August 1, 2023

Commissioner Brooke Cunningham
Minnesota Department of Health
Commissioner's Office
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Cunningham,

On behalf of Nobis IRF Holdings, LLC, I enclose our request to establish a new freestanding 60-bed inpatient rehabilitation hospital within the 7-county Economic Development Region 11 ("EDR 11"),[1] which we define as our Primary Service Area ("PSA" or "planning area"). Nobis has identified this region as a community in need of additional inpatient rehabilitation services.

Inpatient rehabilitation hospitals are acute care specialty hospitals focused on providing intense medical and physical rehabilitation to patients who have incurred a debilitating illness or injury such as a stroke, brain injury or even orthopedic fractures. These rehab hospitals have a rehab team that includes speech, physical, and occupational therapies as well as rehab nurses. The medical rehabilitation team is led by a physician trained in physical and medical rehabilitation medicine. The rehabilitation services are designed individually for each patient to facilitate their functioning at the highest level possible with the goal of returning them to their community. These patients are most often admitted into rehab from short term acute care hospitals, but may also be referred from physician offices, skilled nursing facilities, home health agencies, and other referral sources.

As we document in our application, there exists a current and future need for rehabilitation services within our proposed Primary Service Area. Despite this, the supply of rehabilitation beds and IRUs ("Inpatient Rehabilitation Units") in Minnesota has declined. Based on our extensive experience with inpatient rehabilitation, we believe there will be significant value in approving the development and operation of our 60-bed inpatient rehabilitation hospital.

Please contact Gina Thomas, our Chief Development Officer, by phone at 469- 640-6507 or by email at gthomas@nobisrehabpartners.com at any time to request additional information or if we can provide any clarity on our submission. We look forward to working with you throughout this process.

Sincerely,

Chester Crouch
Founder and President, Nobis Rehabilitation Holdings, LLC

[1] EDR 11 includes: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.

Nobis IRF Holdings, LLC
Public Interest Review Application to Establish a new 60-Bed Inpatient Rehabilitation Hospital

August 2023

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I. Project Overview and Summary

Nobis IRF Holdings, LLC ("Nobis") seeks to establish a freestanding 60-bed inpatient rehabilitation hospital within the 7-county Economic Development Region 11 ("EDR 11"),[2] which we define as our Primary Service Area ("PSA" or "planning area"). Minnesota, and EDR 11, have one of the lowest use rates of rehabilitation services in the United States. Despite this, the counties within EDR 11 have a large and growing senior population, which represents the largest user group for inpatient rehabilitation. (Over 70 percent of all inpatient rehabilitation admissions nationally are Medicare beneficiaries). For these reasons, Nobis has identified this region as a community in need of additional inpatient rehabilitation services.

Inpatient rehabilitation services are provided to patients in a licensed rehabilitation hospital with medical or functional impairments that cannot be provided in a typical acute care hospital. Along with acute care-level nursing services and daily physician oversight, inpatient rehabilitation typically includes speech, physical, and occupational therapies designed to help patients regain lost function or learn adaptive techniques to meet their needs and objectives which are not possible to meet in other lower-level inpatient settings where these therapies are provided. These services are provided in either an Inpatient Rehabilitation Unit ("IRU"), which is a unit within a larger acute-care hospital, or a freestanding hospital, known as an Inpatient Rehabilitation Facility ("IRF"). For compliance with CMS (Centers of Medicare and Medicaid Services), IRUs and IRFs must serve an inpatient population of whom at least 60 percent require intensive rehabilitation services for treatment of one or more of the thirteen conditions listed in 42 CFR 412.29(b)(2).[3] IRUs and IRFs receive discharged adult patients from acute care hospitals, as well as patients referred from physician offices, skilled nursing facilities, home health agencies, and other referral sources.

Between 2010 and 2021, inpatient rehabilitation care has been increasingly provided in freestanding rehabilitation hospitals vs. hospital-based rehabilitation units. This shift in site of care has been occurring for two primary reasons. First, with a larger operating capacity, many freestanding rehabilitation hospitals are better able to create specialized clinical programs and certified services than can typically be created in smaller, hospital-based units. This includes specialty programs such as Spinal Cord Injury, Brain Injury, Stroke Rehabilitation, and other similar programs. By design, a smaller 15 to 20 bed hospital-based rehabilitation unit generally must devote its capacity to generalized patient care, thereby limiting the potential for program specialization. The second major reason for this shift in the site of care is that, because of their size and higher utilization, freestanding rehabilitation hospitals can achieve greater cost efficiencies and provide care at lower costs than can be achieved in smaller hospital-based rehabilitation units. The proposed 60-bed IRF will be the only freestanding rehabilitation hospital in the State.

[2] EDR 11 includes: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.
[3] These conditions include Stroke, Spinal Cord Injury, Congenital Deformity, Amputation, Major Multiple Trauma, Fracture of Femur, Brain Injury, Neurological Disorders, Burns, Arthritis, Joint Inflammation, Osteoarthritis, and Knee or Hip Joint Replacement (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-B/section-412.29, Last Accessed June 22, 2023).

Specialized programs in IRFs can be tailored to the distinct needs of the Twin Cities and surrounding communities, such as targeting stroke and medical rehabilitation programs to accommodate specific disease prevalence. The addition of a freestanding IRF in Minnesota will greatly expand patient access to rehabilitative care, ultimately decreasing unnecessary patient readmissions into general acute care hospitals and significantly improving the quality of life and health outcomes of Minnesotans in need of rehabilitative care.

Nobis has opened 13 inpatient rehabilitation hospitals in the last two years across the United States and has an additional eight hospitals under development. Through proven and reliable methods, Nobis is dedicated to managing hospitals and hospital-based units that care for patients who have experienced life-changing diseases or injuries. Our Nobis-operated inpatient rehabilitation hospitals employ exceptional clinicians and therapists to return these patients to their highest potential quality of life and independence.

Upon opening, our hospitals care for the primary categories of rehabilitation including stroke, brain injury, neurological disorders, spinal cord injury, major multiple trauma, orthopedic injury, amputation, and medically debilitating conditions. Our hospital team collaborates with our Medical Director and Associate Medical Director on an ongoing basis to determine potential services that require further investment and delivery based on community need. As an example, in Shreveport, the prevalence of diabetes is very high compared to other markets and correspondingly, our Shreveport Rehabilitation Hospital prioritizes stroke rehabilitation services.

As we document in our application, a significant need exists for rehabilitation services within EDR 11, our proposed Primary Service Area. For rehabilitation services, Minnesota has one of the lowest inpatient rehabilitation bed-to-population ratios in the entire nation at 4.7 per 100,000 residents. For our proposed PSA, this ratio is 4.8. (3.13 million residents and 151 beds). Within our PSA, Hennepin County is the most populous county with 1.27 million persons. Currently, we estimate a conservative, net rehabilitation bed shortage of 130 beds in 2021, increasing to over 180 beds by 2035 within our proposed PSA. Additionally, the aging of the population is well documented through public health data in the region. There is also a high incidence of obesity, hypertension, and high cholesterol in our proposed planning area. With these population and morbidity increases, this bed shortage will grow, as stated above, and documented below. Furthermore, while several acute care short term general hospitals in the area provide inpatient rehabilitation services, there are no freestanding IRFs in the PSA, which provide care for 55 percent of all Medicare admissions nationally, according to the most recent data available.

Despite the current and growing need for rehabilitation beds in Minnesota, the supply of rehabilitation beds and IRUs in Minnesota has declined. Park Nicollet Methodist Hospital in Hennepin County terminated its rehabilitation services in 2013. Other Minnesota providers which stopped providing rehabilitation services over the last 10 years include CentraCare Health – Monticello in 2016 (Wright County), Lake Region Healthcare Corporation in 2018 (Otter Tail County), and Essentia Health Virginia in 2019 (St. Louis County).

Based on our extensive experience with inpatient rehabilitation, we believe there will be significant value in approving the development and operation of our 60-bed inpatient rehabilitation hospital, which we plan to name as Minneapolis Rehabilitation Hospital upon approval through legal and regulatory processes. These benefits include:

Financial benefit to existing acute-care hospitals, especially those with emergency departments, in the region.

Our inpatient rehabilitation hospitals provide intensive rehabilitation to patients, which is defined by Medicare to be up to three hours of intensive physical, occupational, and/or speech therapy daily, with a minimum of fifteen hours five days per week. Patients must have acute medical needs, but also must be medically stable enough to both tolerate and benefit from such intensive rehabilitation services. As such, our facilities do not compete with existing hospitals in the region that provide services to patients seeking emergent care. Instead, Nobis works closely with these local acute care hospitals through transfer agreements to ensure the streamlined transfer of patients requiring rehabilitation care to our rehabilitation hospital. Our inpatient rehabilitation hospital facilitates bed access at crowded general acute care hospitals by admitting patients who need rehab services to our rehab hospitals, thus, freeing up those general acute care hospital beds. This allows for more efficient, faster admissions, and benefits emergency departments whose patients may require a medical/surgical bed following their admission.

Decreasing readmissions to acute care hospitals.

Additionally, because our focus is providing inpatient rehabilitation services only, we strive to decrease the readmissions and negative financial impacts to the area's general acute care hospitals. Studies have shown that patients who receive rehabilitation care at an inpatient rehabilitation hospital versus a sub-acute rehabilitation center, such as a skilled nursing facility or nursing home, have greater quality outcomes, fewer readmissions, and a higher discharge to community rate. By employing a clinical team dedicated to inpatient rehabilitation and building a close relationship with local acute care hospitals with emergency departments, we can ensure our patients receive the highest quality rehabilitation care and place them back in their community at their highest level of function, thus saving local hospitals and payors time, money, and resources.

Creating jobs and drawing caregivers from schools and the community without impacting the staffing at existing local hospitals.

At each of our hospitals, Nobis focuses on building a skilled, dedicated, and diverse team of caregivers and is committed to creating a workplace where all team members and patients are treated with respect and fairness. To do this, Nobis develops relationships with local colleges that offer physical therapy, occupational therapy, speech therapy, and nursing programs to recruit caregivers that are highly trained in the most cutting-edge skills and techniques. In addition to local colleges, Nobis collaborates with local community groups to help connect job-seeking caregivers, who desire an inpatient rehab hospital environment, with opportunities to help us build a team that can provide culturally competent care that meets the distinct needs of all our patients.

Nobis currently operates facilities in two states where there are severe shortages of caregivers. As such, we have built our organization around recruiting, training, and retaining the best caregivers who are passionate about physical and medical rehabilitative care within an environment of sometimes limited

professional resources. While Nobis accepts all qualified applications, Nobis works to ensure that there is no negative impact on the care provided at area hospitals. To ensure Nobis hospitals always have a complete caregiving team, Nobis has its own nurse travel program to fill any gaps if needed.

Providing lifechanging services to nonpaying or low-income patients.
While Medicare beneficiaries will make up the largest patient demographic at our proposed inpatient rehabilitation hospital, across the country, several Nobis hospitals are located in dense populations of Medicaid patients. At those hospitals where we have significant proportions of patients with minimal financial resources, our team leverages our full resources to provide exceptional care to all of our patients, regardless of their income level.

To do this, each patient seeking admission is clinically assessed to ensure they can meet the criteria for intensive rehabilitation of 3 hours a day. The Nobis hospital team reviews each patient's individualized plan of care and the established clinical and financial metrics at the hospital in their daily team huddles. These reviews ensure that our team is leveraging the best rehabilitation services for all patients while we are employing the best possible staffing plans and the most effective admissions and discharge processes to have a high performing inpatient rehabilitation hospital. Additionally, our proposed hospital will have dedicated Case Managers who will help our clinical rehabilitation team, the patient, and their family connect with needed resources. Using these tested methods, Nobis has in place processes that allow us to provide the highest quality care for all community members.

II. Applicant Description

1. **Submit articles of organization/joint venture/partnerships and other organizational information including the following:**
   a. **Internal Revenue Service (IRS) Section 501(c) status.**

      Nobis IRF Holdings is not a tax-exempt organization. Thus, this question is not applicable.

   b. **A list and organizational chart of all affiliated parties and ownership interests in each.**

      Please see Exhibit 1 for an organizational chart of all affiliated parties.

   c. **Information on where relevant providers currently hospitalize patients.**

      Nobis does not presently operate any facilities in Minnesota. Thus, this question is not applicable.

2. **Provide current or recent IRS forms and billing/collection agreements, for relevant hospitals/organizations, including the following:**
   a. **Schedule H (990 Form).**

      Nobis IRF Holdings is not a tax-exempt organization. Thus, this question is not applicable.

   b. **Community Health Needs Assessment (CHNA) - Section 501(r)(3).**

      Nobis IRF Holdings is not a tax-exempt organization. Thus, this question is not applicable.

   c. **Financial Assistance Policy and Emergency Medical Care Policy - Section 501(r)(4).**

      Nobis IRF Holdings is not a tax-exempt organization; however, Nobis intends to provide financial assistance to persons in need. Please see Exhibit 2 for the Financial Assistance Policy which would be in place at the proposed hospital.

   d. **Signed Hospital Agreement on Billing and Collection with the Minnesota Attorney General (including expiration date).**

      Nobis IRF Holdings is not a tax-exempt organization. Thus, this question is not applicable.

3. **Describe community engagement activities that have informed the proposal with references to Principles of Authentic Community Engagement.**

   The Principles of Authentic Community Engagement include the importance of fostering trust, supporting community-led solutions, and supporting social change.

Nobis strives to meet the needs of the communities in which it provides care. This requires education and knowledge of the community context, and relationships with community organizations and local leaders to understand local needs. Our local presence in the community is led by our Director of Business Development, the clinical liaison team which includes the highest number per rehab hospital in the country, and our leadership team, all of whom are engaged with the community in supporting local efforts from a culture perspective. Outreach efforts have typically included the recognition of the various rehabilitation organizations and societies such as Minnesota Stroke Association, Minnesota Brain Injury Alliance, Spinal Cord Injury Awareness, Amputee Coalition, American Cancer Society, and the American Diabetes Association of Minnesota.

Over time, our hospital team will collaborate with area hospitals and the community to further determine the rehab programs we may want to develop based on community needs. As an example, in Shreveport, the prevalence of diabetes is very high compared to some of our other markets. Our focus on stroke rehabilitation will therefore be even greater for that hospital. A similar assessment will be completed in the proposed PSA as relationships are developed with community organizations and local acute care providers.

Our hospitals engage in their local communities both through the outreach efforts described above, as well as through their employees who will live and work in the area. Understanding the importance of our workforce, we are committed to creating a workplace where employees are treated with respect and fairness. Each of our hospitals celebrate various local and national groups, organizations and awareness or recognition for nationalities, cultures, and religion. Some recent examples:

- Black History Luncheon
- Collaboration with Urban Leagues
- Krewe of Gemini celebration
- Lunar New Year
- State chapters for professional associations for Occupational Therapy, Physical Therapy, Speech Language & Hearing Case Management
- Various professional days for nurses, therapists, hospital week, etc.

We value a diversity of background in our staff and leadership, and so our hospital human resource managers collaborate with and recruit from not only local colleges, but also local groups of different nationalities and cultures to share our latest career opportunities to ensure all people from all walks of life have the necessary information to join our team.

4. Submit a list of stakeholders and affected parties that were identified in planning for the project.

Stakeholders and affected parties for the proposed project include Nobis, local PSA healthcare providers, and the planning area community. An organizational chart for Nobis is included in Exhibit 1.

Nobis builds strong partnerships with other providers in all our market areas to raise awareness about our rehab services and capabilities and would do the same in Minnesota. We do this through our Clinical Liaison team and Business Development leaders, our rehab hospital leadership networks

with area physicians, local hospital discharge planners and social workers, post-acute providers, acute care providers and the surrounding community to ensure rehabilitation needs are met for the people we serve. Our Clinical Liaisons are rehab trained to partner with local short term acute care hospitals and have a clinical, rehab or therapy background. Nobis hospitals have the highest number of Clinical Liaisons per rehab hospital in the country to ensure all people who have experienced a debilitating injury or illness have access to the best rehab services that will improve their functional outcomes.

Upon preparing for a hospital to open, our teams connect with area acute care hospitals and case management teams and begin the process to sign Transfer Agreements, which streamline the flow of patient care when additional medical services are needed. Our team additionally builds relationships with the area physician offices, skilled nursing facilities, and assisted living centers.

There exist 26 acute care hospitals in the PSA. This includes 20 Short-Term Acute Care hospitals, 2 long-term care hospitals, 2 Critical Access Hospitals, and 2 Children's hospitals. We present this list of acute care providers in Table 1.

Table 1: Primary Service Area Acute Care Providers

Name	City	County Name	Avail. Beds	Rehab Beds
Children's Hospitals				
Children's Hospitals & Clinics of MN	Saint Paul	Hennepin	279	0
Gillette Childrens Specialty Hospital	New Brighton	Ramsey	55	0
			334	**0**
Critical Access Hospitals				
Mayo Clinic Health System-New Prague	New Prague	Scott	29	0
			29	**0**
Short-Term Acute Care Hospitals				
Mercy Hospital	Coon Rapids	Anoka	492	0
Ridgeview Medical Center	Waconia	Carver	96	0
M Health Fairview Ridges Hospital	Burnsville	Dakota	150	0
Northfield City Hospital	Northfield	Dakota	37	0
Abbott Northwestern Hospital	Minneapolis	Hennepin	638	39
Hennepin County Medical Center	Minneapolis	Hennepin	448	27
M Health Fairview Southdale Hospital	Edina	Hennepin	313	0
M Health Fairview University of MN	Minneapolis	Hennepin	781	30
Maple Grove Hospital	Maple Grove	Hennepin	108	0
North Memorial Health	Robbinsdale	Hennepin	350	18
Park Nicollet Methodist Hospital	Saint Louis Park	Hennepin	356	0
Veterans Affairs Medical Center	Minneapolis	Hennepin	361	0
M Health Fairview St John's Hospital	Maplewood	Ramsey	184	0
Regions Hospital	Saint Paul	Ramsey	153	21
United Hospital	Saint Paul	Ramsey	388	16

St Francis Regional Medical Center	Shakopee	Scott	89	0
Lakeview Memorial Hospital	Stillwater	Washington	68	0
M Health Fairview Woodwinds Hospital	Woodbury	Washington	86	0
			5,098	**151**
Long-Term Acute Care Hospitals				
M Health Fairview Bethesda Hospital	Saint Paul	Ramsey	15	0
Regency Hospital of Minneapolis LLC	Golden Valley	Hennepin	92	0
			107	**0**

Source: Minnesota Department of Health Healthcare Cost Information System, 2021; CMS Cost Reports, 2021

Nobis' local presence in the community is achieved by our Director of Business Development, the clinical liaison team, and our leadership team, primarily our Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Chief Therapy officer (CTO) and our Medical Director. The hospital team is engaged in the community to support local efforts from a culture perspective. Additionally, to ensure the community rehabilitation needs are met, our local rehab hospital teams coordinate with various rehabilitation organizations and societies such as Minnesota Stroke Association, Minnesota Brain Injury Alliance, Spinal Cord Injury Awareness, Amputee Coalition, American Cancer Society, and the American Diabetes Association of Minnesota, to name a few examples.

III. Project Description

1. Provide a description of the proposed project.

a. Describe the overall project, including objectives, phases, and timelines.

Nobis IRF Holdings, LLC ("Nobis") seeks to establish a freestanding 60-bed inpatient rehabilitation hospital in Ramsey County within the 7-county Economic Development Region 11 ("EDR 11"). This rehabilitation hospital will receive patients discharged from acute care hospitals, as well as a small number of patients referred from physician offices, skilled nursing facilities, home health agencies, and other referral sources who require intensive rehab care following a debilitating illness or traumatic injury. Upon opening, consistent with Medicare regulations, our hospitals care primarily for categories of rehabilitation including stroke, brain injury, neurological disorders, spinal cord injury, major multiple trauma, orthopedic injury, amputation, and medically debilitating conditions.

A description of the phases and timelines is included in our response below.

b. Detail timelines or phases of the project including short- and long-term plans for construction and expectations on when services will be staffed and available at the facility, operating partially and when fully staffed.

Based on the Minnesota legislative calendar, the next legislative session begins February 12, 2024. Assuming Nobis obtains an exception to the Minnesota hospital moratorium from the legislature, we expect this decision to occur by May 2024. Nobis would begin construction of the rehabilitation hospital approximately 30 days following approval of the project, or June 2024. Based on our experience in constructing similar facilities, we expect construction to be completed within approximately 440 days, or by September 2025 with first patient admission by October 2025.

The expected timeline outlined above reflects our best estimate based on information presently available. To the extent this information changes, such as length of time for the approval process, zoning approvals, or other factors outside our control, the project timeline will also change.

c. Define the objectives of the expansion in licensed beds or establishment of a new hospital such as health outcomes, health equity, or improvements in quality of life with supporting quantitative and qualitative evidence.

The objectives of the proposed 60-bed inpatient rehabilitation hospital are clear: to improve the quality of life and health outcomes for residents of the proposed Primary Service Area by providing better access to inpatient rehabilitation services. As is discussed in ***Section III. Project Need*** below, both the State and the proposed seven-county PSA have an IRF/IRU Bed-to-Population ratio that is less than one-half the national rate, resulting in a use rate of IRF services that is also less than one-half the national use rate. Since there are only 151 current IRF/IRU beds in the PSA, the proposed project will increase access by 40 percent.

As noted earlier, the Centers for Medicare and Medicaid Services identifies two types of rehabilitation providers. These are a freestanding rehabilitation hospital, or Inpatient Rehabilitation Facility (IRF) and a hospital-based Inpatient Rehabilitation Unit (IRU). Both IRFs and IRUs are certified and licensed in the same manner and are subject to the same admission criteria and Conditions of Participation. (In many of its annual reports including utilization data, Medicare will use the term "IRF" to describe services provided in both the IRF and IRU setting).

The proposed Minneapolis Rehabilitation Hospital will primarily impact the health outcomes and quality of life of the PSA senior population, as Medicare beneficiaries (both Medicare Fee-For-Service and Medicare Advantage) account for over 70 percent of all IRF admissions nationally. This includes patients that are recovering from strokes, orthopedic injuries and surgeries, head injuries, or other debilitating accidents or illnesses that negatively impact the patient's medical and/or functional status.

In addition, the Minneapolis Rehabilitation Hospital will be the only freestanding IRF in the State and will be able to offer specialized rehabilitation services that most IRUs are unable to provide because of capacity constraints. This includes unique designated nursing care and specialty trained care teams for high acuity patients, such as head injury and spinal cord injury patients, as well as emerging inpatient rehabilitation programs such as oncology rehabilitation. Further, as national data shows, the cost of care provided by freestanding IRFs is significantly less than the cost of care provided by hospital-based IRUs. This is primarily due to the efficiencies and economies of scale of managing a larger patient population. The benefits of providing care in a freestanding IRF is why nationally, from 2013 to 2021, the percentage of Medicare inpatient rehabilitation patients treated in a freestanding IRF has increased from 47 percent of all patients to 55 percent of all patients. Minneapolis Rehabilitation Hospital, as the only freestanding IRF in the state, will be able to offer its service to not only the seven-county PSA but patients from across the state that might be referred to the hospital. Figure 1 and Figure 2 provide quantitative data supporting these facts and trends for IRFs.

Figure 1: March 2018 MedPAC Report to Congress

TABLE 10–10

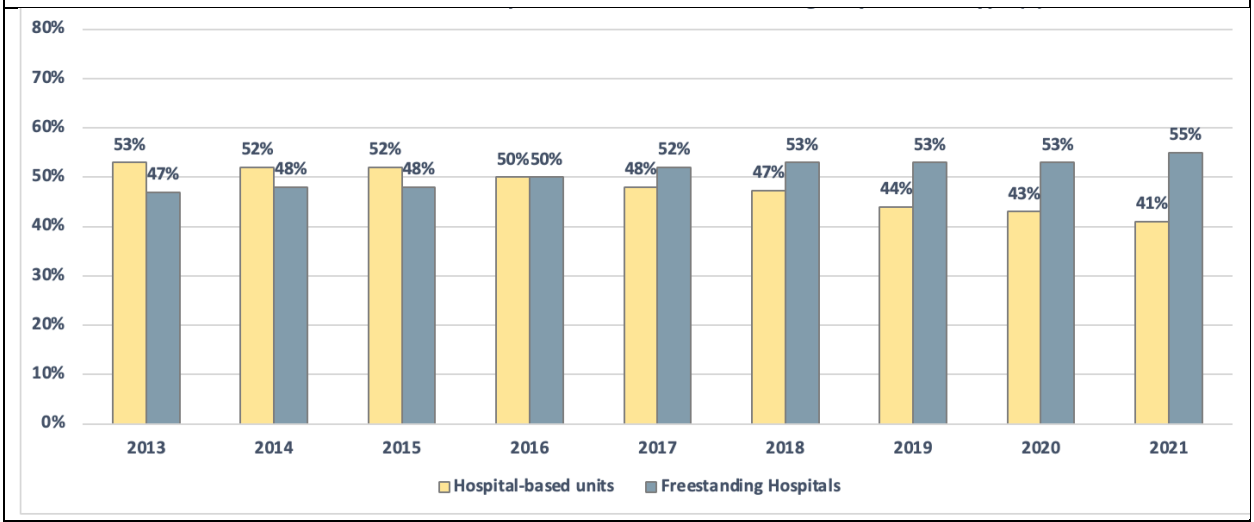
IRFs with fewer beds had much higher standardized costs per discharge, 2016

Type of IRF	Median standardized cost per discharge
All IRFs	$15,494
Hospital based	16,406
Freestanding	11,796
Nonprofit	16,311
For profit	13,315
Government	17,813
Urban	15,185
Rural	17,914
Number of beds	
1 to 10	18,588
11 to 24	16,408
25 to 64	14,239
65 or more	12,103

Source: MedPAC analysis of Medicare cost report and Medicare Provider Analysis and Review data from CMS

Notes: Cost per discharge is standardized for differences in area wages, mix of cases, and prevalence of high-cost outliers, short-stay outliers, and transfer cases. Government-owned facilities operate in a different financial context from other facilities, so their costs are not necessarily comparable.

Figure 2: U.S. Medicare FFS Inpatient Rehabilitation Discharges by Provider Type, 2013 to 2021



Source: 2015 to 2023 MedPAC reports to Congress

In addition to the above quantitative data, as well as the supporting need analysis provided in response to ***Section III. Project Need*** below**,** from a qualitative perspective, in May 2016, an American Stroke Association report stated, *"Whenever possible the ASA strongly recommends that stroke patients be treated at an inpatient rehabilitation facility (IRF) rather than a skilled nursing facility."* The proposed Minneapolis Rehabilitation Hospital will ensure that residents of the seven-county PSA, as well as other patients throughout the State have access to these world-class services.

2. List any potential partnerships, health system affiliations, and role of each participant.

Nobis builds strong partnerships with other providers in our market areas to raise awareness about our rehab services and capabilities. We do this with our Clinical Liaison team and Business Development leaders. In addition, our rehab hospital leadership networks with area physicians, post-acute providers, acute care providers, and the surrounding community to ensure rehabilitation needs are met for the people we serve.

Upon preparing for a hospital to open, our teams connect with area acute care hospitals and case management teams and begin the process to sign Transfer Agreements, which streamline the flow of patient care when additional medical services are needed and facilitate an understanding of our rehab hospital services. Our team additionally builds relationships with the area physician offices, skilled nursing facilities, and assisted living centers.

Given that Nobis is not yet operating in Minnesota, it is premature to identify these relationships which we are continuing to develop. However, Nobis has a track record of successfully developing these relationships in its other markets. For example, in Milwaukee, Nobis has partnerships with the acute care providers Froedtert Memorial Lutheran Hospital and West Allis Memorial Hospital, as well as with the post-acute care providers Linden Grove, Villages of Manor Park, Alexian Village, Brookdale, Oak Creek Place, Wilson Commons, Horizon HHC, Pinnacle, and Therapy at Home.

3. **How will the new facility benefit the community?**

Nobis is patient and family focused, with our primary goal to discharge the patient back into their community at the highest functioning level through high quality care. We support Minnesota's goals for health equity and access, and understand and embrace the culture of diversity, equity, and inclusion.

Nobis strives to meet the needs of the communities in which it provides care. The local presence in the community is achieved by our Director of Business Development, our Clinical Liaison team and our leadership team, primarily our CEO, CNO, CTO and Medical Director. The hospital team is engaged in the community to support local efforts from a culture perspective. Additionally, to ensure the community rehabilitation needs are met, our local hospital teams coordinate with various rehabilitation organizations and societies such as Minnesota Stroke Association, Minnesota Brain Injury Alliance, Spinal Cord Injury Awareness, Amputee Coalition, American Cancer Society, American Diabetes Association of Minnesota, and Minnesota Support Groups such as Stroke Support, Minnesota Parkinson's Support Group, to name a few examples.

Most importantly, our proposed Minneapolis Rehabilitation Hospital will improve access and the level and quality of rehabilitation care for all residents of the PSA, and more broadly, the state as a whole. Currently, inpatient rehabilitation services are provided exclusively through hospital-based inpatient rehabilitation units within short-term acute care hospitals in Minnesota. Inpatient rehabilitation care is increasingly being provided in freestanding IRFs due to the capacity for greater program specialization in dedicated rehab hospitals, as well as the fact that costs are less in IRFs due to higher utilization and greater efficiency.

In contrast to smaller hospital-based IRUs, Nobis' proposed Minneapolis Rehabilitation Hospital will be able to provide dedicated areas for specialty services and offer a greater volume and diversity of onsite providers and therapists. Nobis rehab hospitals focus only on providing the best possible inpatient rehabilitation, tailored to the distinct needs of the community. For the proposed hospital, Nobis would target stroke and medical rehabilitation programs to accommodate the high disease prevalence related to morbidity factors. Approval of the proposed project will allow Nobis to greatly expand patient access to rehabilitative care, ultimately decreasing unnecessary patient readmissions into general acute care hospitals and significantly improving the quality of life and health outcomes of Minnesotans in need of rehabilitative care.

4. **Describe the services provided:**
   a. **List the hospital-based services to be provided directly or through contract, for both acute and non-acute care (both inpatient, outpatient and ambulatory care).**

      Nobis' programs are tailored to the needs of the market, but initially we would offer all primary rehabilitation services. Patient care areas would be included as direct services unless noted as contracted services:

      - Physical Medicine and Rehabilitation Physicians

- Medical Management
- Rehabilitative Nursing
- Occupational Therapy
- Physical Therapy
- Psychology
- Respiratory Therapy (if applicable as determined by Medical Director as a need with patient population)
- Speech Language Pathology
- Case Management- Patient and Family Relations
- Clinical Nutrition
- Laboratory (Contracted Service)
- Pharmacy
- Radiology (Contracted Service)
- Dialysis (Contracted Service)

b. Describe specific services including, for example, imaging/radiology, ambulatory surgery, cancer treatment, or dialysis services.

Services and advanced treatment techniques incorporated into Nobis' individualized rehab programs may include:

- Bowel and bladder management
- Pain management
- Diabetes management
- Spasticity management
- Wound care
- Balance and vestibular rehabilitation
- Mobility courtyard
- Home-like simulation (ADL suite)
- Dysphagia therapy
- Cognitive retraining
- Visual field loss
- Visual spatial neglect
- As noted in 4.A, Radiology and Dialysis and Lab services would be provided as a contract service.

c. Provide an overview of new or improved services to be offered in the primary service area.

Nobis' proposed Minneapolis Rehabilitation Hospital will be able to provide dedicated areas for specialty rehab services and equipment and offer a greater volume of inpatient rehab trained providers, therapists and nurses. Nobis rehab hospitals focus only on providing the best possible inpatient rehabilitation, tailored to the distinct needs of the community. For the proposed hospital, Nobis would initially target stroke and medical rehabilitation focused programs to accommodate the high disease prevalence related to morbidity factors. Approval of the

proposed project will allow Nobis to greatly expand local and regional patient access to rehabilitative care.

5. **Detail the number of licensed beds to be requested and describe whether these will be new beds or drawn from within affiliated hospital system or partnership's existing capacity.**

   The proposed project includes a new 60-bed inpatient rehabilitation hospital. These beds would not be drawn from the existing PSA supply of beds, thus representing a net increase of 60 inpatient rehabilitation beds in the planning area.

6. **Breakdown beds and outpatient care by service category including, for example, the number of medical/surgical, intensive care unit (ICU/CCU), pediatrics, obstetrics, mental health/chemical dependency, and rehabilitation beds.**

   All beds will be utilized for inpatient rehabilitation services.

7. **Provide the proposed admissions criteria or anticipated patient population including, but not limited to, patient diagnoses, acuity or complication levels, and exclusions for admission or provision of services.**

   Please see Exhibit 3 for a copy of our policy for Inpatient Rehabilitation Hospital Admission, Continued Stay, and Discharge Criteria.

8. **Indicate which type(s) of health insurance payment, if any, the hospital plans to receive, for example, Medicare, Medicaid, commercial insurance, worker's comp, auto-med.**

   Nobis plans to accept all types of health insurance payment. Following approval of the proposed project, Nobis will obtain CMS certification for the new rehabilitation hospital. Nobis rehab hospitals admit both unfunded/charity care patients and patients with limited financial resources/coverage following a clinical assessment to determine the criteria are met for intensive rehabilitation. See Exhibit 2.

9. **Describe any imaging, ambulatory surgery, cancer treatment, or dialysis service agreements.**

   Nobis will contract radiology, lab, dialysis, and medical staffing services. The Minneapolis Rehabilitation Hospital is an inpatient rehab hospital focused on providing medical and physical rehabilitation. Patients in need of outpatient services, anesthesia, or surgical procedures will be referred to a local provider.

10. **If an Emergency Department is planned, describe the likely trauma designation.**

    Minneapolis Rehabilitation Hospital is an inpatient rehabilitation hospital without an Emergency Department. This question is not applicable.

11. Describe any provider groups affiliated with, or committed to, the hospital project.

Given that Nobis is not yet operating in Minnesota, it is premature to identify provider group relationships. However, in other markets in which Nobis operates, key affiliations include short term acute care hospitals and their employed physicians as well as other medical groups. For example, in Milwaukee, Nobis has partnerships with the acute care providers Froedtert Memorial Lutheran Hospital and West Allis Memorial Hospital, as well as with the post-acute care providers Linden Grove, Villages of Manor Park, Alexian Village, Brookdale, Oak Creek Place, Wilson Commons, Horizon HHC, Pinnacle, and Therapy at home and numerous medical groups.

12. To the extent possible, please provide information on whether these provider groups currently hospitalize patients and at which facilities patients are hospitalized.

Please see our response to Question 11 above.

13. Describe the site for the proposed project. If additional approvals from local board(s) are needed, please include information on when the project will be heard.

The identified site for the proposed project is 0 Centre Point Dr., Roseville, MN 55113, a 4.5-acre lot that is within the Centre Pointe Business Park. The identified site is zoned as E-2 Employment Center.[4] Within the E-2 zones, hospitals are allowed with a conditional use permit, which is typical for hospital approvals.[5] However, it should be noted that given a potentially lengthy approval process and timeline, the proposed site could change due to availability and access.

Current plans for the proposed hospital include a 63,200 sq. ft., three-story building, with a parking lot that will be code-compliant. Our proposed Minneapolis Rehabilitation Hospital will include 60 private rooms, each with its own ensuite bathroom and shower. The hospital will also include two therapy gyms, a procedure room, extra-wide corridors to accommodate adaptive equipment, and an activity of daily living apartment suite. There will also be an outdoor therapy courtyard, which includes different walking surfaces and a concrete ramp/stairs to be used as part of patient rehabilitation activities.

14. Estimate the total cost of the project including completion of Sections 56 and 57 of the Hospital Annual Report (Capital Expenditure Commitment and Detail). What proportion of the total cost is specific to the proposed hospital?

Please see Table 2 below for projected capital expenditures of the Minneapolis Rehabilitation Hospital.

[4] Zoning-Map (cityofroseville.com), Last Accessed July 13, 2023.
[5] Microsoft Word - PROJ0044_Phase_1_CC_Ordinance_20211108-PASSED (cityofroseville.com), page 87. Last Accessed July 13, 2023.

Table 2: Capital Expenditures	
Item	Amount
Land	$3,484,800
Building Construction	$34,475,200
Furniture, fixtures, and equipment	$1,949,443
Sales Tax (7.375%)	$2,943,321
Total	**$42,852,765**
Source: Applicant	

15. A description of the sources of financing of the project, including municipal bonding, investment capital, private equity or other forms of financing.

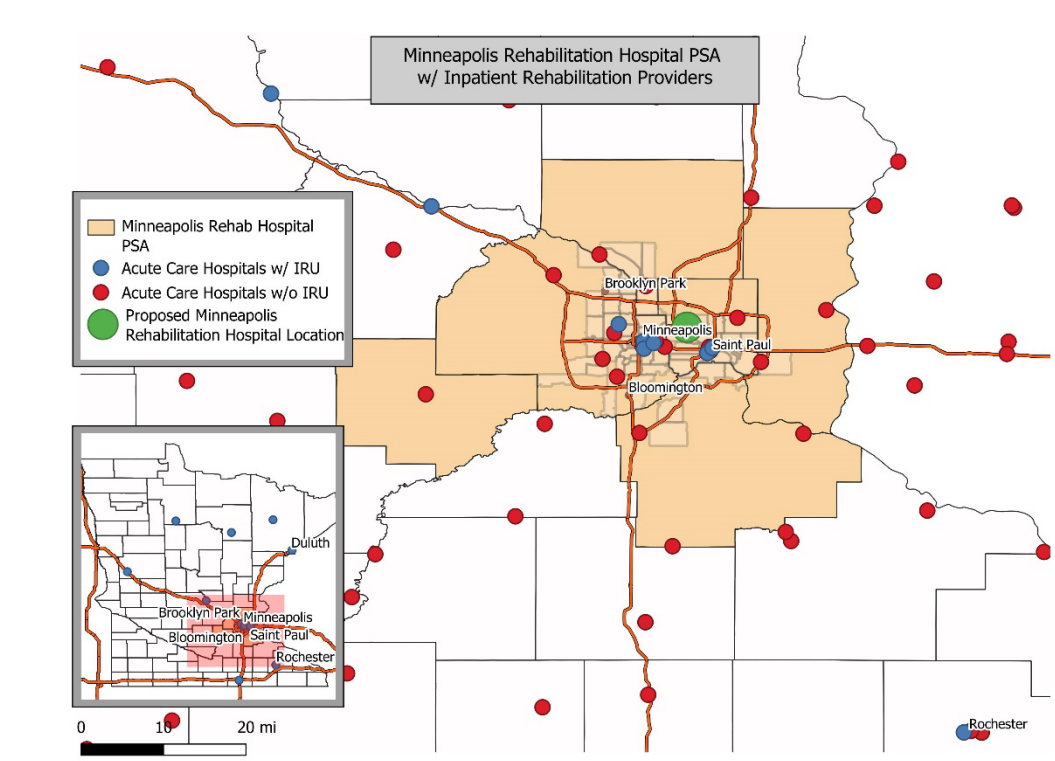
Sources of funding for the project will be comprised of conventional first lien bank debt, along with invested equity from the Developer/Real Estate owner.

IV. Project Need

1. Define the primary service area for the proposed hospital. Please describe the rationale and methods for selecting this area.

The proposed hospital will be in Roseville, MN in Ramsey County, with a Primary Service Area defined as the 7 counties that are part of Minnesota's Economic Development Region 11 ("EDR 11"). These counties include Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. We include a map of this planning area in Figure 3 below and in Exhibit 4.

Figure 3: Planning Area Map



Source: Applicant

This area was selected based on the likely patient catchment area for the proposed hospital. Since this is a specialty rehabilitation hospital, its patients will likely come from a larger geographic area than for a similarly sized short term acute care hospital. As demonstrated in Figure 3, outside of the IRUs in Hennepin and Ramsey counties, there are no other inpatient rehabilitation services in the Primary Service Area. Based on Nobis' experience, and the patterns observed in other states with freestanding rehabilitation hospitals, this 7-county PSA definition is very reasonable.

Furthermore, while there is no record of public interest reviews for inpatient rehabilitation services in Minnesota, the review requests for freestanding psychiatric hospitals, an analogous specialty service, show similarly sized planning areas. For example, the 2021 public interest review request

from Fairview Health Services and Acadia Healthcare defines a 15-county planning area centered around Ramsey County for its 144-bed inpatient psychiatric hospital.

2. **Provide demographic summary of population estimates and projections, if available, for PSA expressed in ZIP codes or another appropriate geographic measure. Include detail regarding: current and future population by age, gender, race, ethnicity, and levels of income relative to federal poverty guidelines or other social determinants of health. Describe the data sources, methods and assumptions used to make these population estimates and projections. This includes projection work done for this project.**

We define our Primary Service Area ("PSA" or "planning area") as the seven-county Economic Development Region 11 ("EDR 11").[6] We present population forecasts for each of the seven counties in Table 3.

Table 3: Population by Geographic Area, 2020 to 2035

Pop Total	2020	2025	2030	2035	2020 to 2025 Average Annual Growth	2025 to 2030 Average Annual Growth	2030 to 2035 Average Annual Growth
Anoka	364,299	371,663	382,053	391,003	0.40%	0.56%	0.47%
Carver	107,286	113,544	120,417	127,034	1.17%	1.21%	1.10%
Dakota	440,317	447,609	460,122	470,901	0.33%	0.56%	0.47%
Hennepin	1,281,267	1,312,559	1,349,791	1,381,964	0.49%	0.57%	0.48%
Ramsey	551,480	560,754	569,538	575,808	0.34%	0.31%	0.22%
Scott	151,265	159,731	168,321	176,497	1.12%	1.08%	0.97%
Washington	268,191	276,702	287,452	297,279	0.63%	0.78%	0.68%
PSA (EDR 11) Total	**3,164,105**	**3,242,562**	**3,337,694**	**3,420,486**	**0.50%**	**0.59%**	**0.50%**
Minnesota State	**5,707,165**	**5,833,655**	**5,976,058**	**6,095,113**	**0.44%**	**0.49%**	**0.40%**

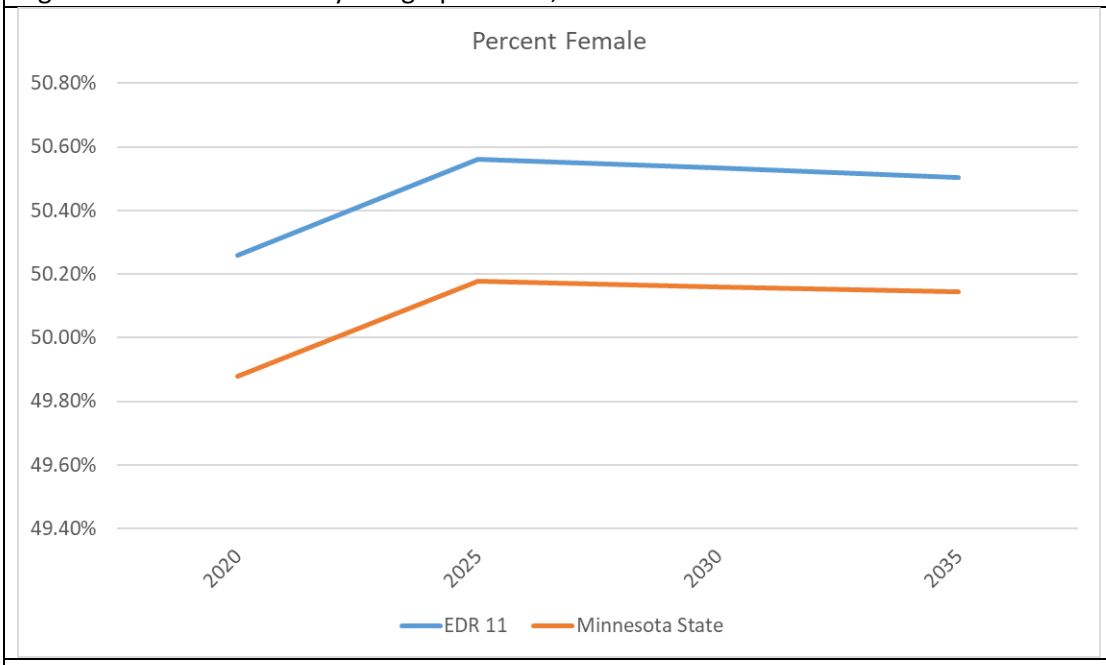
Source: Minnesota State Demographic Center, Minnesota Long Term Population Projections. https://mn.gov/admin/assets/2023-Minnesota-Long-Term-Population-Projections_tcm36-565112.xlsx, Last Accessed 21 June, 2023.

Weighted by population, the counties within the PSA are growing on average about 0.55% per year between 2020 and 2030, and on average, are expected to grow about 0.50% per year between 2030 and 2035. This outpaces Minnesota State overall, and the growth in these seven counties is forecast to constitute over 2/3rds of the total population change across all of Minnesota. The rates of growth within the PSA vary by county. Population in Carver and Scott counties is forecast to grow the fastest, although these represent the counties with the lowest population bases within the PSA. Hennepin is the most populous county in the PSA and paces the overall annual planning area growth at about

[6] EDR 11 includes: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.

0.57% between 2025 and 2030 and about 0.48% between 2030 and 2035. Stratified by gender, the proportion of female residents is forecast to increase. We present the percent female in the PSA and Minnesota State in Figure 4.

Figure 4: Percent Female by Geographic Area, 2020 to 2035



Source: Minnesota State Demographic Center, Minnesota Long Term Population Projections. https://mn.gov/admin/assets/2023-Minnesota-Long-Term-Population-Projections_tcm36-565112.xlsx, Last Accessed 21 June, 2023.

From Figure 4, the proportion of the female population is slightly higher in the PSA (EDR 11) than in Minnesota overall, likely a reflection of the high rates of urbanization in Hennepin and Ramsey counties. The proportion female is forecast to increase slightly between 2020 and 2025, then remain relatively stable over the remaining forecast period. With regards to the use of rehabilitation services, gender mix in a geographic area can be important since women have higher life expectancies and can inform how a population is expected to age. Population forecasts by age cohort groups over the 2020 to 2035 period are presented in Table 4.

Table 4: Population by Age Group and Geographic Area, 2020 to 2035

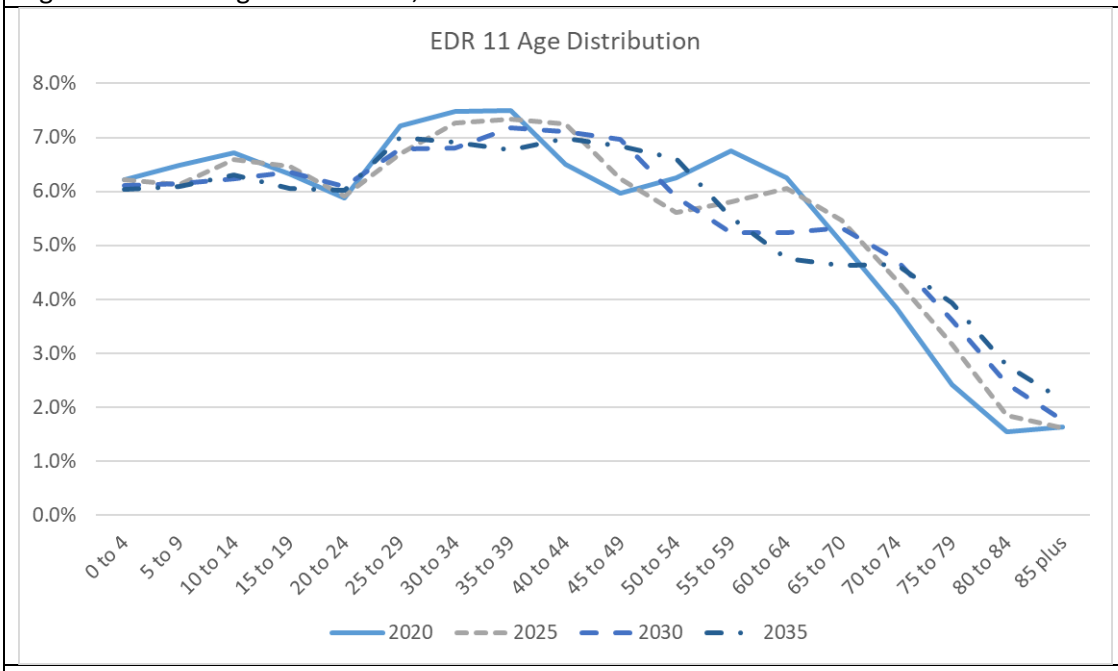
	0 to 17	18 to 64	65 plus	Total
PSA (EDR 11)				
2020	734,008	1,971,611	458,486	3,164,105
2025	739,008	1,970,076	533,478	3,242,562
2030	745,215	1,996,502	595,977	3,337,694
2035	754,126	2,046,546	619,814	3,420,486
2020 to 2035 Avg Annual %Δ	0.18%	0.25%	2.35%	0.54%

Minnesota State				
2020	1,323,716	3,453,410	930,039	5,707,165
2025	1,334,936	3,436,531	1,062,188	5,833,655
2030	1,343,503	3,465,938	1,166,617	5,976,058
2035	1,359,693	3,542,568	1,192,852	6,095,113
2020 to 2035 Avg Annual %Δ	0.18%	0.17%	1.88%	0.45%

Source: Minnesota State Demographic Center, Minnesota Long Term Population Projections. https://mn.gov/admin/assets/2023-Minnesota-Long-Term-Population-Projections_tcm36-565112.xlsx, Last Accessed 21 June, 2023.

As presented in Table 4, the population in EDR 11 and Minnesota State is growing across all ages, although fastest for the 65 plus age group. Proportion-wise, EDR 11 is slightly younger than Minnesota state overall, with about 14.5% of its population aged 65+ in 2020. For comparison, in Minnesota state overall, the proportion aged 65+ is about 16.3%. However, the PSA is forecast to age faster than Minnesota overall, where between 2020 and 2035 the number of persons aged 65 and over is forecast to grow on average about 2.35% per year in EDR 11, compared to just 1.88% per year for Minnesota. This suggests a shifting age distribution across the proposed planning area, which we present in Figure 5 for 2020 and the forecast years 2025, 2030, and 2035.

Figure 5: EDR 11 Age Distribution, 2020 to 2035



Source: Minnesota State Demographic Center, Minnesota Long Term Population Projections. https://mn.gov/admin/assets/2023-Minnesota-Long-Term-Population-Projections_tcm36-565112.xlsx, Last Accessed 21 June, 2023.

From Figure 5, the PSA age distribution is forecast to shift towards older ages, resulting in a greater number of residents in the 65 plus age groups. By 2035, the proportion of residents 65 and over is forecast to equal about 18.1%.

In addition to being slightly younger, the planning area population is also significantly more diverse than Minnesota overall. In 2020, about 29% of PSA residents identified as a non-white, compared to only 21.5% for Minnesota State as-a-whole. For residents outside the PSA, only about 12.5% of persons in Minnesota identified as non-white. We present population by race for the PSA and Minnesota State in Table 5.[7]

Table 5: Distribution by Race and Geographic Area, 2020, 2030, and 2035

	White	Black	AIAN	Asian	NHPI	2+	Hisp
PSA (EDR 11)							
2020	2,253,868	332,859	17,976	256,771	1,525	90,505	210,601
2030	2,212,659	424,745	17,568	321,384	1,846	111,610	247,882
2035	2,181,116	474,290	17,257	354,905	2,024	123,179	267,715
2020 to 2035 Avg Annual %Δ	-0.22%	2.83%	-0.27%	2.55%	2.18%	2.41%	1.81%
Minnesota State							
2020	4,478,755	400,973	60,372	299,463	3,214	136,962	327,426
2030	4,429,040	529,754	64,724	377,056	4,434	171,604	399,446
2035	4,380,251	598,952	66,417	417,059	5,082	190,262	437,090
2020 to 2035 Avg Annual %Δ	-0.15%	3.29%	0.67%	2.62%	3.87%	2.59%	2.23%

Source: Minnesota State Demographic Center, Minnesota Long Term Population Projections. https://mn.gov/admin/assets/2023-Minnesota-Long-Term-Population-Projections_tcm36-565112.xlsx, Last Accessed 21 June, 2023.

Across both the PSA and Minnesota state, the population is forecast to become more diverse, with the proportion non-white growing by about 10 percentage points in each market. In addition to becoming more diverse, there is also variation in minority populations within the planning area. We present population by race for the seven counties within the planning area in Table 6.

Table 6: Distribution by Race for EDR 11 Counties, 2020 and 2035

	White	Black	AIAN	Asian	NHPI	2+	Hisp
Anoka							
2020	78.34%	7.82%	0.61%	5.30%	0.05%	2.79%	5.09%

[7] Note: In Table 5, "AIAN" is defined as American Indian & Alaska Native. "NHPI" is defined as Native Hawaiian & Pacific Islander.

2035	67.93%	13.03%	0.65%	7.29%	0.07%	3.64%	7.39%
Carver							
2020	87.96%	2.14%	0.22%	3.46%	0.03%	1.76%	4.44%
2035	83.81%	3.73%	0.22%	4.56%	0.05%	2.52%	5.10%
Dakota							
2020	76.24%	7.66%	0.36%	5.35%	0.07%	2.67%	7.65%
2035	67.09%	12.14%	0.43%	6.65%	0.08%	3.49%	10.12%
Hennepin							
2020	67.96%	13.72%	0.66%	7.54%	0.04%	3.02%	7.07%
2035	62.20%	16.77%	0.50%	9.30%	0.04%	3.63%	7.56%
Ramsey							
2020	60.21%	12.75%	0.58%	15.50%	0.05%	3.25%	7.66%
2035	50.62%	15.57%	0.48%	20.83%	0.06%	4.08%	8.35%
Scott							
2020	79.04%	5.64%	0.81%	6.51%	0.07%	2.36%	5.56%
2035	70.76%	10.27%	0.85%	7.50%	0.07%	3.16%	7.38%
Washington							
2020	80.59%	5.10%	0.41%	6.79%	0.06%	2.43%	4.63%
2035	73.03%	7.36%	0.43%	9.27%	0.09%	3.40%	6.41%

Source: Minnesota State Demographic Center, Minnesota Long Term Population Projections. https://mn.gov/admin/assets/2023-Minnesota-Long-Term-Population-Projections_tcm36-565112.xlsx, Last Accessed 21 June, 2023.

Within EDR 11, Hennepin and Ramsey counties contain the greater number and proportion of minority populations. In 2020, about one-third of Hennepin's population and two-fifths of Ramsey's population identified as non-white. Within Hennepin, the largest minority population is that of Black/African American persons, while for Ramsey County, Asian is the largest minority group. Across all counties within the PSA, the minority shares of the population are forecast to grow.

We present poverty rates[8] for the planning area counties and Minnesota State in Table 7.

[8] These poverty rates are determined by comparing family income in a given county to Federal Poverty Guidelines. The poverty line is defined as 100% of Federal Poverty Guide. Poverty rates represent the percentage of persons below the poverty line in a given geographic area.

Table 7: Poverty Rates for Planning Area Counties, 2021

	% Below Poverty Level
Anoka	6.6%
Carver	5.3%
Dakota	4.6%
Hennepin	9.7%
Ramsey	12.5%
Scott	4.1%
Washington	5.2%
Planning Area Total	**8.3%**
Minnesota State	**9.3%**

Source: U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates, Table S1701, https://api.census.gov/data/2021/acs/acs1/subject, Last Accessed June 27, 2023

From the data presented in Table 7, poverty rates across the planning area are lower than Minnesota State overall. However, these rates vary by county and Ramsey County has one of the highest poverty rates of all Minnesota counties with 12.5% of its population falling below the poverty line.[9] Hennepin County has a poverty rate approximately equal to the state average, and Anoka, Carver, Dakota, Scott, and Washington counties all have among the lowest poverty rates of all Minnesota counties. However, of all the persons in Minnesota below the poverty line, about half (49.5%) live in one the planning area counties.[10]

Most persons under the poverty level were part of the available labor force, and of those, most were unemployed. However, there exist significant populations of the working poor in EDR 11 and in Minnesota. We present the population proportions by employment status for persons under the poverty line and in the labor force in Table 8.

[9] https://mndatamaps.web.health.state.mn.us/interactive/poverty.html, Last Accessed June 27, 2023.
[10] Estimates from the 2021 American Community Survey indicate about 519,731 residents of Minnesota live below the poverty line, which is defined as 100% of Federal Poverty Guidelines for a given year, as measured across different family sizes, and of these, about 257,677 live in one the counties part of EDR 11 (the proposed planning area).

Table 8: Employment status for persons under the poverty line and in the labor force, 2021

	Worked full-time, year-round in the past 12 months	Worked part-time or part-year in the past 12 months	Did not work
Anoka	9.5%	26.3%	64.3%
Carver	8.0%	18.6%	73.3%
Dakota	8.4%	40.4%	51.2%
Hennepin	7.6%	39.7%	52.7%
Ramsey	6.3%	35.2%	58.5%
Scott	13.7%	34.9%	51.4%
Washington	11.7%	27.9%	60.3%
Planning Area Total	**7.9%**	**36.3%**	**55.8%**
Minnesota State	**7.9%**	**37.0%**	**55.1%**

Source: U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates, Table S1701, https://api.census.gov/data/2021/acs/acs1/subject, Last Accessed June 27, 2023

The counties with the largest proportion of working poor include Dakota (49% of labor force under poverty line), Hennepin (47% of labor force under poverty line), and Scott (49% of labor force under poverty line). Within Dakota and Hennepin counties, most of the working poor were persons with only part time or seasonal work, while in Scott County, nearly 14% of persons in poverty held a full-time, year-round job.

Understanding the demographic profile of the planning area is important for understanding the present and future resident need for inpatient rehabilitation services. While residents of the planning area are, on average, currently younger than the state overall, due to its sheer number of people, the planning area nevertheless contains about half of all Minnesota residents aged 65 and over. Furthermore, as planning area residents are forecast to age faster than Minnesota overall, this proportion will grow. The large and rapidly growing senior population in the PSA suggests that the need for inpatient rehabilitation services will continue to grow.

The relatively diverse population of the planning area, especially within Hennepin and Ramsey counties, also informs the need for inpatient rehabilitation services. Minority groups in the U.S. have historically been disadvantaged and are more likely to live in low-income and disadvantaged

neighborhoods,[11] be uninsured,[12] and have lower life expectancy.[13] Furthermore, Black Americans have higher rates of cardiovascular disease,[14] hypertension, [15] cancer,[16] and cerebrovascular disease.[17]

Many of the increased risk factors for minority populations are driven by the higher rates of poverty in these populations. Institutional racism and discrimination contribute to unequal social and economic opportunities, and residents of impoverished communities often have reduced access to resources that are needed to support a healthy quality of life, such as stable housing, healthy foods, and safe neighborhoods.[18] Furthermore, persons with low income have higher rates of physical limitation, heart disease, diabetes, stroke, and other chronic conditions.[19] Together, these indicate poverty is an important metric in itself, as well as an important mediator in how race and ethnicity are related to health outcomes. As with its other hospitals, Nobis will develop rehabilitation programs that respond to the unique needs of its local service area.

In addition to affecting the pattern of utilization and access, areas with higher rates of poverty will have different rates of health insurance coverage and different patterns of referrals for inpatient rehabilitation care. Importantly, Nobis will accept all types of health insurance payment and obtain CMS certification for the new hospital. Other Nobis hospitals admit people who are unfunded/charity care patients or have limited financial funds; Nobis plans to implement this same objective for the Minneapolis Rehabilitation Hospital. See the Financial Assistance Policy included in Exhibit 2. These measures will ensure all persons, regardless of whether they are insured through Medicare, Medicaid, or not insured at all, have access to needed inpatient rehabilitation services upon meeting the rehabilitative admission criteria.

3. Provide primary service area utilization estimates for the proposed hospital as follows:

a. Projected utilization volumes for the proposed hospital by service.

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[11] Singh GK, Azuine RE, Siahpush M. Widening socioeconomic, racial, and geographic disparities in HIV/AIDS Mortality in the United States 1987-2011. Advances in Preventive Medicine. 2013 DOI: 10.1155/2013/657961. Epub 7 May 2013.

[12] U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates, Table S2701, https://api.census.gov/data/2021/acs/acs1/subject, Last Accessed June 27, 2023.

[13] Kochanek, Kenneth D., Sherry L Murphy, Jiaquan Xu, and Betzaida Tejada-Vera. 2019. Deaths: Final Data for 2017. National Vital Statistics Reports, Vol 68(9). https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf, Last Accessed June 27, 2023.

[14] Singh GK, Siahpush M, Azuine RE, Williams SD. 2015. Widening socioeconomic and racial disparities in cardiovascular disease mortality in the United States 1969-2013. International Journal of MCH and AIDS, Vol 3(2):106–118.

[15] Kochanek, Kenneth D., Sherry L Murphy, Jiaquan Xu, and Betzaida Tejada-Vera. 2019. Deaths: Final Data for 2017. National Vital Statistics Reports, Vol 68(9). https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf, Last Accessed June 27, 2023.

[16] Ibid.

[17] Ibid.

[18] https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty, Lase Accessed June 27, 2023.

[19] Dhruv Khullar Dave A. Chokshi. 2018. Health, Income, & Poverty: Where We Are & What Could Help. Health Affairs Policy Brief. https://doi.org/10.1377/hpb20180817.901935, Last Accessed June 27, 2023.

b. Current and future service utilization rates by service, age, gender, and race/ethnicity.

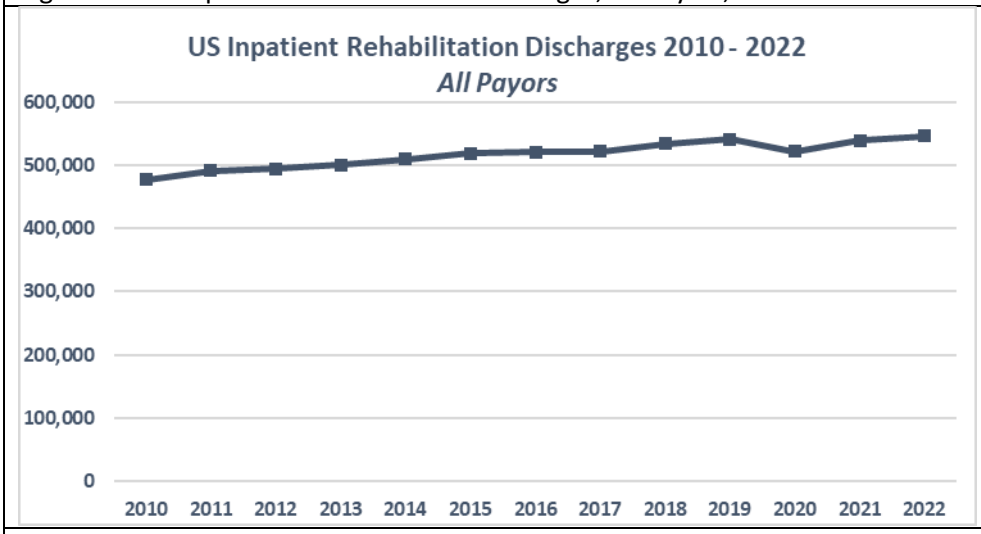
c. Current and future average length of stay by age, gender, and race/ethnicity.

Nobis has projected a **2035 Total Gross Bed Need of 334 IRF beds** in the seven-county PSA, with a **Net Bed Need 183 IRF beds** after subtracting the current inventory of 151 IRF beds in the PSA. However, before detailing the specific components of the Nobis bed need methodology, it is important to consider several key components of the current IRF industry. The following five industry and market factors are central to the inpatient bed need assessment for the Nobis PSA.

1. National Inpatient Rehabilitation Utilization

While the number of IRF/IRU beds in the State has decreased 26 percent from 2012 to 2022 (from 362 beds in 2012 to 269 beds in 2022) and five percent in the Nobis seven-county PSA (from 159 beds in 2021 to 151 beds in 2022), nationally, rehabilitation use has experienced annual increases for most of the last 10+ years. In fact, since 2010 there have been consistent annual increases in IRF/IRU utilization nationally, with only a 3.6 percent decrease in 2020 that was driven by the COVID-19 pandemic interruptions to the health care system nationally. Figure 6 and Table 9 provide a summary of national inpatient rehabilitation discharges 2010 – 2022 as reported by Uniform Data Systems for Medical Rehabilitation. (UDSMR is a rehabilitation outcome measurement system that captures data on 75 – 80 percent of all inpatient rehabilitation discharges nationally).

Figure 6: U.S. Inpatient Rehabilitation Discharges, All Payers, 2010 to 2022



Source: Uniform Data Systems for Medical Rehabilitation

Table 9: U.S. Inpatient Rehabilitation Discharges, All Payers, 2010 to 2022

Inpatient Rehab Metric	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
IP Rehab Discharges	477,243	490,968	494,469	500,175	509,818	518,940	520,653	522,180	533,707	541,614	521,860	539,106	546,175
% Growth From Prior Year		2.9%	0.7%	1.2%	1.9%	1.8%	0.3%	0.3%	2.2%	1.5%	-3.6%	3.3%	1.3%

Source: Uniform Data Systems for Medical Rehabilitation

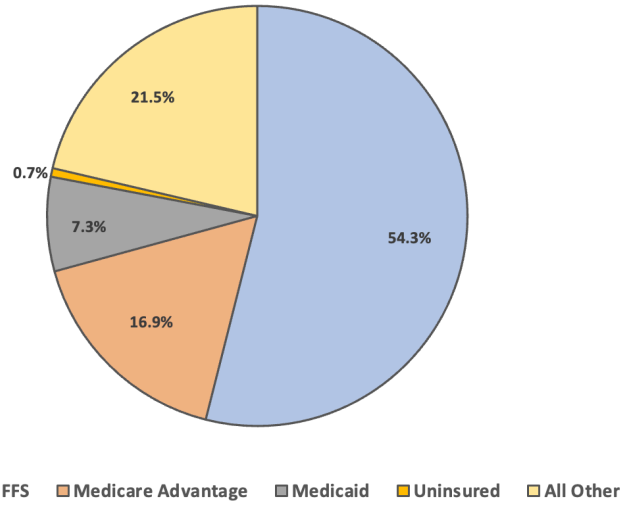
As can be seen in Figure 6 and Table 9, the national inpatient rehabilitation discharges increased approximately 0.5 percent to 2.0 percent annually 2010 – 2019, resulting in a 13.5 percent increase over this nine-year period. There was a 3.6% decrease in utilization in 2020 that was COVID related, although the annual growth in utilization resumed in 2021, and by 2022 the national utilization had exceeded pre-COVID levels.

Over the last 10 – 12 years, this growth trend in rehabilitation has proven to be stable in spite of many changes to the industry such as payor mix, regulations, reimbursement, referral sources and patient mix. As such, this same pattern of one percent to two percent growth per year is projected to continue for the foreseeable future.

2. Medicare Utilization of Inpatient Rehabilitation

When assessing inpatient rehabilitation demand and bed need, it is important to recognize the significant impact that Medicare utilization has on overall industry trends. As Figure 7 shows, Medicare accounts for 71 percent of all rehabilitation admissions nationally, with Medicare Fee-For-Service (Medicare FFS/traditional Medicare) representing 54 percent of all discharges and Medicare Advantage representing 17 percent.

Figure 7: U.S. IP Rehabilitation Discharges by Financial Class, 2022



Source: Uniform Data Systems for Medical Rehabilitation

Because of the impact Medicare trends have on rehabilitation utilization, it is important to note that for the 10 consecutive years prior to the pandemic the total Medicare rehabilitation discharges increased approximately 1.0 – 2.0 percent annually, as shown in Table 10, for an average annual growth rate of 1.6 percent for this period. While there was a 5.2 percent decrease in Medicare utilization in 2020 due to the COVID pandemic, utilization has again

increased in both 2021 and 2022, and with the current Medicare growth rate it was expected to reach full pre-pandemic levels by the end of 2023.

Table 10: U.S. Inpatient Rehabilitation Discharges, Medicare Only, 2010 to 2022

Rehab Metric	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Medicare Discharges	342,084	354,409	358,752	363,969	368,925	375,353	376,720	379,088	388,604	395,461	374,972	380,080	388,973
% Growth From Prior Year	-	3.6%	1.2%	1.5%	1.4%	1.7%	0.4%	0.6%	2.5%	1.8%	-5.2%	1.4%	2.3%

Source: Uniform Data Systems for Medical Rehabilitation
Notes: Includes both Medicare FFS and Medicare Advantage

Along with the overall increases in Medicare utilization of inpatient rehabilitation, an important metric for rehabilitation planning is the percentage of Medicare acute care patients that are discharged into inpatient rehabilitation annually. The Medicare discharge rate from acute care to rehabilitation is particularly important for rehabilitation planning because referrals from acute care hospitals represent **92 percent of all rehabilitation admissions nationally**. The remaining eight percent of referrals to rehabilitation originate from Skilled Nursing Facilities (SNFs), LTCHs, home, and other miscellaneous sites.

As Table 11 shows, the percent of Medicare FFS acute care patients discharged from acute care into inpatient rehabilitation has increased each year from 2009 – 2020. (While there was a decrease in actual Medicare FFS rehabilitation discharges in 2020, as shown in Table 10 above, the percent of Medicare FFS patients discharged into rehabilitation actually increased during this period, as seen in Table 11. This was likely driven by COVID interruptions within acute care providers). While national information regarding the discharge rates of Medicare Advantage is not available, since Medicare Advantage plans include dozens of insurers, the gross number of Medicare Advantage rehabilitation discharges has increased annually as well, even though the Medicare Advantage discharge rate to inpatient rehabilitation tends to be 30 – 35 percent less than that of Medicare FFS.

Table 11: Medicare FFS Acute Care to IRF/IRU Conversion Rate, 2009 to 2022

Discharge Disposition	2009	2012	2013	2014	2015	2016	2017	Estimated 2018	Estimated 2019	Estimated 2020
SNF	19.8%	20.3%	20.7%	21.0%	21.2%	20.8%	20.7%	20.0%	19.7%	19.7%
HHA	15.2%	15.9%	16.5%	16.8%	16.9%	17.2%	17.9%	17.9%	18.1%	20.4%
IRF/IRU	**3.3%**	**3.5%**	**3.6%**	**3.8%**	**3.9%**	**4.0%**	**3.8%**	**3.9%**	**4.1%**	**4.6%**
LTCH	1.1%	1.2%	1.2%	1.2%	1.2%	1.1%	1.1%	1.0%	0.9%	0.9%
Hospice	2.1%	2.7%	2.7%	2.9%	3.0%	3.0%	3.1%	3.2%	3.5%	4.1%
Total	**41.5%**	**43.6%**	**44.7%**	**45.7%**	**46.2%**	**46.1%**	**46.6%**	**46.1%**	**46.4%**	**49.7%**

Source: June 2011 to March 2023 MedPAC Annual Reports to Congress and Annual Data Books. https://www.medpac.gov/document/, Last Accessed June 29, 2023

Utilization Conclusion: These Medicare trends suggest continued growth of inpatient rehabilitation, rather than a decreasing demand. The strong growth of Medicare patients utilizing inpatient rehabilitation, coupled with the projected aging of the population strongly support the planning assumptions of most rehabilitation providers that include projections of additional growth in volume for the foreseeable future.

3. Site of Care Changes

In addition to the overall growth in rehabilitation utilization over the last 10 – 12 years, as shown in Figure 6 above, another significant change that has occurred among providers is a shift from the majority of inpatient rehabilitation care being provided in smaller, hospital-based rehabilitation units to the majority of care now being provided in freestanding rehabilitation hospitals.

This shift in site of care has been occurring for two primary reasons. First, with a larger operating capacity, many freestanding IRFs are better able to create specialized clinical programs and dedicated rehab sections of care than can typically be created in smaller, hospital-based units. This includes specialty programs such as Spinal Cord Injury, Brain Injury, Stroke Rehabilitation, and other similar programs. By design, a smaller 20 to 30-bed hospital-based rehabilitation unit generally must devote all its capacity to generalized patient care, strictly limiting the potential for program specialization.

Contrary to hospital-based IRUs, most freestanding IRFs with a bed capacity of 40 – 60 beds or more will develop one or more specialized programs, with dedicated space, rehab trained staff and specialized rehab equipment, to meet the particular needs of these unique patient populations. This approach ensures that the most integrated and comprehensive clinical care is provided for each patient and is one reason why most rehabilitation care is now being provided in freestanding hospitals.

The second major reason for this shift in the site of care is that, because of their size and higher utilization, freestanding rehabilitation hospitals can achieve greater cost efficiencies and provide care at lower costs than can be achieved in smaller hospital-based rehabilitation units. In fact, a 2018 MedPAC Report to Congress documented that freestanding rehabilitation hospitals were the lowest cost setting for rehabilitation care, a summary of which was provided in Figure 1 above. This same figure also shows that the median cost per discharge decreases as the size of the rehabilitation program increases, with the most cost efficiencies achieved with programs of 65 beds or higher. As such, the proposed 60-bed Minneapolis Rehabilitation Hospital is expected to be among the most efficient providers in the State and in the region.

4. Minnesota Utilization of Inpatient Rehabilitation

At present, Minnesota has among the fewest rehabilitation beds and the lowest rehabilitation use rates in the country. Nationally, there are approximately 40,000 rehabilitation beds of all types (hospital-based units and freestanding hospitals) which equates to 11.9 beds per 100K population. The Bed-to-Population ratio ranges from a high of 30.3 beds per 100K population in Arkansas to a low of 3.0 beds per 100K population in Maryland. (We note that Maryland is the only State in the country that has never participated in the Medicare Prospective Payment System reimbursement model, and as such has utilization patterns different than all other States).

Based on the most recent information available, Minnesota appears to have the 5th lowest Bed-to-Population ratio of all 50 states (plus DC) with only 4.7 rehabilitation beds per 100K population. This Bed-to-Population ratio is less than one-half the national average of rehabilitation beds accessibility. Table 12 provides a summary of the US available rehabilitation beds by state, along with the bed per 100K population ratio.

Table 12: U.S. Inpatient Rehabilitation Beds/100K Population by State, 2020/2021

	State	2021Population (a)	IRF/IRU Beds (b)	Beds/100K Pop
1	Arkansas	3,028,122	914	30.2
2	Louisiana	4,627,098	1,331	28.8
3	District of Columbia	668,791	153	22.9
4	Pennsylvania	13,012,059	2,783	21.4
5	Texas	29,558,864	5,526	18.7
6	Kansas	2,937,922	551	18.8
7	Nevada	3,146,402	581	18.5
8	West Virginia	1,785,526	319	17.9
9	South Carolina	5,193,266	896	17.3
10	New Hampshire	1,387,505	233	16.8
11	Missouri	6,169,823	966	15.7
12	Indiana	6,813,532	1,049	15.4
13	Delaware	1,004,807	153	15.2
14	Tennessee	6,968,351	1,048	15.0
15	Alabama	5,049,846	747	14.8
16	Oklahoma	3,991,225	586	14.7
17	Arizona	7,264,877	1,053	14.5
18	New Mexico	2,116,677	307	14.5
19	Ohio	11,764,342	1,639	13.9
20	Nebraska	1,963,554	270	13.8
21	Kentucky	4,506,589	618	13.7
22	Florida	21,828,069	2,889	13.2
23	Wyoming	579,483	76	13.1
24	Iowa	3,197,689	408	12.8
25	Massachusetts	6,989,690	848	12.1
26	New Jersey	9,267,961	1,065	11.5
27	South Dakota	896,164	101	11.3
28	Mississippi	2,949,586	337	11.4
29	North Dakota	777,934	85	10.9
30	Michigan	10,037,504	1,092	10.9
31	Maine	1,377,238	145	10.5
32	Illinois	12,686,469	1,346	10.6
33	Virginia	8,657,365	897	10.4
34	Utah	3,339,113	311	9.3
35	Idaho	1,904,314	169	8.9
36	Colorado	5,811,297	530	9.1
37	North Carolina	10,565,885	944	8.9
38	Rhode Island	1,096,985	91	8.3
39	Georgia	10,788,029	878	8.1
40	New York	19,857,492	1,500	7.6
41	Montana	1,106,227	74	6.7
42	Wisconsin	5,880,101	357	6.1
43	California	39,142,991	2,394	6.1
44	Hawaii	1,447,154	82	5.7
45	Vermont	646,972	34	5.3
46	Washington	7,740,745	388	5.0
47	Minnesota	5,711,471	269	4.7
48	Connecticut	3,623,355	167	4.6
49	Alaska	734,182	30	4.1
50	Oregon	4,256,301	144	3.4
51	Maryland	6,174,610	184	3.0
	Total	**332,031,554**	**39,558**	**11.9**
	Nobis PSA (c)	**3,164,105**	**151**	**4.8**

Sources: U.S. Census Bureau, AHD.com, and Minnesota State Demographic Center

While the State has a ratio of 4.7 beds per 100K population, which is 60 percent less than the national average, the Nobis seven-county PSA, with a 2020 population of approximately 3.1 million and only 151 IRF/IRU beds, has a Bed-to-Population ratio of only 4.8 beds per 100K population, which is also 60 percent less the national average of 11.9 beds per 100K population.

Importantly, the low Bed-to-Population ratio in Minnesota appears to have significantly impacted rehabilitation utilization in the State, as limited access to services is typically a major factor driving low utilization. As can be seen in Table 13, while nationally there are an estimated 218 rehabilitation discharges per 100K population, Minnesota has the 5th lowest utilization rate in the country, with only 80.3 discharges per 100K population, or 63 percent lower than the national rate. The Nobis PSA, with a use rate of 86.1 discharges per 100K population, is 60 percent less than the national rate.

Table 13: U.S. Inpatient Rehabilitation Discharges/100K Population by State, 2020/2021

	State	2021 Population (a)	Est. Discharges (b,c)	Disch/100K Pop
1	Arkansas	3,028,122	17,150	566.4
2	Delaware	1,004,807	3,923	390.4
3	Louisiana	4,627,098	18,396	397.6
4	West Virginia	1,785,526	6,747	377.9
5	Nevada	3,146,402	11,520	366.1
6	Texas	29,558,864	105,719	357.7
7	New Hampshire	1,387,505	4,987	359.4
8	Alabama	5,049,846	18,059	357.6
9	Kansas	2,937,922	10,051	342.1
10	South Carolina	5,193,266	16,990	327.2
11	Pennsylvania	13,012,059	42,325	325.3
12	Missouri	6,169,823	19,558	317.0
13	District of Columbia	668,791	2,140	320.0
14	Oklahoma	3,991,225	11,588	290.3
15	Tennessee	6,968,351	20,129	288.9
16	Indiana	6,813,532	19,704	289.2
17	Kentucky	4,506,589	12,520	277.8
18	Florida	21,828,069	56,157	257.3
19	New Mexico	2,116,677	5,403	255.3
20	Arizona	7,264,877	18,041	248.3
21	Ohio	11,764,342	29,373	249.7
22	North Dakota	777,934	1,737	223.3
23	South Dakota	896,164	1,944	216.9
24	Virginia	8,657,365	18,863	217.9
25	Massachusetts	6,989,690	14,669	209.9
26	New Jersey	9,267,961	18,988	204.9
27	Michigan	10,037,504	20,502	204.3
28	Iowa	3,197,689	6,365	199.1
29	Nebraska	1,963,554	3,894	198.3
30	Maine	1,377,238	2,697	195.8
31	Mississippi	2,949,586	5,862	198.7
32	Illinois	12,686,469	25,334	199.7
33	Colorado	5,811,297	10,550	181.5
34	Wyoming	579,483	983	169.6
35	Idaho	1,904,314	2,990	157.0
36	North Carolina	10,565,885	16,651	157.6
37	Georgia	10,788,029	16,495	152.9
38	Utah	3,339,113	4,717	141.3
39	Rhode Island	1,096,985	1,527	139.2
40	Montana	1,106,227	1,505	136.0
41	Wisconsin	5,880,101	7,267	123.6
42	New York	19,857,492	24,866	125.2
43	Hawaii	1,447,154	1,550	107.1
44	California	39,142,991	40,963	104.6
45	Connecticut	3,623,355	3,341	92.2
46	Vermont	646,972	570	88.1
47	Minnesota	5,711,471	4,587	80.3
48	Washington	7,740,745	5,969	77.1
49	Oregon	4,256,301	2,938	69.0
50	Alaska	734,182	483	65.8
51	Maryland	6,174,610	3,434	55.6
	Total	**332,031,554**	**722,721**	**217.7**
	Nobis PSA (c)	**3,164,105**	**2,725**	**86.1**

Sources: U.S. Census Bureau, AHD.com, and Minnesota State Demographic Center

The low ratio of rehabilitation Beds-to-Population, which translates into lack of access to rehabilitation care, tends to result in lower utilization of rehabilitation services, as is the case in Minnesota and the Nobis PSA. Unfortunately, when inpatient rehabilitation services are not available, many appropriate patients are instead discharged to SNFs that are not able to provide the same level of rehabilitative care. In fact, a 2014 study that analyzed patient outcomes for a two-year period following an illness or injury requiring rehabilitation found that:

- Patients treated in inpatient rehabilitation hospitals and units have better outcomes, go home earlier and live longer than patients treated in nursing homes.[20]

- Patients treated in inpatient rehabilitation hospitals and units achieve better clinical outcomes in a shorter time and use less facility-based care than those treated in nursing homes.[21]

- Patients treated in skilled nursing facilities have more emergency room visits, are readmitted to hospitals more often, and have an increased risk of death compared to clinically similar patients treated in inpatient rehabilitation hospitals and units.[22]

Additionally, as previously noted, a May 2016 report prepared by the American Heart Association and the American Stroke Association, titled "Guidelines for Adult Stroke Rehabilitation and Recovery," recommends that "Whenever possible the ASA strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility." These studies and other patient outcome analyses consistently highlight the benefits and improved outcomes over less effective alternative programs that might be available in the absence of inpatient rehabilitation.

5. Nobis PSA Demographic Trends

As noted previously, the Age 65+ age cohort is the fastest growing demographic market segment in the seven-county PSA. In fact, from the 10-year planning horizon of 2025 to 2035, while the total PSA population is projected to grow 5.5 percent, the Age 65+ age cohort in the PSA is expected to grow 16.2 percent. This significantly outpaces the state-wide growth of the Age 65+ cohort, which is projected to grow only 12.3 percent over the same 10-year period. Because Medicare beneficiaries utilize inpatient rehabilitation more than any other patient population, the rapid growth of the Age 65+ population is critical for rehabilitation planning. Table 14 and Table 15 provide a summary of the PSA population and demographic projections by age cohort, including the baseline year of 2020 and the 10-year projection period of 2025 – 2035.

[20] https://amrpa.org/For-Patients/Assessment-of-Patient-Outcomes-of-Rehabilitative-Care-Provided-in-IRFs-and-After-Discharge
[21] Ibid.
[22] Ibid.

Table 14: Nobis PSA Population Estimates by Age Cohort, 2020 to 2035

	2020			2025			2030			2035		
County	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total
Anoka	311,376	52,923	364,299	309,069	62,594	371,663	310,835	71,218	382,053	316,900	74,103	391,003
Carver	93,376	13,910	107,286	95,430	18,114	113,544	97,780	22,637	120,417	101,392	25,642	127,034
Dakota	375,292	65,025	440,317	370,737	76,872	447,609	372,834	87,288	460,122	379,768	91,133	470,901
Hennepin	1,095,209	186,058	1,281,267	1,099,657	212,902	1,312,559	1,116,362	233,429	1,349,791	1,142,200	239,764	1,381,964
Ramsey	469,919	81,561	551,480	469,826	90,928	560,754	472,993	96,545	569,538	479,534	96,274	575,808
Scott	133,964	17,301	151,265	137,409	22,322	159,731	140,289	28,032	168,321	143,949	32,548	176,497
Washington	226,483	41,708	268,191	226,956	49,746	276,702	230,624	56,828	287,452	236,929	60,350	297,279
Total	**2,705,619**	**458,486**	**3,164,105**	**2,709,084**	**533,478**	**3,242,562**	**2,741,717**	**595,977**	**3,337,694**	**2,800,672**	**619,814**	**3,420,486**
State	**4,777,126**	**930,039**	**5,707,165**	**4,771,467**	**1,062,188**	**5,833,655**	**4,809,441**	**1,166,617**	**5,976,058**	**4,902,261**	**1,192,852**	**6,095,113**

Source: Minnesota State Demographic Center

Table 15: Nobis PSA Population Growth by Age Cohort, 2020 to 2035

	2020 - 2025 Percent Growth			2025 - 2030 Percent Growth			2030 - 2035 Percent Growth			2025 - 2035 Percent Growth		
County	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total
Anoka	-0.7%	18.3%	2.0%	0.6%	13.8%	2.8%	2.0%	4.1%	2.3%	2.5%	18.4%	5.2%
Carver	2.2%	30.2%	5.8%	2.5%	25.0%	6.1%	3.7%	13.3%	5.5%	6.2%	41.6%	11.9%
Dakota	-1.2%	18.2%	1.7%	0.6%	13.5%	2.8%	1.9%	4.4%	2.3%	2.4%	18.6%	5.2%
Hennepin	0.4%	14.4%	2.4%	1.5%	9.6%	2.8%	2.3%	2.7%	2.4%	3.9%	12.6%	5.3%
Ramsey	0.0%	11.5%	1.7%	0.7%	6.2%	1.6%	1.4%	-0.3%	1.1%	2.1%	5.9%	2.7%
Scott	2.6%	29.0%	5.6%	2.1%	25.6%	5.4%	2.6%	16.1%	4.9%	4.8%	45.8%	10.5%
Washington	0.2%	19.3%	3.2%	1.6%	14.2%	3.9%	2.7%	6.2%	3.4%	4.4%	21.3%	7.4%
Total	**0.1%**	**16.4%**	**2.5%**	**1.2%**	**11.7%**	**2.9%**	**2.2%**	**4.0%**	**2.5%**	**3.4%**	**16.2%**	**5.5%**
State	**-0.1%**	**14.2%**	**2.2%**	**0.8%**	**9.8%**	**2.4%**	**1.9%**	**2.2%**	**2.0%**	**2.7%**	**12.3%**	**4.5%**

Source: Minnesota State Demographic Center

As Table 15 above shows, the Age 65+ cohort is the fastest growing population segment throughout the 10-year projection period. Because Medicare is the largest market segment for inpatient rehabilitation, Nobis prepared age-adjusted projections to estimate the expected growth of rehabilitation for the projection period. The age-adjusted projections assume that 71 percent of the projected rehabilitation growth will be based upon the growth rate of the Age 65+ age cohort, since Medicare accounts for 71 percent of all rehabilitation utilization nationally, and 29 percent of the rehabilitation growth will be based upon the growth of the Age 0 – 64 cohort. The age adjusted projections are summarized in Table 16.

Table 16: Nobis PSA Estimated Age-Adjusted Inpatient Rehabilitation Growth, 2020 to 2035

	2020 - 2025 Age Adj. Growth			2025 - 2030 Age Adj. Growth			2030 - 2035 Age Adj. Growth			2025 2035 Age Adj. Growth		
County	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total	Age 0 - 64	Age 65+	Total
Anoka	-0.2%	13.0%	12.8%	0.2%	9.8%	9.9%	0.6%	2.9%	3.4%	0.7%	13.1%	13.8%
Carver	0.6%	21.5%	22.1%	0.7%	17.7%	18.4%	1.1%	9.4%	10.5%	1.8%	29.5%	31.3%
Dakota	-0.4%	12.9%	12.6%	0.2%	9.6%	9.8%	0.5%	3.1%	3.7%	0.7%	13.2%	13.9%
Hennepin	0.1%	10.2%	10.4%	0.4%	6.8%	7.3%	0.7%	1.9%	2.6%	1.1%	9.0%	10.1%
Ramsey	0.0%	8.2%	8.1%	0.2%	4.4%	4.6%	0.4%	-0.2%	0.2%	0.6%	4.2%	4.8%
Scott	0.7%	20.6%	21.4%	0.6%	18.2%	18.8%	0.8%	11.4%	12.2%	1.4%	32.5%	33.9%
Washington	0.1%	13.7%	13.7%	0.5%	10.1%	10.6%	0.8%	4.4%	5.2%	1.3%	15.1%	16.4%
Total	**0.0%**	**11.6%**	**11.7%**	**0.3%**	**8.3%**	**8.7%**	**0.6%**	**2.8%**	**3.5%**	**1.0%**	**11.5%**	**12.5%**
State	**0.0%**	**10.1%**	**10.1%**	**0.2%**	**7.0%**	**7.2%**	**0.6%**	**1.6%**	**2.2%**	**0.8%**	**8.7%**	**9.5%**

Source: Minnesota State Demographic Center
Notes: Age-Adjusted Rehabilitation Growth weights the total population growth based on 71 percent of national IRF utilization is driven by the Medicare/Age 65+ population cohort (both Medicare FFS

and Medicare Advantage), and 29 percent of IRF utilization is driven by the Age 0-64 population cohort.

Although there are significant variances in use rates based upon patient age, we do not expect notable variances in the inpatient rehabilitation use rate based upon gender or ethnicity beyond those moderated by age or socioeconomic status. The admission patterns of gender and ethnicity tend to reflect the gender and ethnic diversity of the local community, most particularly the local senior community.

Nobis PSA IRF Bed Need Projections

Utilizing the above industry information, as well as local PSA market information, Nobis has prepared the following IRF bed need projections that strongly support the development of the proposed 60-bed Minneapolis Rehabilitation Hospital. The first step was to assess the utilization of the acute care providers in the seven-county PSA, as nationally referrals from acute care hospitals account for 92 percent of all admissions into IRFs/IRUs. This assessment included the utilization by financial class for each of the local hospitals since there are wide variances for inpatient rehabilitation utilization among different payor sources. This information is summarized in Table 17.

Table 17: Nobis PSA 2020/2021 Acute Care Hospital and Utilization by Financial Class

Hospital	Beds (a)	Discharges			
		Medicare FFS	Medicare Adv	All Other	Total
Anoka County					
Mercy Hospital (b)	461	5,807	6,625	15,633	28,065
Carver County					
Ridgeview Medical Center	109	621	621	4,716	5,958
Dakota County					
Allina Health - Hastings Regina Campus	22	272	249	424	945
M Health Fairview Ridges Hospital	172	2,182	2,278	6,436	10,896
Subtotal: Dakota	194	2,454	2,527	6,860	11,841
Hennepin County					
Abbott Northwestern Hospital	577	7,232	5,694	18,440	31,366
Children's Minnesota - Minneapolis	396	8	0	13,897	13,905
Hennepin Healthcare	334	2,679	2,213	10,829	15,721
M Health Fairview Southdale Hospital	332	3,812	4,048	8,908	16,768
M Health Fairview U of M Med Ctr	622	4,383	3,521	17,342	25,246
Maple Grove Hospital	138	787	907	8,129	9,823
Methodist Hospital	352	5,807	5,685	9,615	21,107
North Memorial Health	328	3,556	4,196	7,810	15,562
Subtotal: Hennepin	3,079	28,264	26,264	94,970	149,498
Ramsey County					
Children's MN - St. Paul (c)					
Gillette Children's Specialty Hospital	60	36	0	1,996	2,032
M Health Fairveiw St. John's Hospital	184	2,205	3,093	6,396	11,694
Regions Hospital	424	6,068	5,161	17,467	28,696
United Hospital	329	4,362	4,550	11,988	20,900
Subtotal: Ramsey	997	12,671	12,804	37,847	63,322
Scott County					
Mayo Clnic - New Prague	20	218	90	266	574
St. Francis Regional Medical Center	89	911	839	2,882	4,632
Subtotal: Scott	109	1,129	929	3,148	5,206
Washington County					
Lakeview Hospital	68	1,156	839	1,712	3,707
M Health Fairview Woodwinds Hospital - Woodbury	86	1,082	1,496	4,049	6,627
Subtotal: Washington	154	2,238	2,335	5,761	10,334
Total	**5,103**	**53,184**	**52,105**	**168,935**	**274,224**

Sources: 2021 Medicare Cost Report, obtained through ahd.com.

Notes: (a) Includes medical/surgical beds only; excludes psychiatric, rehabilitation, and SNF beds. (b) Includes Mercy Hospital – Unit Campus. (c) Includes in Children's Minnesota – Minneapolis data.

The next several steps in the Nobis bed need methodology take the most recent acute care information summarized above, and utilizing national industry standards for inpatient rehabilitation, project the potential admissions and bed need for the baseline year and for the 10-year projection period of 2025 – 2035. Each of these steps is summarized in Table 18 on the following page.

Table 18: Nobis PSA 2025-2035 Inpatient Rehabilitation Bed Need

I. Est. 2021 PSA Acute Care Utilization (a)	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Total
Est Medicare FFS Discharges (a)	5,807	621	2,454	28,264	12,671	1,129	2,238	53,184
Est. Medicare Advantage Discharges	6,625	621	2,527	26,264	12,804	929	2,335	52,105
Est. Discharges - All Other	15,633	4,716	6,860	94,970	37,847	3,148	5,761	168,935
Est. Total Discharges	28,065	5,958	11,841	149,498	63,322	5,206	10,334	274,224
II. Est. 2021 Potential Conversion From Acute Care to IRF (b)								
Medicare FFS	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
Medicare Advantage	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%
III. Est. 2021 Potential IRF Admissions From Acute Care								
Medicare FFS	267	29	113	1,300	583	52	103	2,447
Medicare Advantage	205	19	78	814	397	29	72	1,614
Subtotal Medicare	472	48	191	2,114	980	81	175	4,061
All Other Payors (c)	193	20	78	863	400	33	71	1,658
Subtotal: Potential Admissions from Acute Care	**665**	**68**	**269**	**2,977**	**1,380**	**114**	**246**	**5,719**
IV. Admissions From Other Referral Sources (d)	58	6	23	259	120	10	21	497
V. Est. 2021 Potential IRF Admission From All Sources	723	74	292	3,236	1,500	124	267	6,216
VI. Est. 2021 ADC & Bed Need								
Est. ADC (e)	26	3	11	117	54	5	10	225
Est. Bed Need (f)	33	3	13	146	68	6	12	281
VII. Est. 2025 - 2035 Nobis PSA Gross Bed Need (h)								
2021	33	3	13	146	68	6	12	281
2025	36	3	14	158	72	7	13	303
2030	40	4	15	170	75	8	14	326
2035	41	4	16	174	75	9	15	334
VIII. Existing Nobis PSA IRF/IRU Beds (i)	0	0	0	114	37	0	0	151
IX. Est. 2025 - 2035 Nobis PSA IRF/IRU Net Bed Need								
2021	33	3	13	32	31	6	12	130
2025	36	3	14	44	35	7	13	152
2030	40	4	15	56	38	8	14	175
2035	41	4	16	60	38	9	15	183

Sources: 2021 Medicare Cost Report, obtained through ahd.com.

Notes: (a) Source: ahd.com; (b) Medicare FFS rate equals the most recent estimated national conversion rate utilizing MedPAC Annual Report to Congress; Medicare Advantage estimated to be one-third lower than Medicare FFS; (c) All Other equals 29% of total IRF volume, since nationally Medicare FFS + Medicare Advantage represent 71% of total admissions; (d) Nationally, acute referrals represent 92% of all rehabilitation admissions (UDSMR 2020 user data) (e) Assumes 13.2 ALOS, which is the 2022 national ALOS for all providers (UDSMR); (f) Bed need assumes 80% target occupancy; (h) Projected 2025-2035 bed need applies the weighted population growth estimates presented in Table 16; (i) Source: 2021 Medicare Cost Report, obtained through ahd.com.

As can be seen in Table 18, the Nobis IRF bed need projection methodology shows a total estimated net bed need for an additional 130 beds in the PSA in 2021, increasing to an unmet bed need of 183 beds by 2035. While this may seem to represent a significant growth in demand from the current bed inventory of 151 beds, the total PSA bed need resulting from the Nobis bed need methodology would create a 2035 PSA IRF Bed-to-Population ratio of 9.8 Beds per 100K population, which is almost 20 percent lower than the current national Bed-to-Population ratio of 11.9 Beds per 100K population. Table 19 provides a summary of the PSA rehabilitation bed need, with the corresponding Bed-to-Population ratio if that number of beds was available in the market.

Table 19: Minnesota Rehabilitation Hospital PSA 2021-2035 Gross Bed Need/100K Population

Nobis PSA 2021 - 2035 Bed Need/100K Population

Year	Proj. Bed Need	Est. Population	Proj. Bed Need
2021	281	3,179,926	8.8
2025	303	3,242,562	9.3
2030	326	3,337,694	9.8
2035	334	3,420,486	9.8

The 2020/2021 US National Avg is 11.9 IRF Beds/100K Population

Source: Applicant

Importantly, however, upon approval and operation of the proposed 60-bed Minneapolis Rehabilitation Hospital, the seven-county PSA would only have a total bed inventory of 211 beds. This would create a 2025 Bed-to-Population ratio of just 6.5 Beds per 100K population and a 2035 Bed-to-Population ratio of 6.2 Beds per 100K population. This is just over one-half the 2022 national rate of 11.9 Beds per 100K population.

Based upon this analysis, Nobis believes that the proposed 60-bed Minneapolis Rehabilitation Hospital is supported both by current national benchmarks for IRF utilization, as well as local acute care utilization and PSA population projections. The project will significantly improve access to IRF services for the local community and help improve the health status for the PSA population.

d. Current future ambulatory visit rates by service, age, gender, and race/ethnicity.

The Minneapolis Rehabilitation Hospital will be an inpatient hospital only. This question is not applicable to the proposed project.

e. Describe the data sources, methods and underlying assumptions used to estimate and project the primary service area hospital utilization rates.

The data sources from the demand and bed need projections above include:

1. Minnesota State Demographic Center – this data source was used for all county and state demographics projections included in the demand and bed need projections.

2. The Medicare Payment Advisory Commission (MedPAC) Annual Reports to Congress – this data source was used to determine past and current IRF use rates for Medicare beneficiaries, the largest user of IRF services.

3. Acute Care Provider Medicare Cost Reports – this data source was used to determine the acute care utilization, by financial class, for the acute care hospitals in the Nobis PSA. Specifically, the acute care data was from Worksheet S-3 of each provider cost report and

was utilized in the demand and bed need analysis. The Medicare Cost Report information was obtained using the subscriber based American Hospital Directory database, ahd.com.

4. Uniform Data Systems for Medical Rehabilitation (UDSMR). UDSMR is a subscriber-based rehabilitation outcome measurement system that captures clinical data on 75 – 80 percent of all inpatient rehabilitation discharges nationally. This data source was used to determine the overall payor mix of all IRF/IRU providers nationally, the percent of patients admitted into IRF/IRUs by referral source (acute care, SNF, LTCH, etc.), and the national ALOS for all rehabilitation providers.

4. Care access--Describe any geographic barriers to care, including:

a. For people who live in the PSA, average driving times during rush hour and non-rush hour periods.

The average driving times to the proposed location in Roseville from the population centers for the counties in the planning area are:

County	Population Center (City)	Non-Rush Hour	Rush Hour
Anoka	Blaine	15 to 20 mins	15 to 30 mins
Carver	Chaska	35 to 60 mins	50 to 90 mins
Dakota	Lakeville	35 to 50 mins	45 to 75 mins
Hennepin	Minneapolis	10-20 mins	15 to 25 mins
Ramsey	St. Paul	15 to 25 mins	20 to 30 mins
Scott	Shakopee	35 to 50 mins	50 to 90 mins
Washington	Woodbury	25 to 30 mins	25 to 45 mins

Source: Google Maps Driving Directions

b. For people who live in the PSA, average ambulance run times to the nearest trauma center.

Given the proposed project is for an inpatient rehabilitation hospital and will not have an emergency department, this question is not applicable.

c. How will these change with the proposed new hospital?

Please see our response to 4.b. above.

d. Share relevant information on communities in the PSA including medically underserved, those on public coverage, and uninsured populations.

The Health Resources and Services Administration ("HRSA") compiles information on shortages of providers and services for primary care, dental, and mental health. Within the planning area there exist a handful of designated Medically Underserved Areas located within Hennepin and

Ramsey counties with shortages of Primary Care services.[23] Furthermore, there are numerous areas in the seven planning area counties which have been designated as Health Provider Shortage Areas.[24]

There is no analogous tool or government agency which identifies shortages of inpatient rehabilitation services. However, as we document elsewhere in our application, there exists a current and future need for inpatient rehabilitation care within the planning area. Given the declining supply of rehabilitation beds in Minnesota and within the PSA, as well as the aging population in the local market, this need has grown and will continue to grow.

The counties within the planning area have relatively low rates of uninsured, especially for the primary users of rehabilitation services, persons aged 65 and over. We present uninsured rates by county and age cohort group in the PSA and In Minnesota State in Table 20.

Table 20: Uninsured Rates for Planning Area Counties, 2021

	Under 19 years	19 to 64 years	65 years and older
Anoka	1.3%	6.5%	0.2%
Carver	2.0%	2.5%	0.0%
Dakota	1.5%	5.6%	0.1%
Hennepin	3.1%	6.0%	0.6%
Ramsey	2.5%	6.8%	1.2%
Scott	3.1%	5.0%	0.0%
Washington	1.9%	4.1%	0.2%
EDR 11 Total	**2.4%**	**5.8%**	**0.5%**
Minnesota State	**3.2%**	**6.1%**	**0.3%**

Source: U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates, Table S2701, https://api.census.gov/data/2021/acs/acs1/subject, Last Accessed June 27, 2023.

From Table 20, the rates of uninsured within the planning area tend to be lower than Minnesota State overall. The two exceptions to this are Anoka and Ramsey counties, the latter of which also has high rates of poverty. However, since Medicare is available to nearly all persons aged 65 and older, there are few uninsured persons among the elderly. This fact, combined with use rates of rehabilitation services being highest among the elderly, results in, nationally, Medicare beneficiaries comprising over 70 percent of all users of inpatient rehabilitation services.

[23] Search for MUAs within the ERD 11 Counties through the HRSA MUA tool: https://data.hrsa.gov/tools/shortage-area/mua-find; Last Accessed June 27, 2023.
[24] Search for HPSAs within the ERD 11 Counties through the HRSA HPSA tool: https://data.hrsa.gov/tools/shortage-area/hpsa-find, Last Accessed June 27, 2023

e. Disclose proposed financial assistance policy/emergency medical care policy and agreements on discounts and billing practices for uninsured patients such as signed agreements with the Minnesota Attorney General.

The Minneapolis Rehabilitation Hospital would not have an emergency or trauma center. Please see Exhibit 2 for our proposed financial assistance policy.

5. Financial access--Describe any financial barriers to care for patients in the PSA and how the plan may address them, including:

a. What is the volume of uncompensated care provided by existing facilities in the PSA?

While the Minnesota Department of Health provides public data on the amount of uncompensated care each hospital in the State provides annually, these reports do not break down the amount of uncompensated care by service line. Therefore, because all of the current rehabilitation providers in the State are hospital-based units, and not freestanding hospitals, Nobis is not able to utilize State data to determine the volume of uncompensated care for existing rehabilitation programs in the State. However, as shown in Figure 7, uncompensated care represents only 0.7 percent of all IRF/IRU discharges nationally in 2022.

The reason that the uncompensated care is lower for inpatient rehabilitation than it is for many other healthcare services is that, as pointed out previously, inpatient rehabilitation is heavily driven by the senior patient populations, which tend to be covered by Medicare FFS and Medicare Advantage. These two payors represent over 70 percent of all admissions. Much of the remaining 29 percent are patients who are covered by either Medicaid or employer-sponsored private insurance. As such, nationally only 0.7 percent of all IRF/IRU discharges are uncompensated care patients. Since no State data specific to inpatient rehabilitation services in Minnesota is presently available, Nobis assumes that the uncompensated care rate in the PSA is reasonably similar to the national uncompensated care rate of 0.7 percent.

b. What is the estimated uncompensated care volume for the proposed hospital?

Nationally, about 0.7 percent of inpatient rehabilitation patients receive uncompensated care. This statistic is consistent with Nobis' experience in its other 13 hospitals, and likewise expects about 0.7 to 1 percent of the patients at the proposed Minneapolis Rehabilitation Hospital to receive uncompensated care. However, it is Nobis' policy to admit all patients regardless of ability to pay, so actual operations may vary.

c. Provide any other relevant information on how the new facility will serve the low income, medically underserved and uninsured populations.

The Minneapolis Rehabilitation Hospital will admit patients who meet the criteria for intensive rehabilitation regardless of ability to pay. This is consistent with its Financial Assistance Policy. Please see Exhibit 2.

6. **To the extent possible, discuss the relative acuity of the population in the primary service area (for example, are hospital utilization rates for people living in the primary service area higher or lower than the statewide average)?**

   As shown in the demographic analysis provided in Table 4, the Age 65+ age cohort in the PSA is increasing more rapidly than the same age cohort statewide. Because Medicare FFS and Medicare Advantage patients account for over 70 percent of all IRF/IRU admissions nationally, it is anticipated that the need for inpatient rehabilitation services in the PSA are increasing more rapidly than the need for inpatient rehabilitation services statewide.

7. **Provide incidence or prevalence of disease, behavioral risk factors, and acuity mix for PSA as it relates to proposed hospital services.**

   As discussed earlier, nationally, 92 percent of all IRF/IRU admissions are patients that have been referred to a rehabilitation provider by an acute care hospital. As such, the most critical metric for "incidence rate" is the percent of acute care patients that require inpatient rehabilitation services following discharge from acute care. As shown in Table 18 above, based on MedPAC data, in 2020, the most recent year for which data is available, 4.6 percent of all Medicare FFS acute care patients were discharged into an IRF/IRU setting. Nationally, Medicare FFS patients represent 54 percent of all IRF/IRU admissions. While there is no similar national database on the conversion rate for Medicare Advantage patients, the Nobis experience in other markets for these patients is that the conversion rate is approximately 30 – 35 percent less than Medicare FFS. The Nobis bed need projections above assume a Medicare Advantage conversion rate of 3.1 percent, or one-third less than the Medicare FFS rate. The conversion rate for Medicare Advantage tends to be lower than Medicare FFS because of required prior authorization approvals for these patients that is not required for Medicare FFS patients. Because Medicare Advantage patients represent 17 percent of all IRF/IRU admissions nationally, the total Medicare population accounts for 71 percent of all IRF/IRU admissions. The conversion rates for the remaining payors are much lower, since Commercial/Managed Care, Medicaid and other third-party plans have a far higher proportion of younger patients who rarely require inpatient rehabilitation (such as Obstetrics, Pediatrics, ENT, etc.). However, all together these plans account for 29 percent of IRF/IRU patients nationally, and that is the figure that was utilized in the Nobis PSA projections.

8. **Provide estimates on the anticipated share of PSA by service line along with a description of how the project fits into the relevant market for specified geographic areas. Include, for example, any unique aspects of the project and reasons for why the project will meet patient needs that are not currently being addressed.**

   As noted earlier, the only service line addressed by the proposed Minneapolis Rehabilitation Hospital is inpatient rehabilitation. No other service line will be provided. As such, the project fits into the relevant market for the seven-county PSA because, as noted in Table 12 above, access to rehabilitation care in Minnesota is currently extremely limited, and as stated above, the IRF/IRU Bed-to-Population ratio in the PSA is also very low, being less than one-half the Bed-to-Population ratio nationally. Additionally, because of limited access, the actual utilization of inpatient rehabilitation

services in the PSA is less than one-half the national rate. This project will improve access to care by increasing the number of IRF/IRU beds in the service area, where the significant shortage of rehabilitation beds is not currently being addressed by any other provider.

9. Describe any new or improved services for patients in the PSA, including:

a. Describe how specific new or improved services would address documented disease burden (i.e., incidence or prevalence of disease or behavioral risk factors) and health disparities.

As noted earlier, the access to inpatient rehabilitation services is less than one-half the national rate, which has led to use rates that are less than one-half the national use rate. As such, the proposed 60-bed Minneapolis Rehabilitation Hospital will help address this health access disparity in the PSA by improving the functional outcomes of those affected by a debilitating injury or illness.

b. Provide any empirical evidence supporting whether new or improved services would advance patient outcomes.

As noted in the response to the last two items, the proposed project will advance patient outcomes by improving access to inpatient rehabilitation services in the seven-county PSA. In addition, Table 21 provides a summary of the outcomes data for a peer Nobis IRF located in a comparable market that illustrates how the Nobis IRF outperforms peer IRFs in its patient quality performance metrics. Similar outcomes would be expected by the proposed Minneapolis Rehabilitation hospital, thus improving healthcare service for the seven-county PSA.

Table 21: Quality Metrics for Nobis Rehabilitation Hospital in Comparable Market

	IRF Score		
Metric	**Nobis IRF**	**Weighted National (a)**	**Comment**
Average Onset Days	13.9	15.9	Onset days represents how quickly the IRF admitted a patient following the injury or illness requiring rehab. (Lower LOS is desired.)
Average Length Of Stay	12.0	13.7	Lower LOS is desired.
Discharge Disposition			
Home (inc w/ HHA)	81.7%	77.4%	The primary goal of IRF is discharge to home. Higher percentage is desired.
Acute Care Hospital	5.6%	10.7%	Fewer discharges to acute care suggest IRF better able to manage higher acuity patients than peers.
Change in Functional Status			A Medicare requirement for IRFs is that upon admission the functional abilities of each patient is assessed using a standard scoring tool for 30+ common tasks such as bathing dressing, walking, etc. The exact same scoring system is again used for the same tasks upon discharge to determine the patient improvement. This change in functional status is then used to assess the performance of the IRF against regional and national peers. A higher change in functional status means that the IRF outperforms peer hospitals on the same measure. As such, a higher change score is desired.
Shower/Bathe	1.8	1.5	
Upper Body Dressing	2.1	1.6	
Lower Body Dressing	2.2	1.9	
Walk 10 Feet	1.9	1.7	
Walk 50 Feet with Two Turns	2.2	1.9	
Walk 150 Feet	2.2	1.9	
Walk 10 Feet Uneven Surfaces	2.3	1.7	

Source: Applicant
Notes: Weighted national score means that the comparative national population has the same Case Mix Index.

c. Identify which patient populations or demographic groups would most benefit from the new and improved services.

As noted earlier, nationally the Medicare patient population, including both Medicare FFS and Medicare Advantage, accounts for 71 percent of all IRF/IRU admissions. As such, the Age 65+ cohort will most benefit from improved access to inpatient rehabilitation services. However, all residents in the PSA could benefit from greater access to inpatient rehabilitation care, when that type of care is required.

d. Define any actions that will be taken to promote a better patient experience (e.g., culturally competent staffing, improving continuity of care or reducing transfers to other facilities, etc.).

As discussed in our response to Item 9.b. above, Nobis IRFs promote a positive patient experience by achieving patient outcomes that exceed industry norms. As Table 21 shows, peer Nobis IRFs have a shorter LOS, discharge more patients to home, and have more patient improvement/functional gains than industry benchmarks. These factors clearly highlight a positive patient experience.

V. Market Analysis

1. Describe how persons who live in the primary service area currently receive hospital services proposed for the new facility.

Presently there exist no freestanding IRFs in Minnesota. Minnesota residents, and residents of the planning area for the proposed project, receive inpatient rehabilitation services through one of the hospital-based IRUs located in acute care hospitals, or a limited number of patients may out-migrate to out-of-state providers. As presented in Table 1, within the planning area there are 6 IRUs, averaging about 25 beds per unit.[25] Outside of these planning area rehabilitation units, there are few other IRUs in Minnesota. These include IRUs in the counties of:

- Beltrami – Sanford Bemidji Medical Center (17 rehab beds)
- Itasca – Grand Itasca Clinic and Hospital (14 rehab beds)
- Olmsted – Mayo Clinic St. Mary's Hospital in Rochester (32 rehab beds)
- St. Louis – Essentia Health Duluth (39 rehab beds); St Lukes Hospital of Duluth (19 rehab beds)
- Stearns – St. Cloud Hospital (20 rehab beds)

The only IRUs outside the PSA that might be expected to admit a small percentage of PSA residents are the 36-bed IRU at Mayo Clinic St. Mary's Hospital in Rochester and the 19-bed IRU at St. Cloud Hospital in St. Cloud. However, because most patients receive rehabilitation care in the same community where they receive acute care services, only limited out-migration would be expected.

2. List of the market shares of hospitals that have five percent or more market share for each major service category that are included in the new project (e.g., percentage of admissions, patient days, or ambulatory visits).

There are six current inpatient rehabilitation providers in the PSA, all hospital-based IRUs. Currently virtually all patients residing in the planning area who receive inpatient rehabilitation care, receive it in one of these six IRUs because there are no other IRUs immediately outside of the PSA that would be expected to draw/admit a significant number of patients from the PSA. The only IRUs outside the PSA that might be expected to admit a small percentage of PSA residents are the 36-bed IRU at Mayo Clinic St. Mary's Hospital in Rochester and the 19-bed IRU at St. Cloud Hospital in St. Cloud. However, because most patients receive rehabilitation care in the same community where they receive acute care services, only limited out-migration would be expected. As such, each of the existing rehabilitation providers appears to have an inpatient rehabilitation market share of five percent or more.

The six current IRU providers and their most recent utilization and market share are summarized in the following table.

[25] See hospital list in Table 1.

Table 22: Planning Area Existing Inpatient Rehabilitation Providers with FY 2021 Utilization

Hospital	County	Beds	Discharges	ADC	Occupancy	PSA IRF/IRU Market Share Beds	PSA IRF/IRU Market Share Discharges	PSA IRF/IRU Market Share ADC
Abbott Northwestern Hospital	Hennepin	39	705	28.4	72.8%	25.8%	25.9%	27.3%
Hennepin Healthcare	Hennepin	27	303	10.5	38.9%	17.9%	11.1%	10.1%
M Health Fairview U of M Med Ctr	Hennepin	30	711	25.0	83.3%	19.9%	26.1%	24.0%
North Memorial Health	Hennepin	18	260	9.0	50.0%	11.9%	9.5%	8.6%
Subtotal: Hennepin	**-**	**114**	**1,979**	**72.9**	**63.9%**	**75.5%**	**72.6%**	**70.0%**
Regions Hospital	Ramsey	21	413	18.6	88.6%	13.9%	15.2%	17.9%
United Hospital	Ramsey	16	333	12.7	79.4%	10.6%	12.2%	12.2%
Subtotal: Ramsey	**-**	**37**	**746**	**31.3**	**84.6%**	**24.5%**	**27.4%**	**30.0%**
Total	**-**	**151**	**2,725**	**104.2**	**69.0%**	**100.0%**	**100.0%**	**100.0%**

Source: CMS Provider Data, available through ahd.com

Unfortunately, Nobis does not have access to the IRU-specific patient origin data for the patients admitted into each of the six IRUs in the PSA. While there are likely patients admitted into some of these IRUs who reside outside of the PSA, based upon the patient profile of similar IRFs/IRUs in other metropolitan areas, it is expected that greater than 85 percent of all current IRU admissions are from patients that reside in the PSA. (See response below for data corroborating the 85 percent estimate).

a. For each facility listed, list the percentage of admissions and patient days that originate from the primary service area.

This question requires patient origin data for rehabilitation services, which is not available to individuals or organizations not part of the Minnesota Hospital Association. However, it is possible to perform this patient origin analysis using publicly available data from CMS for all hospital discharges for patients covered by Medicare. We present this data in Table 23.

Table 23: CMS Patient Origin Data, Planning Area Hospitals, 2021

Name	PSA Cases	PSA Days	All Cases	All Days	PSA % of Total Cases	PSA % of Total Days
Abbott Northwestern Hospital	8,820	47,331	12,075	67,262	73.0%	70.4%
Hennepin County Medical Center	4,875	35,276	4,953	35,991	98.4%	98.0%
M Health Fairview University of MN	6,747	50,622	7,656	57,605	88.1%	87.9%
North Memorial Health	6,569	35,801	7,262	39,887	90.5%	89.8%
Park Nicollet Methodist Hospital	10,624	51,081	11,090	53,694	95.8%	95.1%
Regions Hospital	9,383	55,614	10,981	65,354	85.4%	85.1%
United Hospital	7,604	40,234	8,390	44,914	90.6%	89.6%
Total	**54,622**	**315,959**	**62,407**	**364,707**	**87.5%**	**86.6%**

Sources: CMS Patient Origin Data, 2021.
Note: Includes only hospitals with CMS Certified Inpatient Rehabilitation Units.

3. **What is the anticipated impact of the new facility on existing facilities in a 25-mile radius which provide uncompensated care.**

   Because the PSA has such limited access to inpatient rehabilitation services, compared to national benchmarks including utilization, the proposed Minneapolis Rehabilitation Hospital is not expected to negatively impact the utilization of any existing IRU within a 25-mile radius, including those that provide uncompensated care. Nobis intends to develop referral sources from physicians and hospitals that do not currently refer their patients to inpatient rehabilitation, in order to increase the utilization rate of the planning area so that it may achieve a level close to national norms.

   Further, because the demand and bed need for inpatient rehabilitation far exceeds the current supply, the proposed 60-bed Minneapolis Rehabilitation Hospital is not expected to have any meaningful impact on the existing PSA inpatient rehabilitation providers.

4. **The public interest review statute requires that MDH examine "how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff." Please provide information on the staffing needs of the proposed hospital and the estimated impact on existing facilities in the state.**

   We expect the proposed 60-bed Minneapolis Rehabilitation Hospital to require approximately 140 FTEs (full-time and part-time workers) across about 40 occupations, when it reaches its target occupancy. This includes about 17 RN FTEs and 3.5 Pharmacist FTEs. Based on statistics from the U.S. Bureau of Labor Statistics ("BLS"), the Minneapolis-St. Paul-Bloomington MSA has almost 40,000 RNs and over 4,000 pharmacists.[26] As such, from a staffing perspective, the impact of the proposed hospital will be negligible.

   It should also be noted with the burnout of most healthcare workers across the nation and with many healthcare workers leaving their specific healthcare career completely, we have seen these same people return to the workforce at our hospitals for a lower stress environment with a renewed 'sense of passion' towards their healthcare career. We believe our workplace environment has provided these people a 'break' which can even facilitate a positive impact towards bringing other health care staff back to those critical acute care positions.

5. **To the extent possible, estimate the impact of the new facility on vacancy rates, length of time to fill new positions and wage for staff, particularly for nurses, pharmacists and radiological technicians. To the extent possible, estimate the impact of the new facility on vacancy rates, length of time to fill new positions and wage for staff, particularly for nurses, pharmacists and radiological technicians.**

[26] Minneapolis-St. Paul-Bloomington, MN-WI - May 2022 OEWS Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Estimates (bls.gov), Last Accessed June 30, 2023.

As described above, from a staffing perspective, the impact of the proposed hospital will be negligible. Thus, the impacts on vacancy rates, length of time to fill new positions and occupational wages are also expected to be negligible.

6. Describe potential pro- or anticompetitive effects the plan will have on other hospitals, including on price, total health care expenditures, or operating and administrative costs.

As presented in Figure 1, the 2018 MedPAC Report to Congress included data that showed that freestanding IRFs have an average cost per discharge 28 percent less than hospital-based IRUs, with a freestanding IRF average cost per discharge of $11,796 and a hospital-based IRU with an average cost of $16,406. As such, as the only freestanding IRF in the PSA, the proposed Minneapolis Rehabilitation Hospital will have a positive impact on total healthcare expenditures in the PSA.

7. Describe the anticipated financial impact of the proposed facility on facilities listed above, including:

a. Describe the expected market share by major service category overall for new hospital or additional licensed beds as a percentage of admissions, patient days, or ambulatory visits.

b. Describe the expected market share by major payer category (i.e., commercial, Medicaid, Medicare, uninsured, and other payers) for new hospital or additional licensed beds as a percentage of admissions, patient days, or ambulatory visits.

With the proposed 60 beds, the Minneapolis Rehabilitation Hospital will have 28 percent of the total of 211 available rehabilitation beds upon opening. (This assumes that no additional providers are developed along with the current six IRUs containing a total of 151 beds.). As shown in Table 22 above, there is a fairly high correlation in the market between the percentage of available beds and current market share for both admissions and patient days/ADC. As such, Nobis estimates that upon achieving its target utilization that its market share within the PSA will be 25 – 30 percent for admissions and patient days/ADC. This approximate market share is expected to be achieved for all major payor categories.

c. Provide single-year projections for the next 10 years on patient volume and major payer market shares.

Table 24 provides single year projections of PSA demand and bed need for the 2025 – 2035 projection period. These projections are based upon the demand analysis provided earlier, with straight-line growth projections included for each year between the 2025, 2030 and 2035 projections in the previous response to Project Need. Additionally, as noted above, Nobis estimates that upon achieving its target utilization that its market share within the PSA will be 25 – 30 percent for admissions and patient days/ADC. This approximate market share is expected to be achieved for all major payor categories.

Table 24: Estimated 2025 to 2035 PSA Potential IRF Utilization

Year	Discharges	ADC	Bed Need
2025	6,703	242	303
2026	6,805	246	308
2027	6,907	250	313
2028	7,009	253	316
2029	7,111	257	321
2030	7,212	261	326
2031	7,247	262	328
2032	7,282	263	329
2033	7,317	265	331
2034	7,352	266	333
2035	7,388	267	334

Source: Applicant

8. Describe the anticipated staffing impact of the proposed facility on existing hospitals with emergency departments in the region.

As described above, from a staffing perspective, the impact of the proposed hospital will be negligible.

9. Provide a staffing plan that includes detailed personnel classifications and full-time equivalent (FTE) hour amounts for each position, when the hospital is fully staffed and operating at planned capacity.

Please see Table 25 below, for the total number of FTEs expected when the Minneapolis Rehabilitation Hospital achieves its target occupancy, as described above.

Table 25: FTE Schedule, Full Operations

Position	FT	PT	FTE
ADMIN ASSISTANT	1	0	1
ADMISSIONS CLERK	1	0	1
ADMISSIONS COORDINATOR	1	0	1
CASE MANAGER	2	5	4.5
CERTIFIED NURSING ASSISTANT	8	7	11.5
CERTIFIED OCCUPATIONAL THERAPY ASSISTANT	0	1	0.5
CHIEF EXECUTIVE OFFICER	1	0	1
CHIEF NURSING OFFICER	1	0	1
CHIEF THERAPY OFFICER	1	0	1
CLINICAL LIAISON	10	0	10
COOK	5	0	5
DIETITIAN	1	3	2.5
DIRECTOR OF BUSINESS DEVELOPMENT	1	0	1
DIRECTOR OF FACILITIES MANAGEMENT	1	0	1
DIRECTOR OF PHARMACY	1	0	1
DIRECTOR OF QUALITY	0	1	0.5
ENVIRONMENT SERVICES AIDE	3	0	3
ENVIRONMENT SERVICES MANAGER	1	0	1
FLOOR TECH	1	0	1
FOOD SERVICE AIDE	2	0	2
FOOD SERVICES MANAGER	1	0	1

HEALTH INFORMATION MANAGEMENT SPECIALIST	1	0	1
IRF-PAI COORDINATOR	1	0	1
LICENSED PRACTICAL NURSE	9	1	9.5
MAINTENANCE TECH	1	0	1
MARKET HUMAN RESOURCES MANAGER	0	0	0
MATERIALS TECH	0	0	0
NURSING SCHEDULER	1	0	1
NURSING SUPERVISOR	6	2	7
OCCUPATIONAL THERAPIST	9	9	13.5
PATIENT CARE TECH	4	2	5
PHARMACIST	0	7	3.5
PHARMACY TECH	1	5	3.5
PHYSICAL THERAPIST	8	5	10.5
PHYSICAL THERAPIST ASSISTANT	0	2	1
RECEPTIONIST	0	1	0.5
REGISTERED NURSE	10	14	17
REHAB TECH	1	0	1
RESPIRATORY THERAPIST	1	0	1
SPEECH LANGUAGE PATHOLOGIST	5	4	7
TRAVEL REGISTERED NURSE	0	0	0
UNIT SECRETARY	3	0	3
TOTAL	**104**	**69**	**138.5**

Source: Applicant
Notes: Part-Time ("PT") employees assumed to equal 0.5 FTEs. An FTE is assumed to work 2,080 hours a year.

10. List existing vacancy rates for relevant personnel (e.g., registered nurses, pharmacists, and radiological technicians) for the primary service area.

According to the Minnesota Hospital Association, the overall vacancy rate for healthcare workers in the State decreased from 22 percent in 2022 to 17 percent in 2023. In addition, while there is still a need for healthcare workers, MHA reports that hiring of healthcare workers reached an all-time high for the State in 2023. Specific to the nurse staffing, in 2023 the hiring of CNAs increased by 38 percent over 2022, the hiring of RNs increased 23 percent, and the hiring of Medical Assistants increased 32 percent. Each of these factors point to healthcare staffing trending in a positive direction, and it is expected that this will continue to improve as Nobis anticipates a 2025 opening of Minneapolis Rehabilitation Hospital.

Although there are still challenges for recruiting for many providers in healthcare, the proposed 60-bed Minneapolis Rehabilitation Hospital is only budgeting approximately 104 full-time employees and 69 part-time employees for all functions after achieving its targeted occupancy, including 17 RN FTEs and 32 Therapy FTEs, two of the major staffing disciplines in inpatient rehabilitation. In order to support its recruitment efforts, Nobis ensures competitive salaries and wage rates, educational opportunities, clinical ladders, flexible work schedules and other employee benefits that create a positive work environment at Nobis IRFs. Additionally, the smaller, more personal environment of a 60-bed IRF is preferred by many professionals compared to larger acute care providers that have more complex organizational structures and frequently less personal employee relations.

According to the May 2022 statistics provided by the U.S. Bureau of Labor Statistics, the Minneapolis-St. Paul-Bloomington MSA has almost 40,000 RNs, 7,000+ therapists (PT, OT and Speech/Language Therapists) and almost 14,000 Nursing Assistants. As such, Nobis does not anticipate significant obstacles in recruiting the staffing levels previously identified. While there are certainly challenges recruiting staffing in today's environment, Nobis has not experienced any unique recruiting challenges in any of its other markets that would not be reasonably expected in those markets. Additionally, Nobis has established its own travel nurse program to utilize as needed.

11. Describe anticipated timeline, approach and wage/salary structure to meet staffing plan needs for services.

As described above, we anticipate the proposed hospital to begin admitting patients in Q3 of 2025. At full operation, we project the proposed hospital will require 104 Full Time and 69 Part Time employees (Table 25). Although there is a significant need for rehabilitation services in the planning area, it will take time to reach our target occupancy of 80%. Based on our experience, we expect this ramp period to require about 8 months. We expect the hospital to be about half-staffed at opening, and to add about 15 FTEs per month until it is operating at its target occupancy in Q2 of 2026.

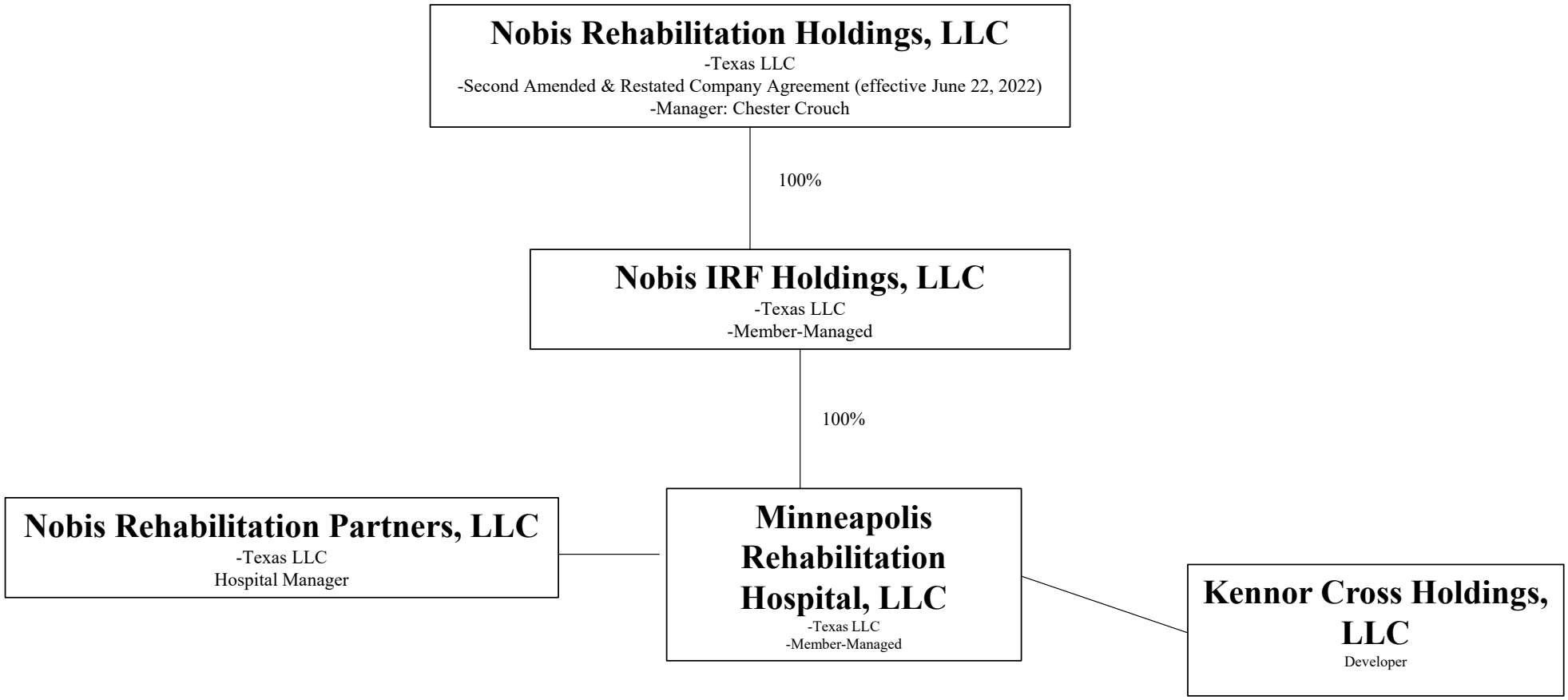
Nobis has experience operating in states with significant staffing challenges and has successfully negotiated with healthcare worker unions and believes it will be able to overcome any healthcare staffing challenges in Minnesota. Nobis has multiple resources including an experienced recruiting team with dedicated hospital human resources to assist with the identification and recruitment of appropriate and qualified personnel. Nobis posts career listings on the hospital website and on multiple search engines and social media platforms' listing sites. Nobis offers a supportive and collaborative work environment, opportunities for advancement, a competitive wage scale, market and position-based sign-on bonuses, and a comprehensive health and wellness package including medical, dental, vision, and prescription drug coverage.

Exhibit 1

Organizational Charts

Minneapolis Rehabilitation Hospital, LLC

Corporate Structure



Minneapolis Rehabilitation Hospital, LLC

Management Structure

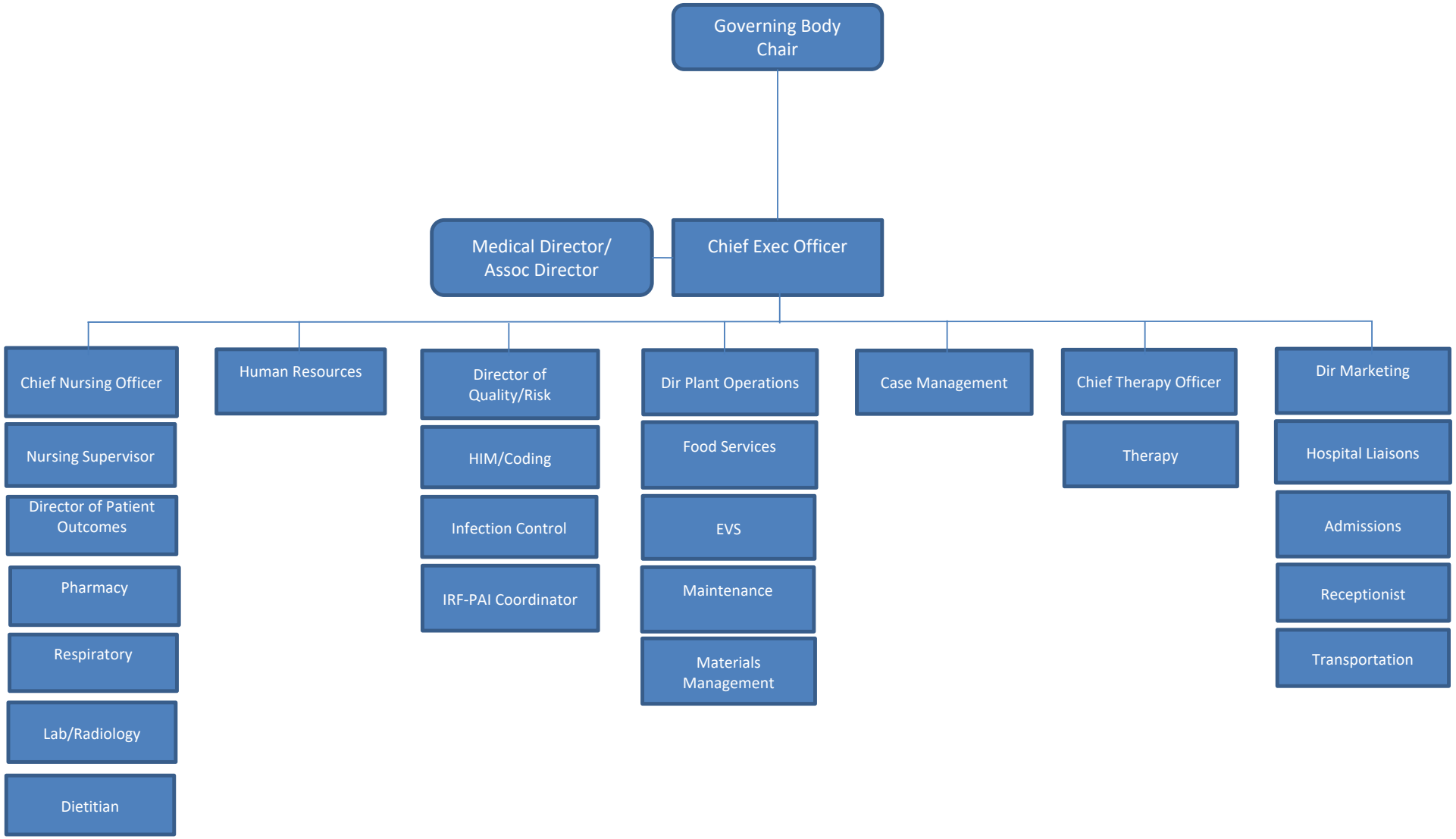


Exhibit 2

Financial Assistance Policy

Financial Assistance Policy

Financial Assistance, Billing and Collections

Financial Assistance Policy

If you do not have health insurance, Minneapolis Rehabilitation Hospital provides financial assistance for medically necessary care as a discount from our normal charges if your household income does not exceed four times the Federal Poverty Guidelines and you are a US Citizen. All applicants will be screened for Medicaid coverage and must cooperate with the Medicaid representatives to be considered for financial assistance. If you are eligible for financial assistance under our Policy, you will receive free or discounted assistance according to the following income criteria:

• If your annual household income is up to 200% of the Federal Poverty Guidelines, you may qualify for free care.

• If your annual household income is between 201% and 400% of the Federal Poverty Guidelines, you may receive care discounted to the amount we generally bill insured patients for such services.

Even if you have insurance, as long as you meet our income criteria, you may be eligible for financial assistance if: your insurance does not provide coverage for the medically necessary services you are seeking or you have exhausted your lifetime maximum insurance benefits. Financial Assistance cannot be used to cover deductibles or coinsurance for your insurance plan.

Additional Ways to Qualify

If you do not meet the income criteria above, you may be considered on a case-by-case basis for financial assistance under the following circumstances:

• Catastrophic Balance: If you will have a balance due to Minneapolis Rehabilitation Hospital of greater than 25% of your annual household income, you may be considered for financial assistance.

• Special Medical Circumstances: If you are seeking treatment that can only be provided by Minneapolis Rehabilitation Hospital or you would benefit from continued medical services from Minneapolis Rehabilitation Hospital for continuity of care, you may be considered on a case-by-case basis for financial assistance for that specific treatment.

Charges Will Not Exceed Amounts Generally Billed

If you receive financial assistance under our Policy, you will not be charged more for medically necessary care than the amount we generally bill patients having commercial insurance or Medicare coverage.

Financial Assistance Application Form and Process:

How to Obtain Copies of Our Policy and Application

You may obtain a free copy of our Policy and the Financial Assistance application form:

(1) On the Minneapolis Rehabilitation Hospital website

(2) In our Admission Office.

(3) By mailing a request to the Minneapolis Rehabilitation Hospital

How to Apply and Obtain Assistance

Application for Financial Assistance must be completed and approved prior to admission. Our team can assist and advise you in the completion process.

Any Financial Assistance Application whether completed in person, online, delivered or mailed in, will be forwarded to the Financial Services team for evaluation and processing.

If you need any help in applying, please contact the Minneapolis Rehabilitation Hospital Admissions Office.

Patient Billing and Collections:

Minneapolis Rehabilitation Hospital strives to work with every patient who does not qualify for financial assistance, to resolve unpaid balances.

1. Mail at least 4 statements to the patient/responsible party to the address on file.

2. Attempt to contact the patient/responsible party by phone.

Private Pay: PLEASE NOTE that this excludes the preadmission prompt pay requirement for private-pay patients. For any patients needing to privately pay for services, payment is due prior to services being rendered or a deposit is made with a Payment Agreement. For additional information related to privately paying for services please contact the Minneapolis Rehabilitation Hospital.

Financial Assistance Application Form

PATIENT NAME IN FULL	M F	AGE	DATE OF BIRTH

ARE YOU A CITIZEN OF THE UNITED STATES	RESIDENT OF OKLAHOMA	HAVE YOU APPLIED FOR MEDICAL ASSISTANCE (MEDICAID)	IF YES, INDICATE MONTH	YEAR
Yes No	Yes No	Yes No		

ARE YOU OR YOUR SPOUSE SELF-EMPLOYED	DID YOU FILE A FEDERAL TAX RETURN	STATE TAX RETURN	DO YOU HAVE THIRD-PARTY INSURANCE COVERAGE
Yes No	Yes No	Yes No	Yes No

RESPONSIBLE PARTY INFORMATION

APPLICANT		APPLICANT'S SPOUSE		
NAME		NAME		
ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER ( )	CELL PHONE ( )	PHONE NUMBER ( )	CELL PHONE ( )	
SOCIAL SECURITY NUMBER		SOCIAL SECURITY NUMBER		
EMPLOYER		EMPLOYER		
IF UNEMPLOYED, LAST DATE WORKED		IF UNEMPLOYED, LAST DATE WORKED		
DATE LAST CHECK RECEIVED		DATE LAST CHECK RECEIVED		

FAMILY AND PATIENT INFORMATION

FAMILY MEMBERS LIVING IN THE HOME

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	SOCIAL SECURITY NUMBER

FAMILY INCOME
List Amounts of Each

Patient	SALARY / WAGES / TIPS	INTEREST / DIVIDENDS	ALIMONY	SOCIAL SECURITY	PENSION / RETIREMENT
	DISABILITY	UNEMPLOYMENT	WORKERS COMP	SELF EMPLOYMENT - ATTACH SCHEDULE C	
Spouse	SALARY / WAGES / TIPS	INTEREST / DIVIDENDS	ALIMONY	SOCIAL SECURITY	PENSION / RETIREMENT
	DISABILITY	UNEMPLOYMENT	WORKERS COMP	SELF EMPLOYMENT - ATTACH SCHEDULE C	

FAMILY RESOURCES

Checking Account(s)		
Savings Account(s)		
IRA / 401K / 430B		
Food Stamps (list amount received)	WIC ☐ No ☐ Yes (Need Qualifying Letter)	LOW INCOME HOUSING ☐ No ☐ Yes (Need Qualifying Letter)

PROPERTY (HOUSE OR PERSONAL PROPERTY OTHER THAN YOUR RESIDENCE) - *DESCRIPTION AND LOCATION*	MARKET VALUE
	$
IS THIS HOSPITAL SERVICE / PHYSICIAN SERVICE A RESULT OF A PERSONAL INJURY/ACCIDENT CASE FROM WHICH YOU EXPECT TO RECEIVE A SETTLEMENT ☐ Yes ☐ No	IF YES, EXPECTED AMOUNT $

I hereby acknowledge that I have read this document. It has been provided in printed format or explained to me in my native language and was understood. I certify that all information regarding income and assets are true. I understand that the information which I submit concerning my income, assets, liabilities, and family size is subject to verification. I hereby authorize the release of any necessary information from individuals, universities or colleges, businesses, public or private organizations to determine my eligibility. I assign and transfer to Minneapolis Rehabilitation Hospital all my rights to benefits, monies, and sums payable to me for hospitalization, sickness, or accident liability coverage. I understand that failure to disclose information and/or payments will result in denial of the application.

PATIENT - SIGNATURE	DATE	TIME

PERSON COMPLETING FORM, IF OTHER THAN PATIENT - SIGNATURE	RELATIONSHIP TO PATIENT	DATE	TIME

INTERPRETER / WITNESS - SIGNATURE

DATE TIME

PATIENT LABEL

Exhibit 3

Policy for Admission, Continued Stay, and Discharge Criteria

Policy Title: Inpatient Rehabilitation Facility Admission, Continued Stay and Discharge Criteria

Purpose:
The purposes of this policy are to ensure that patients are admitted to the Inpatient Rehabilitation Facility (IRF) based on appropriate admission criteria and that all care provided in the IRF is reasonable and necessary as it applies to decisions for admission, continued stay and determination of the timing for discharge.

Scope:
This policy applies to Acute Inpatient Rehabilitation Facility services.

Policy:
All inpatient rehabilitation services provided shall meet the appropriate medical necessity criteria and all care provided in the IRF shall be reasonable and necessary as it applies to decisions for admission, continued stay and determination of the timing for discharge.

Definitions:
A. "Federal health care program" means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to, Medicare, Medicaid,, managed Medicare/Medicaid, TriCare/VA/CHAMPUS, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, and Preexisting Condition Insurance Plans (PCIPs).

B. "Managed Care Payer" means, for the purposes of this policy, any contracted third-party payor who pays, or is expected to pay, benefits to the Unit under a health insurance policy. Managed Care Payer includes managed Federal health care programs (e.g., managed Medicare and managed Medicaid). Managed Care Payer does not include any other Federal healthcare program.

Procedure:
A. Admission Criteria

Patients must meet the stated criteria to be admitted to the Hospital. All inpatient rehabilitation services provided shall meet the appropriate medical necessity criteria as set forth in this policy.

For patients who are covered by any payer other than traditional Medicare (*e.g.,* a Managed Care Payer, other non-Medicare Federal healthcare programs, etc.) the Clinical Liaisons, Admission Coordinator and Rehabilitation Physicians are responsible for ensuring that the IRF adheres to all of the applicable non-Medicare payer's requirements including without limitation, preauthorization or pre-certification requirements, coverage criteria and billing requirements. These requirements may be specified in a Managed Care

Agreement, program manuals for non-Medicare Federal health care program payers and other written or verbal instructions from the payer. The IRF is responsible for understanding those requirements and ensuring the adherence to these requirements by the IRF. In addition, those who submit claims to the payer on behalf of the IRF shall also ensure that they understand the requirements so the billing for care is accurate. Program management and billing personnel are expected to confer during the course of the patient's stay as a means to ensure that billing is accurate.

The Hospital shall comply with all documentation requirements described in Attachment A.

1. The patient must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:

    a. Active and ongoing intervention of multiple therapy disciplines (Physical Therapy (PT), Occupational Therapy (OT), Speech- Language Pathology (SLP), or prosthetics/orthotics), at least one of which must be PT or OT;

    b. An intensive rehabilitation therapy program, generally consisting of:
        - Three hours of therapy per day at least 5 days per week; or
        - In certain well documented cases, at least 15 hours of intensive rehabilitation therapy within a 7-consecutive day period, beginning with the date of admission;

    c. Reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program (the patient's condition and functional status are such that the patient can be reasonably be expected to make measurable improvement, expected to be made within a prescribed period of time and as a result of the intensive rehabilitation therapy program, that will be of practical value to improve the patient's functional capacity or adaptation to impairment(s);

    d. Physician supervision by a rehabilitation physician, with face-to-face visits at least 3 days per week to assess the patient both medically and functionally and to modify the course of treatment as needed; and

    e. An intensive and coordinated interdisciplinary team approach to the delivery of rehabilitative care.

2. Rehabilitation Physicians and other personnel are accountable for documenting justification for the admission within the medical record. The Medical Director or other admitting rehab physicians are supported but held accountable to make the final decisions for admission to the IRF programs. It is therefore incumbent upon them to detail the level of functional and medical severity that supports the admission and the decision to care for the patient in the IRF setting and determine that the

patient care requirements are within the experience level of the treatment team, the needed resources can be obtained, and there is an established plan of care as evidenced in the History and Physical.

C. Continued Stay Criteria

Acute inpatient rehabilitation requires evidence of an interdisciplinary, coordinated rehabilitation team review at least once weekly, which should document ALL of the following:

1. Evidence of active participation in a multi-disciplinary rehabilitation program; AND

2. Evidence of progress toward stated goals documented by objective functional measures; AND

3. Identification of range and severity of the individual's problems, including medical status and stability, self-care, mobility, psychological status, and communication status ; AND

4. Consideration of special equipment needs when appropriate; AND

5. Goal modification based on current status, progress, and potential for improvement; AND

6. Projected length of stay and discharge/disposition planning; AND

7. Status of training provided to the patient and family members/caregivers by various rehabilitation disciplines regarding post discharge care; AND

8. Identification of barriers to progress, including any medical complications likely to impede progress; AND

9. Information regarding the status of the underlying medical condition

D. Discharge Criteria

Discharge from acute inpatient rehabilitation is appropriate if one or more of the following is present.

1. Treatment goals necessitating the inpatient setting were achieved; OR

2. Absence of participation in an interdisciplinary rehabilitation program; OR

3. The individual has limited potential for recovery (e.g. the individual's functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame; OR

4. Individual is unable to actively participate in an intensive rehabilitation program (most typically defined as at least 3 hours of multidiscipline therapy per day, at least 5 days per week): OR

5. The overall medical status is such that no further progress is anticipated or only minimal gains that could be expected to be attained with either less intensive therapy or regular daily activities.

E. Responsible Person

The CEO is responsible for ensuring that all professional level rehabilitation personnel inclusive of the Medical Director adhere to the requirements of this policy. If the CEO is unable to create adherence to this policy, the IRF Program Director shall immediately report the non-adherence to this policy to the Hospital Compliance Coordinator.

F. Auditing and Monitoring

Corporate Compliance shall monitor adherence to this policy during its full scope audits.

G. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Those employees who fail to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance improvement may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

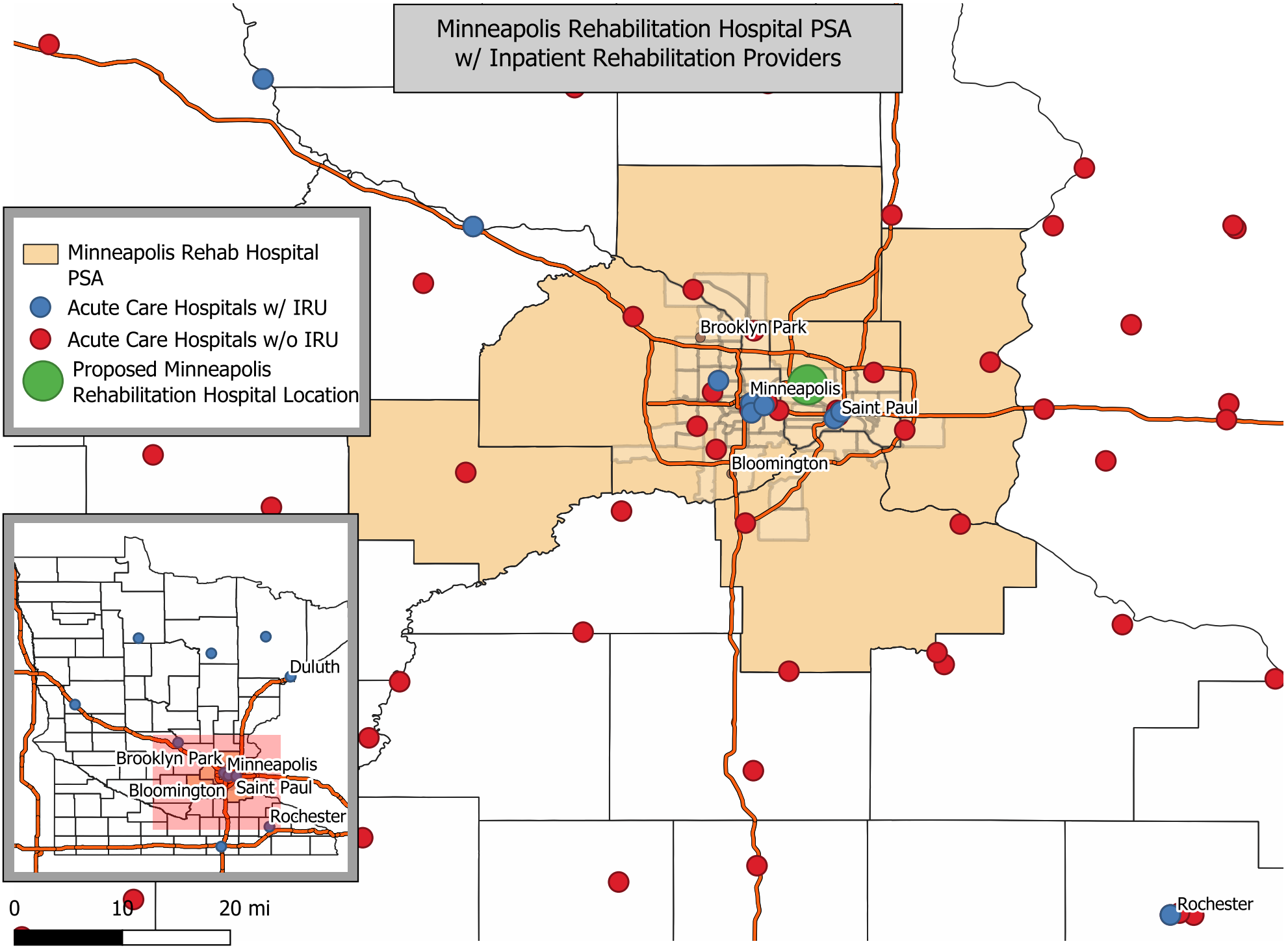
REFERENCES:

- Medicare Benefit Policy Manual, Ch. 1-110-Inpatient Hospital Services Covered Under Part A Inpatient Rehabilitation Services
- 42 CFR § 412.23 (b)
- 42 CFR § 412.25 (a)(2)
- 42 CFR § 412.29
- 42 CFR § 412.622 (a)(3)-(5)

KEYWORDS: Admissions, Medical Director, Rehabilitation Physician, CEO

Exhibit 4

Planning Area Map


Minneapolis Rehabilitation Hospital PSA
w/ Inpatient Rehabilitation Providers
Minneapolis Rehab Hospital PSA
Acute Care Hospitals w/ IRU
Acute Care Hospitals w/o IRU
Proposed Minneapolis Rehabilitation Hospital Location
Brooklyn Park
Minneapolis
Saint Paul
Bloomington
Rochester
Duluth
0
10
20 mi