Begin with the End in Mind

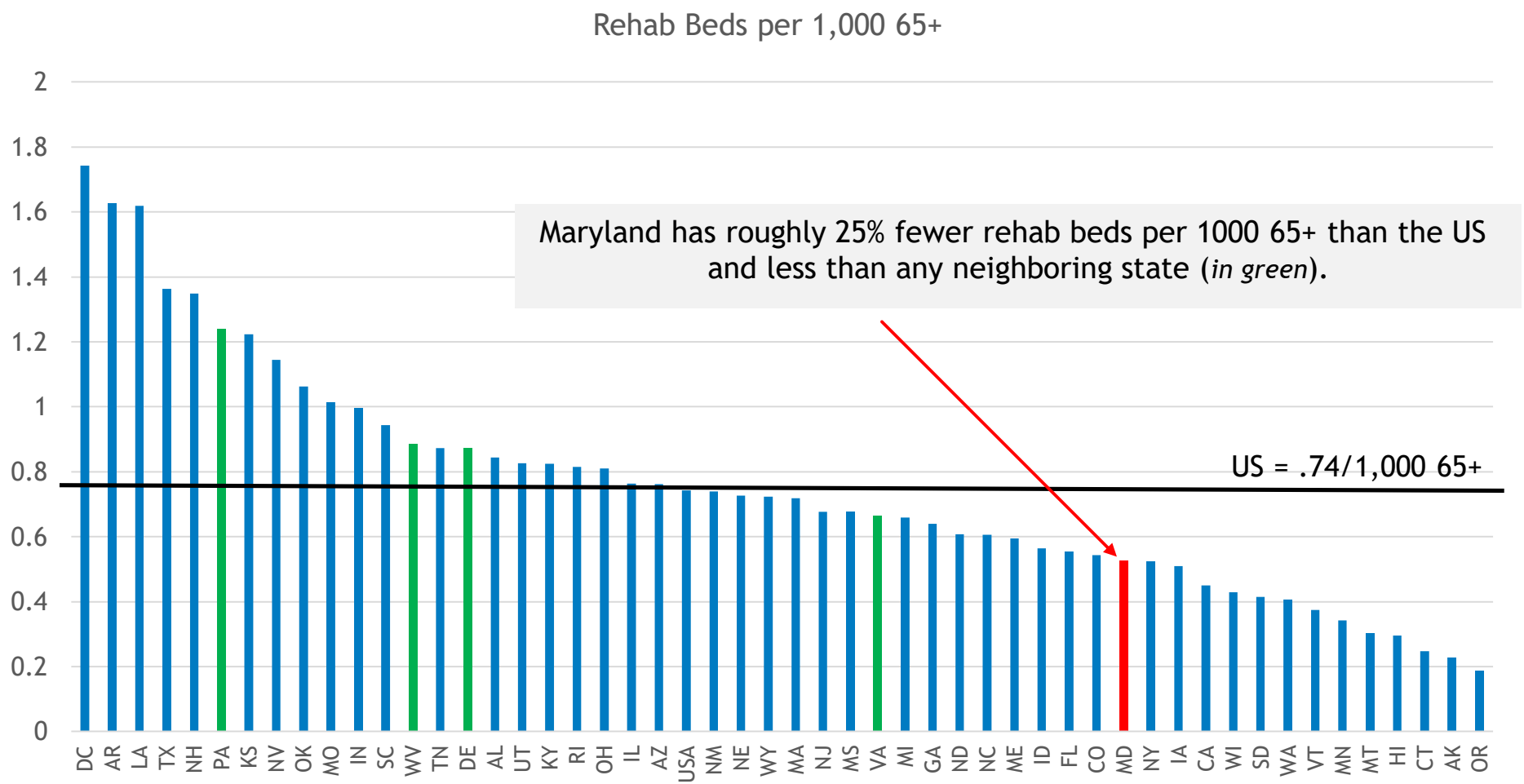
"In fact, looking at just the 65+ age group. The use rate/1000 for the three counties in Encompass-Salisbury's service area is:

- **Almost 50% higher than that of the three other mid to lower shore counties**
- **278% higher than that of Montgomery County**
- **294% higher than that of Central Maryland**
- **249% higher than that of Western Maryland**
- **435% higher than that of Southern Maryland**
- **And 252% higher than that of the State of Maryland**

This information raises significant questions regarding why the IRF use rate in Encompass-Salisbury's service area is so much higher than the use rates elsewhere in Maryland. *We would like you to elaborate on why this disparity exists and provide an explanation as to why we should not conclude that – for some reason – there is overuse occurring in this market*, and that additional beds should not be authorized in such an environment."

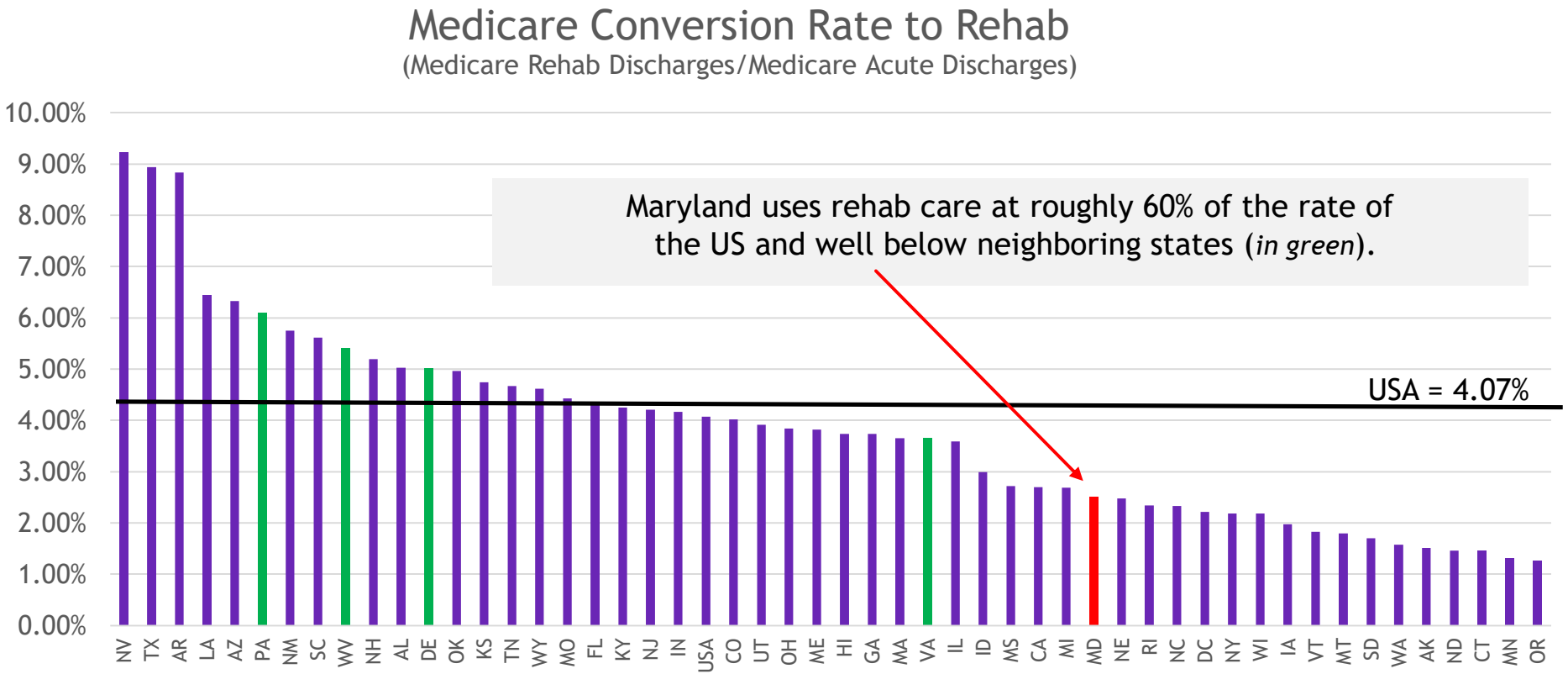
October 16, 2019 Maryland Health Commission letter, page 2

Maryland Ranks Below the US on Rehab Beds per 1000 65+



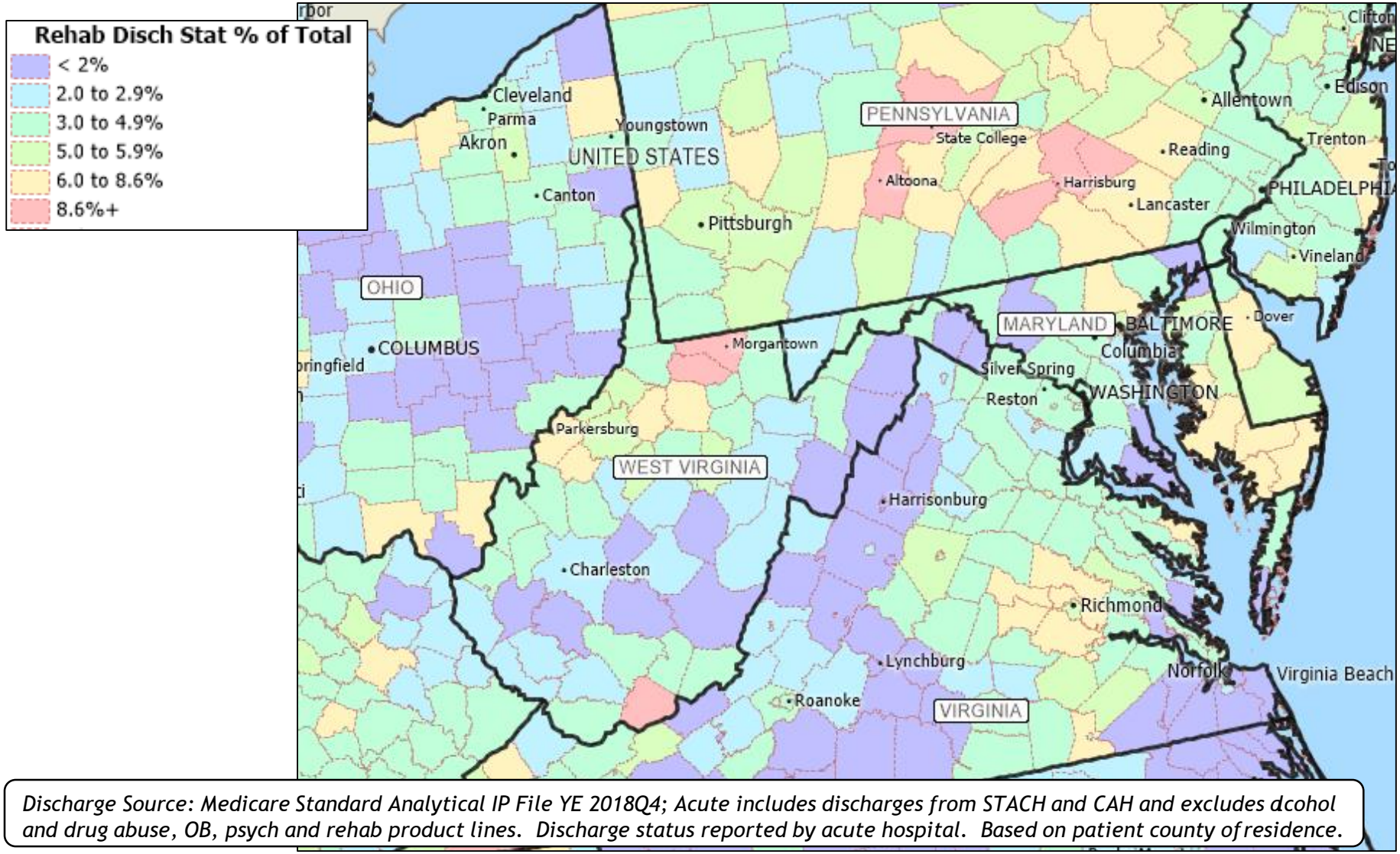
Rehab Beds: Cost Reports, other market research
Population Source: Claritas - Pop-Facts Advanced 2019

Maryland is also on the Lower Range of Rehab Utilization



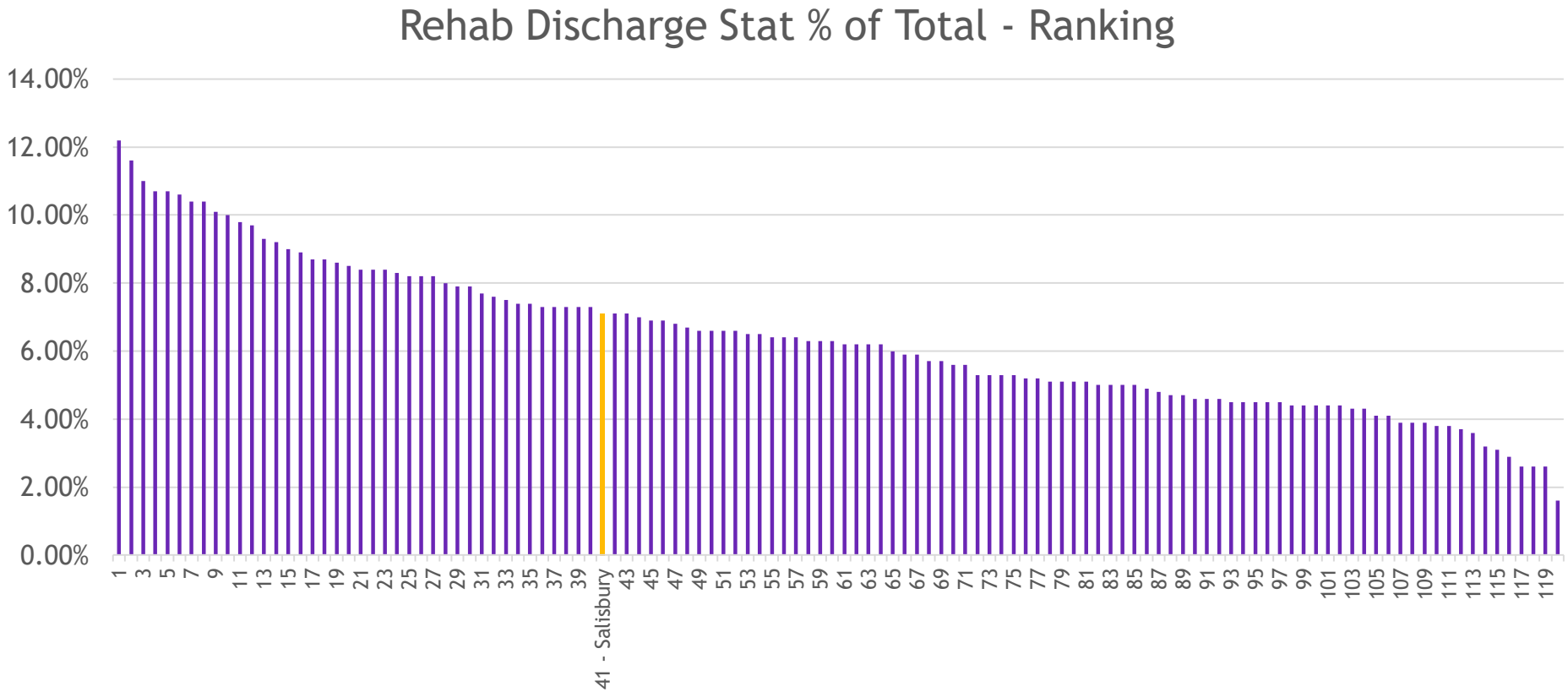
Discharge Source: Medicare Standard Analytical IP File YE 2018Q3, Md DPU's report with their anchor hospital so our analysis adds DPU volumes to more accurately calculate this metric

The Region Shows that the Higher Rehab Utilization Counties are Quite Common



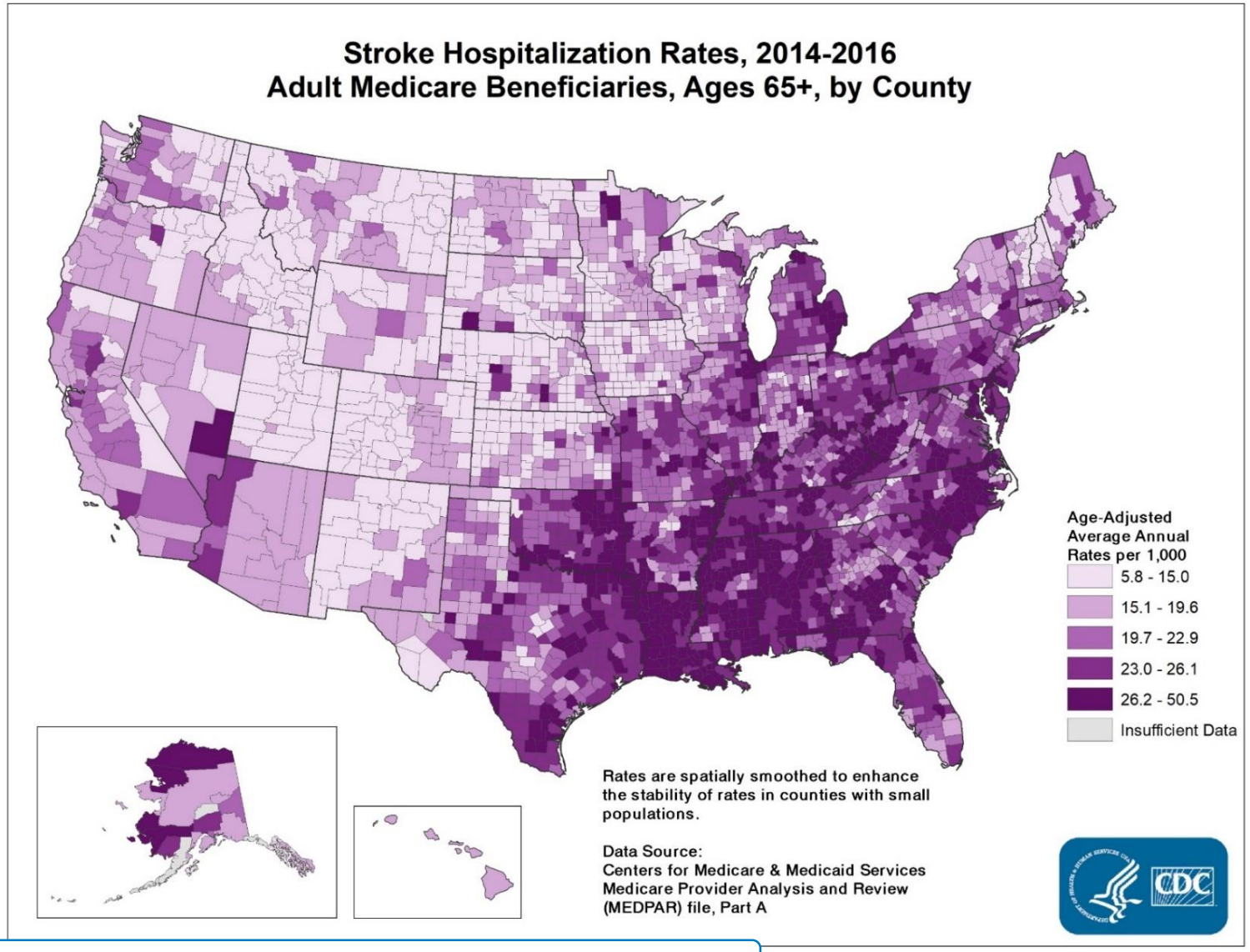
Discharge Source: Medicare Standard Analytical IP File YE 2018Q4; Acute includes discharges from STACH and CAH and excludes alcohol and drug abuse, OB, psych and rehab product lines. Discharge status reported by acute hospital. Based on patient county of residence.

Encompass' Experience in 120 Markets Also Shows Wide Variation in Utilization, but Demonstrates the Salisbury Rates are Quite Common



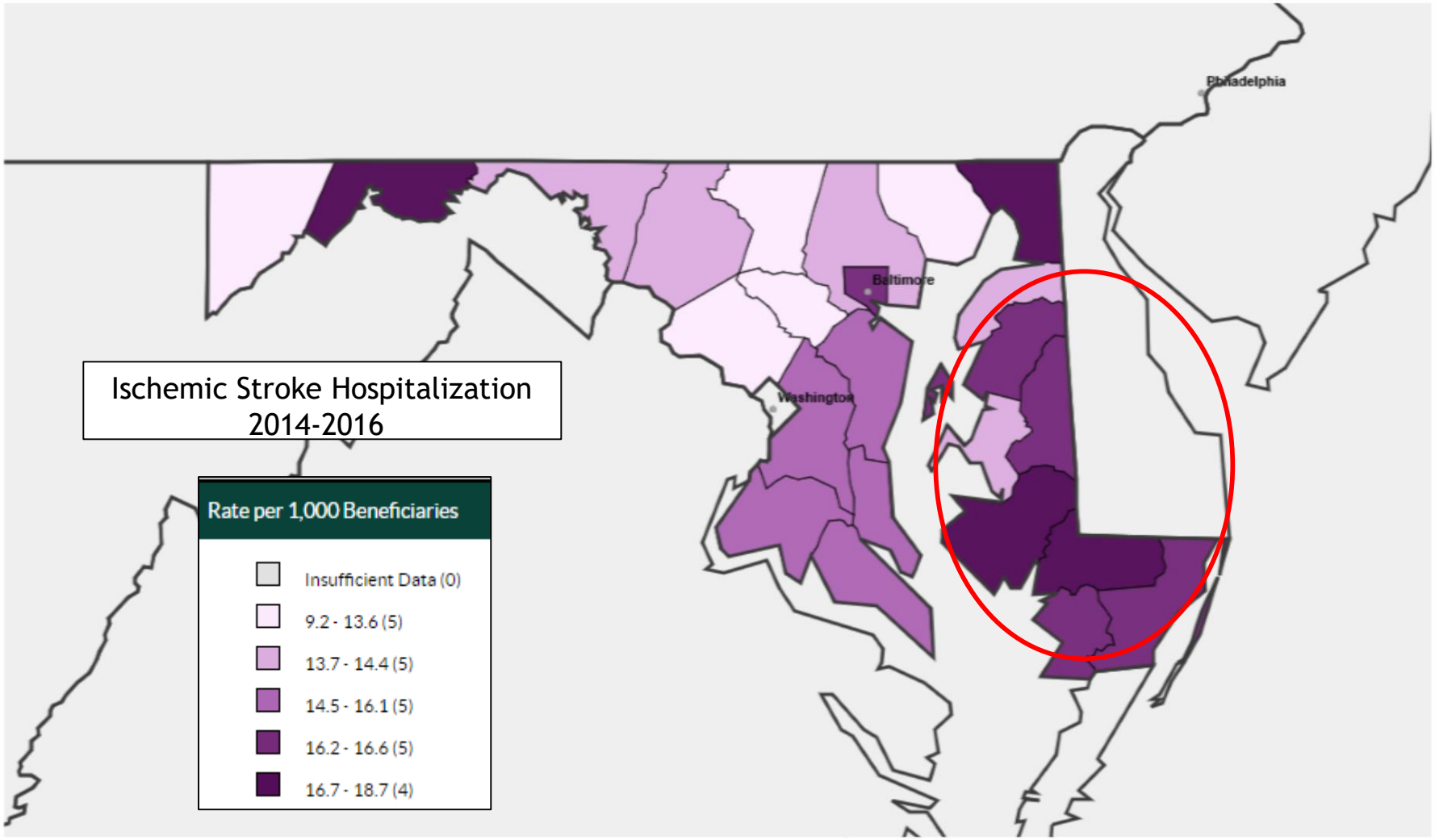
Source: Medicare Standard Analytical IP File YE 2018Q4, Encompass Health "Primary Service Areas" of 119 markets.

Underlying Community Health Also Impacts Utilization Rates



Source: Centers for Disease Control, Public Data

Highest Stroke Rates are in this Region of Maryland, Impacting Higher Use Rates for Appropriate Rehab Care



Source: Centers for Disease Control, Public Data

Licensing, Care Requirements, and Patient Acceptance Processes All Ensure that Only Appropriate Patients Can be Served in an Encompass Health IRF

Requirements of an Inpatient Rehabilitation Facility/Hospital
IRFs must satisfy regulatory/policy requirements for hospitals, including **Medicare hospital conditions of participation**.
IRF must be **TJC** accredited by Medicare standards and **CARF** accredited by Maryland standards
Medicare restricts patients that can receive IRF care to a **stringent "60 % rule"** ratio of **"CMS 13"** patient diagnoses deemed appropriate by Medicare for rehab care.

Requirements of Care
All patients, regardless of diagnosis/condition, must **demonstrate rehabilitation need, medical necessity** and receive at least three hours of **intensive therapy** five days a week.
All patients must see a rehabilitation **physician "in person"** three times weekly at a minimum. (5-6 times a week in Salisbury)
IRFs are required to provide 24 hour, 7 day per week **nursing care**, many nurses are RN's and CRRN's (Certified Rehabilitation Registered Nurses).
IRFs are required to use a coordinated **inter-disciplinary team** approach led by a rehab physician; includes a rehab nurse, a case manager, a licensed occupational therapist and a licensed physical therapist, who must meet weekly to evaluate/discuss each patients case. (In addition a licensed speech therapist, dietician and pharmacist may participate depending on patient needs)

Requirements for Patient Acceptance
IRFs are required to follow stringent admission/coverage policies and must **carefully document justification** for each admission.
Most patients are referred by acute care hospitals with **review of their discharge planning staff and physician order**.
All patients must be approved by a rehabilitation physician. **A decision to use inpatient rehab care is solely at the direction of a physician.**
Medicare requires an IRF to conduct **pre-admission screening** by a licensed healthcare professional of any patient to assure they are clinically deemed to benefit from intensive rehab care.
An **addiitional assessment is performed with in 24 hours of admission by the rehabiliation physician** of all admissions, referred to as the PAPE.
Third party payers have stringent approval processes requiring pre-approval by their own clinical experts.
Medicare reviews patients post IRF stay and **can deny payment after the patient is discharged.**
Encompass Salisbury currently admits patients at a **45% conversion** rate meaning for every 1,000 referrals, 450 are accepted for admission by our Medical Staff

Exhibit 9

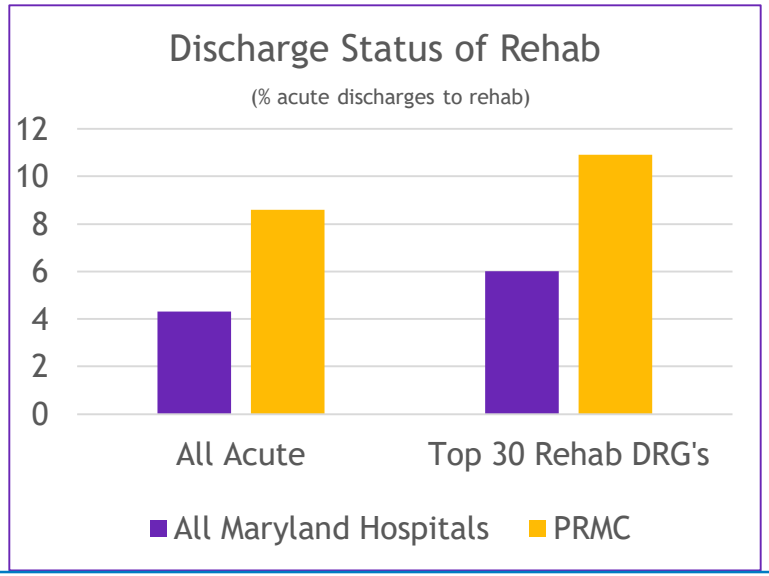
Rehabilitation Hospitals: A Different Level of Service

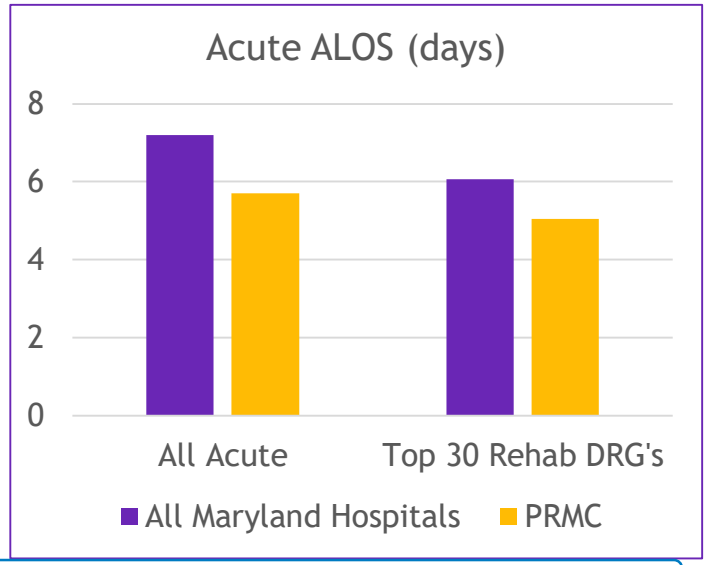
Inpatient rehabilitation hospital	Nursing home
Average length of stay = 12.7 days	**Average length of stay = 38.4 days**
Requirements:	**Requirements:**
IRFs must also satisfy regulatory/policy requirements for hospitals, including Medicare hospital conditions of participation.	No similar requirement; Nursing homes are regulated as nursing homes only
All patients must be approved by a rehab physician.	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.

The Transfer of Peninsula Regional Hospital's (PRMC) Discharged Patients for the Inpatient Rehab Care Provided at EHRHS Has Lowered PRMC's Acute ALOS Below that of Maryland Acute ALOS

PRMC Top 10 Acute Care DRG's Discharged to Rehab

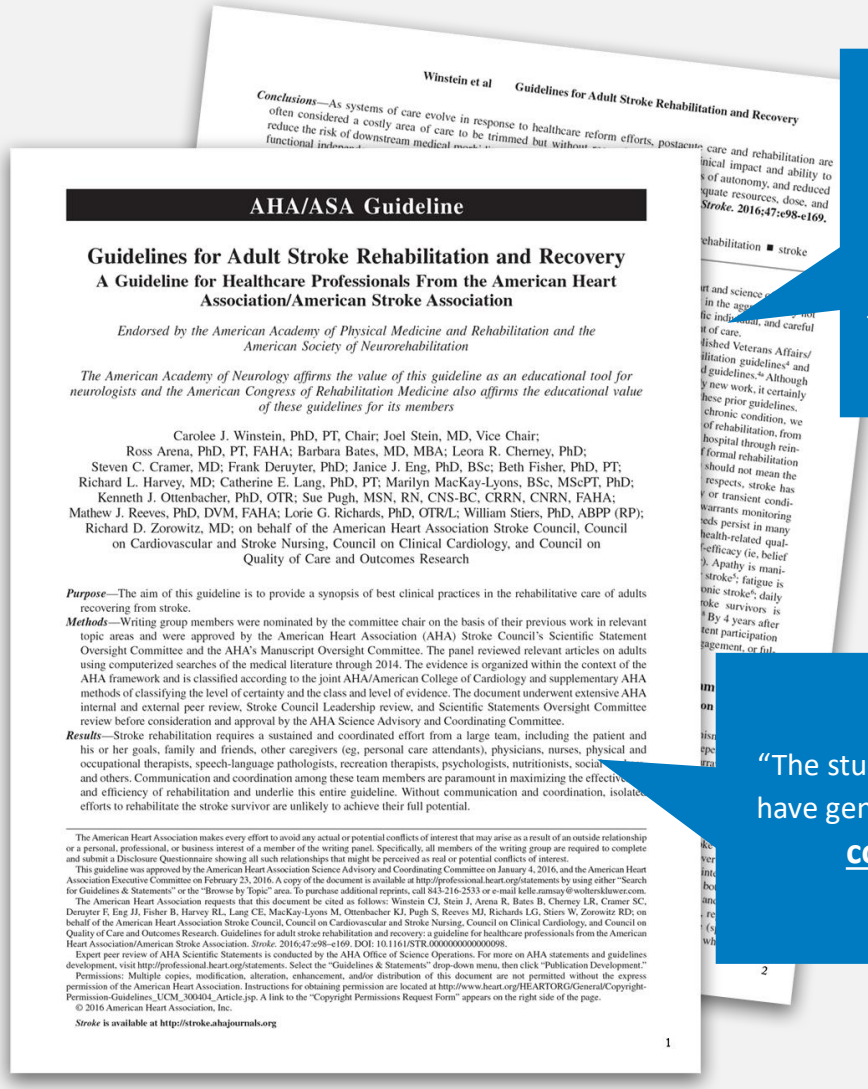
DRG	DRG_Desc
65	Intracranial hemorrhage or cerebral infarction w CC or TPA
470	Major hip & knee replacement or reattach lower extremity w/o
871	Septicemia or severe sepsis w/o MV >96 hours w MCC
189	Pulmonary edema & respiratory failure
64	Intracranial hemorrhage or cerebral infarction w MCC
481	Hip & femur procedures except major joint w CC
872	Septicemia or severe sepsis w/o MV >96 hours w/o MCC
641	Misc disorders of nutrition,metabolism,fluids/electrolytes w
291	Heart failure & shock w MCC or peripheral ECMO
690	Kidney & urinary tract infections w/o MCC





Discharge Source: Medicare Standard Analytical IP File YE 2018Q4, discharge status of acute patient reported in claim file.

Independent Research Concludes Inpatient Rehabilitation is the Optimal Post Acute Care for Stroke Patients



Winstein et al Guidelines for Adult Stroke Rehabilitation and Recovery

Conclusions—As systems of care evolve in response to healthcare reform efforts, postacute care and rehabilitation are often considered a costly area of care to be trimmed but without ... inical impact and ability to reduce the risk of downstream medical ... s of autonomy, and reduced functional ... quate resources, dose, and ... *Stroke.* 2016;47:e98-e169.

... rehabilitation ■ stroke

... urt and science ... in the age ... ific ... ual, and careful ... t of care. ... lished Veterans Affairs/ ... ilitation guidelines[4] and ... d guidelines.[4a] Although ... y new work, it certainly ... hese prior guidelines. ... chronic condition, we ... of rehabilitation, from ... hospital through rein- ... f formal rehabilitation ... should not mean the ... respects, stroke has ... or transient condi- ... warrants monitoring ... eds persist in many ... health-related qual- ... -efficacy (ie, belief ...). Apathy is mani- ... stroke[5]; fatigue is ... onic stroke[6]; daily ... roke survivors is ... By 4 years after ... tent participation ... agement, or ful...

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AHA/ASA Guideline

Guidelines for Adult Stroke Rehabilitation and Recovery

A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

Endorsed by the American Academy of Physical Medicine and Rehabilitation and the American Society of Neurorehabilitation

The American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists and the American Congress of Rehabilitation Medicine also affirms the educational value of these guidelines for its members

Carolee J. Winstein, PhD, PT, Chair; Joel Stein, MD, Vice Chair; Ross Arena, PhD, PT, FAHA; Barbara Bates, MD, MBA; Leora R. Cherney, PhD; Steven C. Cramer, MD; Frank Deruyter, PhD; Janice J. Eng, PhD, BSc; Beth Fisher, PhD, PT; Richard L. Harvey, MD; Catherine E. Lang, PhD, PT; Marilyn MacKay-Lyons, BSc, MScPT, PhD; Kenneth J. Ottenbacher, PhD, OTR; Sue Pugh, MSN, RN, CNS-BC, CRRN, CNRN, FAHA; Mathew J. Reeves, PhD, DVM, FAHA; Lorie G. Richards, PhD, OTR/L; William Stiers, PhD, ABPP (RP); Richard D. Zorowitz, MD; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research

Purpose—The aim of this guideline is to provide a synopsis of best clinical practices in the rehabilitative care of adults recovering from stroke.

Methods—Writing group members were nominated by the committee chair on the basis of their previous work in relevant topic areas and were approved by the American Heart Association (AHA) Stroke Council's Scientific Statement Oversight Committee and the AHA's Manuscript Oversight Committee. The panel reviewed relevant articles on adults using computerized searches of the medical literature through 2014. The evidence is organized within the context of the AHA framework and is classified according to the joint AHA/American College of Cardiology and supplementary AHA methods of classifying the level of certainty and the class and level of evidence. The document underwent extensive AHA internal and external peer review, Stroke Council Leadership review, and Scientific Statements Oversight Committee review before consideration and approval by the AHA Science Advisory and Coordinating Committee.

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

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This guideline was approved by the American Heart Association Science Advisory and Coordinating Committee on January 4, 2016, and the American Heart Association Executive Committee on February 23, 2016. A copy of the document is available at http://professional.heart.org/statements by using either "Search for Guidelines & Statements" or the "Browse by Topic" area. To purchase additional reprints, call 843-216-2533 or e-mail kelle.ramsay@wolterskluwer.com.

The American Heart Association requests that this document be cited as follows: Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE, MacKay-Lyons M, Ottenbacher KJ, Pugh S, Reeves MJ, Richards LG, Stiers W, Zorowitz RD; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Guidelines for adult stroke rehabilitation and recovery: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke.* 2016;47:e98–e169. DOI: 10.1161/STR.0000000000000098.

Expert peer review of AHA Scientific Statements is conducted by the AHA Office of Science Operations. For more on AHA statements and guidelines development, visit http://professional.heart.org/statements. Select the "Guidelines & Statements" drop-down menu, then click "Publication Development."

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***Stroke* is available at http://stroke.ahajournals.org**

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"Whenever possible, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility. While in an inpatient rehabilitation facility, a patient participates 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."*

"The studies that have compared outcomes in hospitalized stroke patients … have generally shown that **IRF patients have higher rates of return to community living and greater functional recovery**."**

Discharge Status of Medicare Acute Patients

% Discharged to Rehab

Patient County	Rehab	% to Rehab
Wicomico County	365	8.1%
Worcester County	210	7.9%
Baltimore County	2241	6.2%
Talbot County	122	6.1%
Dorchester County	103	6.0%
Somerset County	77	6.0%
Montgomery County	1254	5.4%
Baltimore city	1517	5.2%
Caroline County	61	5.0%
Allegany County	194	4.4%
Howard County	251	3.9%
Kent County	40	3.8%
Queen Anne's County	59	3.8%
Washington County	211	3.3%
Harford County	297	3.2%
Carroll County	228	3.0%
Prince George's County	646	3.0%
Anne Arundel County	379	2.1%
Charles County	63	1.6%
Cecil County	48	1.6%
Frederick County	113	1.6%
Calvert County	36	1.3%
Garrett County	8	0.9%
St. Mary's County	25	0.8%
	8548	**4.3%**

% Discharged to SNF

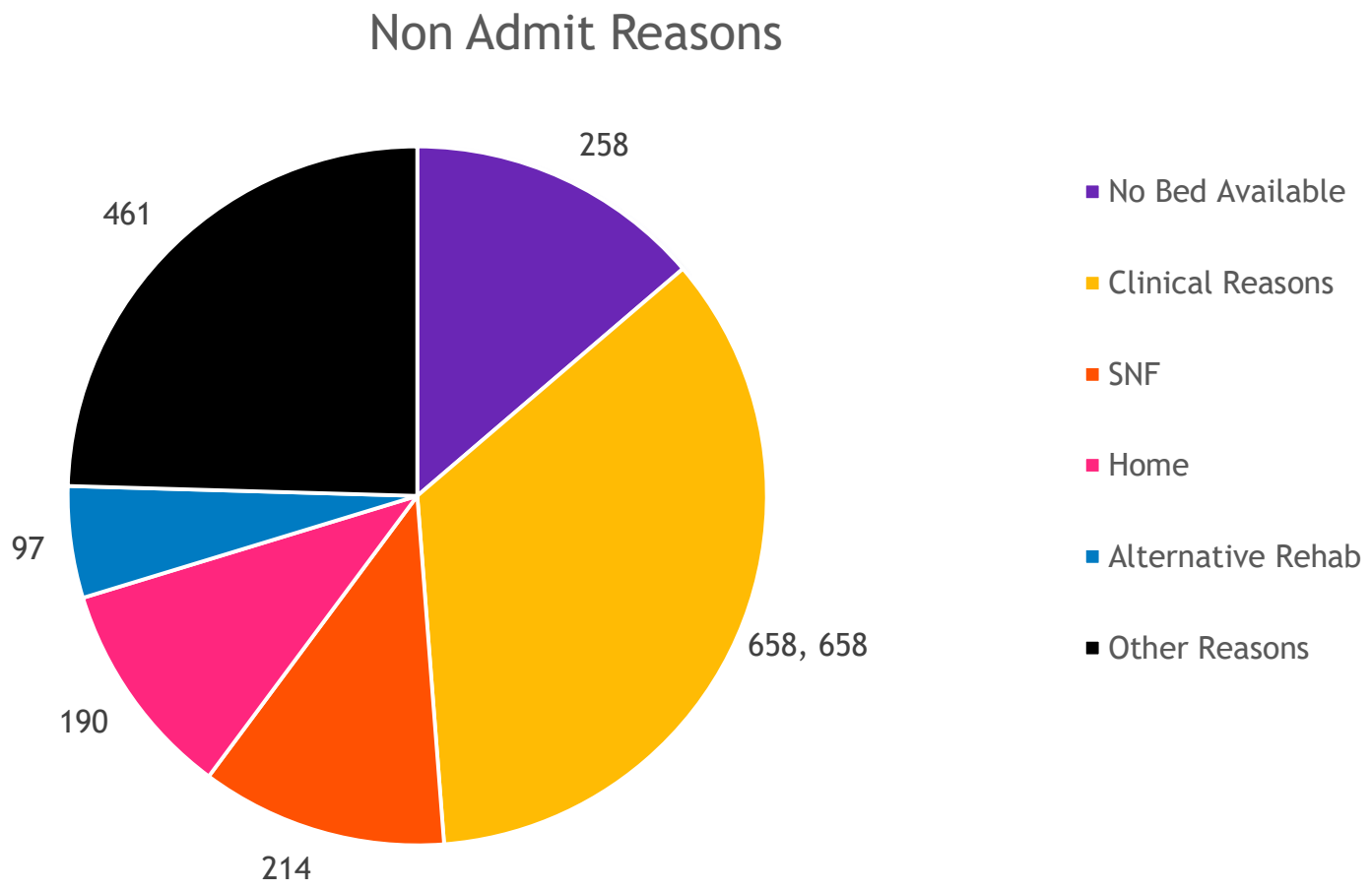
Patient County	ICF/SNF	% to SNF
Garrett County	263	28.5%
Montgomery County	6438	28.0%
Kent County	274	26.3%
Frederick County	1792	24.6%
Washington County	1536	24.2%
Allegany County	1022	23.1%
Howard County	1489	23.1%
Charles County	896	22.7%
Caroline County	272	22.4%
Harford County	2042	22.2%
Cecil County	666	22.1%
Dorchester County	374	21.8%
Prince George's County	4657	21.6%
Anne Arundel County	3980	21.6%
Baltimore County	7832	21.5%
Baltimore city	6178	21.3%
St. Mary's County	625	21.1%
Somerset County	266	20.7%
Talbot County	404	20.3%
Carroll County	1517	20.2%
Worcester County	529	20.0%
Queen Anne's County	305	19.8%
Calvert County	540	19.7%
Wicomico County	855	19.0%
	44752	**22.5%**

% Discharged to Post Acute (SNF or Rehab)

Patient County	% to post acute
Garrett County	44.9%
Montgomery County	41.0%
Dorchester County	38.3%
Kent County	37.9%
Allegany County	37.2%
Washington County	36.6%
Baltimore County	35.3%
Howard County	34.6%
Talbot County	33.9%
Baltimore city	33.9%
Cecil County	32.9%
Wicomico County	32.7%
Worcester County	32.6%
Queen Anne's County	32.5%
Somerset County	32.1%
Caroline County	32.0%
Harford County	31.9%
Prince George's County	31.2%
Frederick County	31.2%
Carroll County	31.0%
Charles County	29.4%
Anne Arundel County	29.3%
St. Mary's County	27.2%
Calvert County	25.1%

Discharge Source: Medicare Standard Analytical IP File YE 2018Q4, discharge status of acute patient reported in claim file by patient county of residence.

55% of Patients Referred to EHSRH are not Admitted for Rehab Care



Source: EHSRH Internal Reporting, YTD through Nov 13, 2019, annual estimate is ***that 300 patients will be turned away in 2019*** *due to "no bed available".*

EHRHS Currently Operates at 93% Occupancy Limiting its Ability to Serve Patients Today and in the Future

Provider Name	Period	Year	Patient Days	Proposed Beds	Occupancy Rates
EHRHS	CY	2018	21144	64	90.5%
		2019	**21669**	**64**	**92.8%**
		2020	22010	64	94.2%
		2021	23499	74	87.0%
		2022	23919	74	88.6%
Shore Health	FY	2018	3510	20	48.1%
		2019	3650	13	76.9%
		2020	3509	14	68.7%
		2021	3559	13	75.0%
		2022	3610	14	70.6%
TOTAL		2018	24654	84	80.4%
		2019	25319	77	90.1%
		2020	25519	78	89.6%
		2021	27058	87	85.2%
		2022	27529	88	85.7%

2019 YTD EHRHS volumes are on track with the projections made in the CON.

While not expected, a 10% decline in utilization rates would still leave EHRHS operating above the 79% occupancy guideline.

Source: Final Submitted CON Application, EHRHS; Shore Health Easton CON Application