifebridge Sinai Hospital	3	0	19	1	3	26	2.9%
MedStar Good Samaritan	0	4	19	2	1	26	2.9%

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Table 20 Inpatient Rehabilitation Admissions for Service Area Residents, Maryland Hospitals only* FY21 (July 1, 2020 – June 30, 2021)							
Hospital	**Calvert County**	**Charles County**	**Prince George's County**	**St. Mary's County**	**Anne Arundel County***	**Total**	**% of Discharges**
Meritus Health System (Wash. Co.)					1	1	0.1%
UM Rehab & Ortho. Institute (acute)	8	26	81	4	34	153	17.1%
UM Shore Medical Center at Easton	0	2	1	0	1	4	0.4%
Total	**36**	**70**	**646**	**25**	**119**	**896**	**100.0%**

Source: Maryland HSCRC Abstract Inpatient Database, FY21 data (excluding 73 discharges from Mt. Washington Pediatric Hospital).

*__Notes__: The Applicant has submitted an application (through a consultant) for the D.C. Inpatient Discharge Data; however, that information has not yet been provided to the Applicant as of this time. *See* CON Application, p. 34.

As noted in the CON Application, to the extent there is some marginal impact on other providers as a result of re-licensing ten IRF beds and locating them at Encompass Hospital, as this Application proposes, Encompass Hospital expects the greatest impact would be on UM Rehab & Orthopaedic Institute in Baltimore. Encompass Hospital anticipates this impact may result due to the relationship between Encompass Health and UMMS, which will be formalized through the joint venture arrangement, and the resulting integration of provider and referral relationships that each system has in the Southern Maryland region. The following table reflects the marginal projected impact that Encompass Hospital's project will have on UM Rehab & Orthopaedic Institute, UM Shore Medical Center at Easton (the other UM facility with inpatient rehabilitation beds in the state), and Encompass Salisbury, each of which serve patients from the defined service area.

Table 21 Estimated Impact of Proposed Project on UMMS and Encompass IRFs Based on Rehab Admissions Served from Defined Service Area in FY21			
Hospital	**Discharges from Service Area**	**Percent Redirected to Encompass Hospital Bowie**	**Cases Lost to Encompass Hospital Bowie**
UM Rehab & Orthopaedic Institute (acute)	153	80%	122
UM Shore Medical Center at Easton	4	100%	4
Encompass Salisbury	6	100%	6
Total, UM and Encompass IRF Providers	**163**	**--**	**132**

Table 21 Estimated Impact of Proposed Project on UMMS and Encompass IRFs Based on Rehab Admissions Served from Defined Service Area in FY21			
Hospital	Discharges from Service Area	Percent Redirected to Encompass Hospital Bowie	Cases Lost to Encompass Hospital Bowie
Source: Maryland HSCRC Abstract Inpatient Database, FY21 data (July 1, 2020 – June 30, 2021). Note: Numbers may not calculate exactly as shown due to rounding.			

Encompass Hospital projects that the ten-bed unit will serve 199 patients in its first year. *See* CON Application, Exhibit 1, Table I. Assuming all of Encompass Hospital's patients were redirected to it from existing providers, there would be 67 patients (199 total projected patients minus 132 redirected from UMMS and Encompass IRFs) who may be redirected to Encompass Hospital from providers outside the Southern Maryland region. The following analysis assumes the remaining 67 patients will be lost by each IRF provider outside the Southern Maryland region in proportion to the providers' market share (exclusive of UMMS and Encompass Health's facilities and their service area patients).

Table 22 Estimated Impact of Proposed Project on Providers' Patient Volume from Service Area After Accounting for Impact on UMMS and Encompass Health IRFs			
Hospital	**FY21 Discharges from Service Area**	**% of Service Area Discharges**	**Estimated Impact, Service Area Patients Only**
Adventist Rehabilitation Hospital (Rockville)	73	10.0%	7
Adventist Rehabilitation Hospital at White Oak	448	61.1%	42
Johns Hopkins	79	10.8%	7
Johns Hopkins Bayview (acute)	76	10.4%	7
Lifebridge Levindale (Formerly 21205)	4	0.5%	0
Lifebridge Sinai Hospital	26	3.5%	2
MedStar Good Samaritan	26	3.5%	2
Meritus Health System (Wash. Co.)	1	0.1%	0
Total	**733**	**100.0%**	**67**
Source: Maryland HSCRC Abstract Inpatient Database, FY21 data (July 1, 2020 – June 30, 2021). Note: numbers may not calculate exactly as shown due to rounding.			

Table 22 above demonstrates that there will be no material impact on any existing provider currently serving residents from the Applicant's proposed service area as a result of the 10-bed addition to Encompass Hospital. While Adventist Rehabilitation Hospital at White Oak is estimated to lose the most patients from Encompass Hospital's service area (with a projected

loss of 42 patients), that facility's admissions in FY21 totaled 1,064 patients. The estimated loss of 42 patients from Encompass Hospital's service area is immaterial.

The estimates of impact shown in the tables above are based on the historically low utilization of IRF services for residents in the Southern Maryland region and assume that all patients of the Encompass Hospital 10-bed addition will be redirected from existing providers. These estimates, therefore, do not take into account the recognized barriers to access to inpatient rehabilitation care in the region. As discussed in the CON Application and in response to Questions #8 and 10 above, many patients of the Southern Maryland region who would benefit from inpatient rehabilitation care currently receive post-acute care in a less intensive setting due to insufficient capacity at area IRFs. When taking into account the documented need in the region for additional inpatient rehabilitation beds, the projected impact that a 70-bed Encompass Hospital facility would have on existing providers is even lower.

Table 23
The 70-bed Encompass Hospital will Not Materially Impact Existing Providers

Service Area Residents' Rehab-Appropriate Discharges, FY21 Data	2,646
Minus Service Area Resident's FY21 Rehab Admissions to Maryland Hospitals	969
Equals Rehab-Appropriate Discharges Remaining for Encompass Hospital	1,677
Minus Encompass Hospital Projected CON Year 1 Discharges for 70 Beds	1,564
Equals Remaining Rehab-Appropriate Discharges for All Providers After Accounting for New 70-bed Encompass Hospital	113

Sources: Maryland HSCRC Abstract Inpatient Database, FY21 data and CON Exhibit 1, Table F.
Note: service area residents' FY21 admissions to IRFs include pediatric admissions to Mount Washington Pediatric Hospital.

Please note that the above analysis (Table 23) excludes patients who expired or were discharged to a designated cancer center, a psychiatric facility, to court/law enforcement, hospice at home, or a hospice facility (consistent with the analysis presented in Table 20, *supra*). In order to be consistent in the exclusion of this subset of patients discharged from general acute care hospitals with identified MSDRGs that most commonly necessitate intensive inpatient rehabilitation care, Encompass Hospital provides updated bed need calculations to those presented in CON Application, Table 11, p. 49:

Table 24 **Projected Inpatient Rehab Bed Need for Defined Service Area, Updated Projection to Omit Select Patient Populations***	
Inpatient Rehab Bed Need Calculations for Defined Service Area	**Projected Need, FY21 Data**
Service Area Residents' Rehab-Appropriate Discharges, All Payors	22,163
Multiplied by Expected (or Target) Discharge Rate to Inpatient Rehab	11.9%
Equals Total Proj. Rehab Discharges in Service Area in Need of Rehab Bed	2,646
Multiplied by Statewide Inpatient Rehab Average Length of Stay, FY21	13.58
Equals Total Proj. Service Area Inpt Rehab Pt Days in Need of Rehab Bed	35,927
Divided by Calendar Days	365
***Equals* Inpatient Rehab Bed Need @ 100% Occupancy**	**98.4**
Divided by Target Occupancy based on Average Daily Census	80%
Equals Service Area Beds Needed at Target Occupancy	123
Minus CON-approved Beds	70
***Equals* Net Bed Need**	**53**

Source: Maryland HSCRC Abstract Inpatient Database, FY21 data.
*Note: discharges excluded from the analysis include patients who expired or were discharged to a designated cancer center, a psychiatric facility, to court/law enforcement, hospice at home, or a hospice facility. Numbers may not calculate exactly as shown due to rounding.

13. In the Impact analysis, please include the impact on average length of stay, and case mix.

Applicant Response

The Applicant does not anticipate any impact on average length of stay and case mix on any acute rehabilitation provider because of the minimal loss of patients estimated in the tables above in response to Question #12. However, Encompass Hospital does anticipate a positive impact on the length of stay at acute care hospitals for patients waiting for discharge to an IRF.

Construction Costs

14. The construction cost has increased from $289 per square foot in the original 60 bed project to a current estimate of $1381 per square foot. Please explain all the factors contributing to this increase.

Applicant Response

Encompass Hospital notes that the projected cost per square foot of $1,381 is for the ten-bed addition that is the subject of this CON application only. It does not represent an

increase in the costs per square foot for the 60-bed CON project as indicated in this question, and is not the combined cost per square foot of the two projects, which will be completed pursuant to separate CON determinations (if one is granted for the pending application) and separate construction contracts.

The approved 60-bed facility, as modified, will have estimated construction costs of $527 per square foot. *See* In re Encompass Health Rehabilitation Hospital Inpatient Rehabilitation Hospital, Matter No. 18-16-2423, April 27, 2022 Modification, Exhibit 4. The proposed 10-bed addition has substantially higher costs per square foot due to several factors, including the impact of significant and unprecedented inflation, increased labor costs, and the economies of scale achieved by larger construction projects not present for this project. As a general rule, costs per square foot are typically lower the larger the overall project. The smaller the project, the higher the cost per square foot given that smaller projects still require mobilization, set-up, and demolition costs along with general construction costs. Encompass Health's Salisbury project, for example, involved new construction of 1,437 square feet, and construction costs for new construction (building plus site/infrastructure line items) of $1,125,445, or $783 per square foot in new construction cost, for a project approved in 2019. *In re Encompass Health Rehabilitation Hospital of Salisbury*, Matter No. 18-22-2435, Dec. 21, 2021 Supplement to Request for First Use Review and Certification, Final Project Budget.

Financial Feasibility

15. Please provide an analysis of your staffing expense projections as compared to other similar hospitals.

Applicant Response

Generally speaking, staffing expenses for an inpatient rehabilitation facility can be divided into two broad categories:

(i) Clinical staffing, which comprises the majority of staffing (and thus staffing expenses) for an inpatient rehabilitation hospital; and,

(ii) Non-clinical, or support and administrative staff.

Clinical staffing levels for Encompass Hospital are based upon Encompass Health's experience and standard hours of care, applied to the anticipated patient volumes and patient acuity mix at the Encompass Hospital facility. Nursing and therapy staffing levels are sufficient to meet the medical and rehabilitation needs of the patients and to achieve service excellence.

Non-clinical/support staffing levels for administrative and non-clinical support services are largely a fixed cost based on duties, the size of the facility, and daily coverage without regard to the patient census.

Encompass Hospital's projected staffing expenses (see CON Application, Table L – Workforce Information) correlate with projected patient volume, patient acuity, and facility design, based on the experiences of other Encompass Health facilities in the mid-Atlantic, including Encompass Salisbury, Encompass Health Rehabilitation Hospital of Northern Virginia, and Encompass Health Mid-Atlantic Region (which includes 16 inpatient rehabilitation facilities in 5 states: Maryland, Virginia, West Virginia, North Carolina, and Eastern Tennessee). As

summarized below, Encompass Hospital's projected staffing expenses are comparable to other area facilities.

Table 25 **Proposed Project's Staffing Expense Projections are Comparable to Other Providers**				
Factor	**Encompass Bowie[1]**	**Encompass Salisbury[2]**	**Encompass Northern Virginia[2]**	**Encompass Mid-Atlantic Region[2]**
Total FTEs	197.9	190.1	166.8	2,929.4
Avg. Daily Census	65.8	59.6	53.5	913.9
FTE/Occupied Bed	3.0	3.2	3.1	3.2
Salaries Expense	$15,740,320	$11,651,731	$12,840,599	$188,577,311
Salaries per FTE	$79,537	$61,293	$76,982	$64,375

[1] Source: Table L – Workforce Information, CON Year 5.
[2] Source: Encompass Health, 2019 data.

Minimum Size Requirements

16. Please provide your average daily census projections for at least 3 years as required by part (b) of the standard.

Applicant Response

Please see the following table for the average daily census ("ADC") projections for the first three years for the total facility (70 beds) and the proposed 10-bed addition, specifically. Supporting data are included in the table for ease of review.

Table 26 **Calculation of ADC for Proposed Project** **(10 bed Addition and 70 beds in Total)**			
	CON Year 1	**CON Year 2**	**CON Year 3**
Beds	**70**	**70**	**70**
Discharges	1,564	1,726	1,922
Patient Days	18,759	20,709	23,079
ALOS	12.0	12.0	12.0
ADC	**51.4**	**56.7**	**63.2**
Occupancy %	73.4%	81.1%	90.3%

Table 26 Calculation of ADC for Proposed Project (10 bed Addition and 70 beds in Total)			
	CON Year 1	**CON Year 2**	**CON Year 3**
Beds	**10**	**10**	**10**
Discharges	199	208	261
Patient Days	2,379	2,491	3,145
ALOS	12.0	12.0	12.1
ADC	**6.5**	**6.8**	**8.6**
Occupancy %	65.2%	68.2%	86.2%
Sources: CON Exhibit 1, Tables F and I.			

Transfer and Referral Agreements

17. Please provide a status on the condition in the original CON for the 60-bed hospital related to transfer and referral agreements. Also describe how this will continue with the 10-bed addition.

Applicant Response

Please see CON Exhibit 10 for a signed patient transfer agreement between Encompass Hospital and the UM Capital Region Medical Center. This transfer agreement is for the entirety of the Encompass Hospital facility, including the proposed 10-bed addition.

Consistent with its commitment in the approved 60-bed hospital CON Application, Encompass Hospital will obtain written transfer and referral agreements with facilities, agencies, and organizations that provide alternative treatment programs appropriate to the needs of patients who have sub-acute care needs. Such agreements will be with specific outpatient therapy providers, home health agencies, nursing homes, and hospice providers. Encompass Hospital has not yet executed transfer and referral agreements with these providers, given that the facility is still under construction and not expected to open until June 13, 2023. Discussions to establish formal agreements are expected to begin approximately 90-120 days prior to the opening of the 60-bed hospital.

The Applicant does not anticipate any difficulties obtaining the necessary transfer and referral agreements, particularly given its joint-venture arrangement with UMMS.

Availability of More Cost-Effective Alternatives

18. During your planning process for the 10-bed addition what were the primary goals/objectives that were established?

Applicant Response

The primary goals/objectives of the Encompass Hospital 10-bed addition are to improve access to post-acute inpatient rehabilitation care in the Southern Maryland region and to provide

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a home for the ten temporarily delicensed beds most recently located at UM Prince George's Hospital Center. As described in detail in response to Question #8, a recognized barrier to accessing inpatient rehabilitation care exists in the Southern Maryland region. Moreover, there is a demonstrated need for additional inpatient rehabilitation bed capacity to adequately address the post-discharge needs of patients. To address this need, Encompass Hospital and UMMS, as its joint-venture partner, focused their planning for the ten-bed addition on determining the most efficient, cost-effective way to provide adequate access to inpatient rehabilitation care in the region and to ensure sufficient beds will be available as the need for such care continues to grow.

The ten beds that Encompass Hospital seeks to relocate were not delicensed due to a lack of utilization. Rather, UM Capital Region Medical Center lacked sufficient space to accommodate these beds. *See* CON Application, pp. 61-62. As discussed in the responses to Question # 8 and 9, finding adequate and appropriate discharge options for patients of UM Capital Region Medical Center who are not yet ready to be discharged home continues to remain a challenge. Due to the lack of available post-acute care rehabilitation beds in the region, the average length of stay for inpatients of UM Capital Region Medical Center has increased. This issue will persist unless additional IRF beds are added to the region as UM Capital Region Medical Center continues to grow as a premier regional medical center.

UMMS, Encompass Hospital's joint-venture partner in this project, has identified a number of priorities as part of its strategic planning for the Southern Maryland region that will increase UM Capital Region Medical Center's market share. In turn, this will drive the demand for local post-acute care inpatient rehabilitation beds. As discussed in the CON Application, the population within Prince George's county has grown more than any other county in the state since 2010 and such growth is projected to continue. *See* CON Application, pp. 39-44. This population growth, coupled with the planned expansion of clinical programs in areas of cardiovascular treatment, oncology, neurosciences, women's services, and orthopedics at UM Capital Region Medical Center will increase patient volumes. In fact, UM Capital Region Health has already experienced increases in its elective surgical volumes in these clinical specialties in the most recent fiscal quarter. Beginning this fiscal year, UM Capital Region Health anticipates further growth as it continues investment in surgical robotics, neuroscience and neuro-critical care, physician recruitment, and its Cancer Center. Through the growth and expansion of UM Capital Region Health's integrated care delivery model, its market share in the Southern Maryland region will increase. This will not only sustain the need for post-acute inpatient rehabilitation services in the region, but patients of UM Capital Region Health will increasingly expect to access such care locally.

As discussed more fully in the CON Application, Encompass Hospital and UMMS considered a number of alternatives to increase access to inpatient rehabilitation care in the Southern Maryland region to accommodate local patients. Ultimately, Encompass Hospital and UMMS determined that alternative options to relocate the ten delicensed beds would require substantially higher capital investment, and, in the case of constructing a new standalone rehabilitation hospital, would not be consistent with the Commission's published bed need projections. Encompass Hospital determined that to achieve the primary objectives of restoring access to the delicensed beds and thereby improve the availability of necessary inpatient rehabilitation care, the construction of the ten-bed addition would be the most cost-effective option.

19. You state on average IRF patients receive 3 hours of therapy a day, which is more that SNFs or home health. How many hours of therapy a day are averaged in these other two care settings?

Applicant Response

The minimum three hours of therapy per day, five days a week (or 15 hours over a 7-day period), that must be provided by an IRF is set by federal regulation as a condition for payment by Medicare. *See* 42 C.F.R. § 412.622. There is no regulatory minimum requirement, however, for therapy hours provided to patients in SNFs or home health. As described above in response to Question #8, many patients who need physical, occupational, or speech therapy and would benefit from the intensive therapy offered in an IRF are unable to access IRF care due to insufficient bed capacity. As a result, patients with rehab-appropriate needs but who are discharged to SNFs or home health generally receive fewer hours of therapy. The following figure, included in the CON Application as Figure 11, highlights the disparities in intensity of care due to the lack of standardized minimum therapy hours set by regulation in the SNF setting compared with an IRF.

Figure 14
Patients Receive Fewer Hours of Therapy in SNFs Compared With IRFs

Required by Medicare	**Inpatient Rehabilitation Hospital**	**Nursing Home**
Minimum Stay at the Acute	None	3 days
Physician Visits	Min. 3 times per week	Min. ~1x/month or every 30 days
Rehabilitation Program	Min. 3 hours per day, 5 days a week or 15 hours over 7 days	Not required
Multi-Disciplinary Team Approach/ Coordinated Program of Care	Required	Not required
MD or DO Rehabilitation Director	Required	Not required
RN Oversight and Availability	24 hours per day	Min. 8 consecutive hours per day
Nursing Training and Expertise	Rehabilitation Specialty Expertise	None
Discharge to Community (Industry Avg.)	**67.3%**	**38.6%**
Encompass Health	**80.8%**	

Sources: CMS regulations, MedPAC March 2022 Report to Congress, and Investor Reference Book, Post Q2 2020 Earnings Release Updated March 9, 2021, Encompass Health.

Note: Discharge to Community rates are 2020 data.

Viability

20. Your application states that you will reach a 94% occupancy by the fifth year of operation, how do you plan to achieve this high occupancy rate?

Applicant Response

Encompass Hospital will achieve its projected occupancy through the community and provider education discussed in response to Question #10 above. Encompass Health has had recent success in reaching high occupancy rates as a result of its provider education efforts at other regional facilities. For example, Encompass health recently opened a new inpatient rehabilitation hospital facility in relative proximity to Maryland: Encompass Health Rehabilitation Hospital of Middletown, Delaware ("Encompass Middletown"). The following table demonstrates the average annual occupancy growth of Encompass Middletown over a five year period, beginning with the first full year after the facility opened on December 15, 2014 and continuing through 2019. The table thus represents a full pre-pandemic 5-year occupancy trend of a facility comparable to Encompass Hospital.

Table 27
Encompass Middletown Average Annual Occupancy Percentage
Year 1 to Year-to-Date

Years 1 – 5 After Opening (Pre-COVID)					COVID Impact		
2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**YTD2022**
83%	95%	90%	95%	97%	94%	97%	98%

Source: Encompass Health internal data. Hospital is a 40-bed hospital.
Note: data are for calendar years. YTD2022 is January 1 through May 31, 2022.

As a comparable facility in a contiguous state, Encompass Middletown's first five-year occupancy data supports Encompass Hospital's projections that it will reach 94% occupancy by the fifth year of operation. Encompass Hospital's projections are consistent with Encompass Health's experience in a similar market, and Encompass Hospital will implement similar proven education and outreach initiatives to achieve high occupancy rates.

21. Please provide the job descriptions and/or describe the positions in the added 2.2 FTE's under "Other Support"?

Applicant Response

The CON Application, Table L includes 2.2 Other Support FTEs by CON Year 5 for the proposed 10-bed expansion. These positions represent the two non-clinical positions of Rehab Liaison and Admissions Liaison. Position descriptions for each of these roles are provided below:

- **Rehab Liaison.** Position purpose: The Rehab Liaison is responsible for developing census as defined through targeted goals of the business plan and developing referral relationships within the geographic territory with an emphasis on face-to-face contacts. In addition, the liaison will assist with coordination of referral to admission conversion process and represent Encompass Hospital in community-related activities.

- **Admissions Liaison.** Position purpose: The Admissions Liaison assumes the responsibility for the coordination of an effective, efficient admission process for all patients by receiving referrals, gathering and verifying pertinent information, and completing necessary procedures to schedule and admit inpatients and/or outpatients. This position is a key pull-thru person for referrals and compiles and inputs statistical information into appropriate hospital systems.

Table E Budget

22. What is included in the $100,000 expense for pre-opening costs line 2d?

Applicant Response

Encompass Hospital has included a budget provision of $100,000 for anticipated pre-opening costs comprised primarily of marketing and community outreach expenses.

23. There is no inflation allowance in the budget, please explain.

Applicant Response

Encompass Hospital included an inflation factor for the construction costs of the project within individual line items, as referenced in the architect's letter at CON Application, Exhibit 9. "Due to the fact that this estimate was derived from this year's averages and construction will commence in 2024, an adjustment for inflation has been added to arrive at $1,381 per square foot." Exhibit 9. The estimated construction cost, $8,148,616, includes 15 months of added escalation at 1.5%/month.

Table G Revenues and Expenses

24. In the original 60 bed application the assumption used for Medicaid percent of total revenue was approximately 3%. Please explain the lower utilization (less than 1%) of the Medicaid population in the current application.

Applicant Response

The original 60-bed Encompass Hospital facility Application reflects Patient Mix as a percent of Total *Gross* Revenue, whereas the current application reflects Patient Mix as a percent of Total *Net* Revenue. When reviewed on an "apples to apples" basis measuring Medicaid *Gross* Revenue, the current application's Medicaid utilization is similar to the original 60-bed application, as detailed below.

Table 28 Medicaid as a Percent of Total Gross Revenue: 60-bed and 70-bed Comparison			
	Current Application: 70-Beds		**Original Application: 60-Beds**
Patient Mix	**Gross Revenue**	**% of Gross Rev.**	**% of Gross Rev.**
Medicaid	1,197,616	2.2%	2.6%
Sources: Table G - current and original applications.			

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I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated June 16, 2022 are true and correct to the best of my knowledge, information, and belief.

July 15, 2022

Cynthia A. Kelleher, MBA, MPH
President and CEO
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I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated June 16, 2022 are true and correct to the best of my knowledge, information, and belief.

July 14, 2022

Josh Beam
Vice President, Treasury & Business Analytics
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I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated June 16, 2022 are true and correct to the best of my knowledge, information, and belief.

John R. Tschudin, Jr.

July 15, 2022

John Tschudin
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I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated June 16, 2022 are true and correct to the best of my knowledge, information, and belief.

July 11, 2022

Marty Chafin, FACHE
President
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I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions Dated June 16, 2022 are true and correct to the best of my knowledge, information, and belief.

July 14, 2022

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