

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

SemperCare Hospital of Orlando, Inc./CON #9544
2745 North Dallas Parkway, Suite 300
Plano, Texas 75093

Authorized Representative: Robert A. Lefton, President
(972) 836-1300

2. Service District/County

District 7 (Orange)

B. PUBLIC HEARING

A public hearing was not held or requested with regard to the establishment of a long-term care hospital (LTCH) in Orange County. However, the application does contain letters of support for the project, all of which state a need for the proposal, as follows:

- Dr. Ross Edmundson, Florida Hospital medical director for case management and bed utilization, writes in support of the project and states that LTCHs provide a lower cost alternative for high acuity, long stay patients which are increasing in number; however, to attain long-term care, Central Florida patients must travel to Jacksonville or Tampa, which creates hardships for the patient and the family, and disrupts continuity of care with the patient's treating physician. Dr. Edmundson also states that nursing homes, home health agencies, and sub-acute care facilities cannot provide the level of care necessary for these patient's needs.

However, the quote below from an article titled “Long-Term Care Hospital under Medicare: Facility-Level Characteristics”¹ and published in the Winter 2001 addition of *Health Care Financing Review*, indicates otherwise.

*Understanding the role of LTCHs (long-term care hospitals) in post-acute care is particularly important because the LTCH PPS (prospective payment system) is being developed in a changing landscape of payment systems for all post-acute providers. For example SNF (skilled nursing facility) PPS was implemented in July 1998 and the BBA (Balanced Budget Act of 1997) mandated that PPSs for rehabilitation hospitals and psychiatric hospitals be implemented in October 2001 and October 2002, respectively. In this dynamic environment, incentives created by each type of post-acute facilities’ new payment system will affect the behavior of the targeted provider type, and likely also of other types of providers. **Because there is some degree of patient overlap between LTCHs and other types of post-acute facilities, LTCHs will be affected not only by the LTCH PPS that is being developed but also by the PPS for other post-acute care providers.***

(bold added for emphasis)

Further, it is unlikely that the proposed project will lower costs for third party payers, although the project will likely lower costs for the discharging acute care facility (Florida Hospital).

- Dr. Rebecca Moroosse, medical director of the Florida Hospital Cancer Institute and a hematologist/oncologist practicing in Central Florida for 16 years, writes in support of the project and states that currently patients requiring long-term acute care such as ventilator dependent patients must be transferred to a facility in

¹ Korbin Liu, SC.D., et al “Long-Term Care Hospitals Under Medicare: Facility-Level Characteristics”, *Health Care Financing Review*, Volume 23, Number 2, Winter 2001, page 17. NOTE: The authors are with the Urban Institute and the research published in this article was funded by the Centers for Medicare and Medicaid Services (CMS) under Contract Number 500-95-0055/04.

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Tampa, which places a great hardship on the patient's family and could isolate patients from their support system of family and friends in their own community. Dr. Moroosse also states that cancer patients requiring long-term acute care could benefit from such a facility.

- Dr. Lawrence Gilliard, a practicing pulmonologist in Orlando, writes in support of the project and states that the current treatment location (ICU and medical/surgical units) is not the most favorable setting for the long-term acute care patient population due to acute care bed unavailability which requires emergency rooms to be used as a holding area for these acutely ill patients. Dr. Gilliard also notes that the only discharge option for the specialized services is to Tampa or Jacksonville, which creates an overwhelming hardship for the patient and family. Unfortunately, Dr. Gilliard does not quantify the number of affected patients.
- Dr. Lee Adler writes in support of the project and recognizes a growing trend of medical admissions with increased severity of illness and older population, resulting in a longer average length of stay. It is noted that Florida Hospital's overall average length of stay has recently been *decreasing*. Dr. Adler also states that patients must be sent to Tampa for needed care and that causes hardships for patients, families, and physicians. Dr. Adler notes that the current ICU, OR, and medical/surgical unit settings are more expensive and skilled nursing facilities and home health care agencies are unable to provide the higher level of care necessary for the higher acuity patients.
- Dr. Paul Garrett Jr. writes in support of the project and cites the sizable distance from Florida Hospital to the nearest long-term care hospital.
- Dr. Daniel Haim, a practicing pulmonologist in Orlando with the Central Florida Pulmonary Group, P.A., writes in support of the project and notes that the travel time to existing providers in Tampa or Jacksonville, where some of the patients are sent, creates a hardship on the patient and family. Dr. Haim also states that he sees an increasing number of patients spending hours or even days in the emergency department waiting for an

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inpatient bed and that having a local long-term care hospital would definitely improve the overall quality of care to their patients. Again, unfortunately Dr. Haim does not quantify the number of affected patients.

- Dr. Manoucher Manoucheri, a practicing internist in Orlando, Dr. Francis Covelli, of Covelli Clinic, P.A., in Maitland, and Dr. Shirish Kirtane, of Kirtane Associates, P.A., of Altamonte Springs and medical director of the ICU at Florida Hospital Altamonte, and Dr. Ivan Castro, a practicing internist in Winter Park, each wrote in support of the project and expressed similar concerns to those raised in the foregoing letters of support.

C. PROJECT SUMMARY

SemperCare Hospital of Orlando, Inc. (CON #9544) proposes the establishment of a new 35-bed long-term care hospital to be located at the Orlando campus of Florida Hospital in District 7, Orange County. The facility will consist of approximately 14,190 square feet of space currently occupied by Florida Hospital's hospital-based skilled nursing unit. This skilled nursing unit is housed in a freestanding building on Florida Hospital Orlando's main campus.

The applicant agrees to condition award of the certificate of need on the following: a minimum of two percent of total annual patient days will be provided to Medicaid patients and a minimum of one percent of total annual patient days will be provided to indigent/charity care patients.

The proposed project cost is \$1,305,983 and will involve 14,190 GSF (3,200 GSF of renovation and \$562,000 in renovation cost).

D. REVIEW PROCEDURE

The evaluation process is structured by the certificate of need review criteria found in Section 408.035, Florida Statutes. These criteria form the basis for the goals of the review process. The goals represent desirable outcomes to be attained by successful applicants who demonstrate an overall compliance with the criteria. Analysis of an applicant's capability to undertake the proposed project successfully is conducted by assessing the responses provided in the application, and independent information gathered by the reviewer.

Applications are analyzed to identify strengths and weaknesses in each proposal. If more than one application is submitted for the same type of project in the same district (subdistrict), applications are comparatively reviewed to determine which applicant best meet the review criteria.

Ch. 59C-1.010(2)(b), Florida Administrative Code, allows no application amendment information subsequent to the application being deemed complete. The burden of proof to entitlement of a certificate rests with the applicant. As such, the applicant is responsible for the representations in the application. This is attested to as part of the application in the Certification of the Applicant.

As part of the fact-finding, the consultant, Richard Patterson, analyzed the application in its entirety with consultation from the Financial Analyst, John Williamson, who evaluated the financial data, and the Architect, Joel Hill, who evaluated the architectural and the schematic drawings as part of the application.

E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA

The following indicate the level of conformity of the proposed project with the criteria and application content requirements found in Sections 408.035 and 408.037, Florida Statutes; applicable rules of the State of Florida, Chapter 59C-1 and 59C-2, Florida Administrative Code (F.A.C.); and Local Health Plans.

1. **Fixed Need Pool**
 - a. **Does the project proposed respond to need as published by a fixed need pool? Ch. 59C-1.008, Florida Administrative Code.**

Need is not published by the Agency for long-term care hospital beds. It is the applicant's responsibility to demonstrate need, pursuant to Ch. 59C-1.008(2)(e), Florida Administrative Code.

Ch. 59C-1.002(28), Florida Administrative Code, defines "long-term care hospital" as a hospital licensed under Chapter 395, Part 1, Florida Statutes, which meets the requirements of Part 412, subpart B, paragraph 412.23(e), Code of Federal Regulations (1994), and seeks exclusion from the Medicare prospective payment system for inpatient hospital services. LTCHs typically serve patients with complex medical, nursing and therapeutic requirements that are beyond the capabilities of nursing homes and/or home care and outside of the services provided by rehabilitation hospitals. This type of care may be applied to the treatment of a wide variety of medical conditions. A recent historical study funded by CMS and referenced earlier (Heath Care Financing Review, Winter 2001, see Footnote 1), indicates that there are generally four types of LTCHs operating in the United States: multispecialty, respiratory, rehabilitation and mental.

- b. **If no agency policy exists, the applicant will be responsible for demonstrating need through a needs assessment methodology which must include, at a minimum, consideration of the following topics, except where they are inconsistent with the applicable statutory or rule criteria:**
 1. **Population demographics and dynamics;**
 2. **Availability, utilization and quality of like services in the district, subdistrict, or both;**
 3. **Medical treatment trends; and**
 4. **Market conditions.**

b.1. Population Demographics and Dynamics:

The applicant presented a population-based need methodology to project the need for LTCH beds in District 7. Charts 1 and 2 of the application display the Orange County and District 7 population for 2000-2007 and the population growth rate for 2002-2007 for ages 0-64, 65+, and total population. The data indicates that Orange County has a higher rate of growth as compared to District 7 in all categories, especially in the 65+ cohort (13 percent vs. 11 percent), which represents the majority of patients typically requiring long-term care hospital services. The applicant states that as those age 65 and over constitute a larger portion of the total population, the demand for health care increases at a rate higher than the general population increase, because along with increasingly longer life spans, the length and severity of diseases is also increasing.

In developing the population-based need methodology, the applicant analyzed the utilization of the existing LTCHs in Florida and used the 65 and older per 1,000 population. Chart 3 of the application shows the LTCH use rate in Florida, as follows:

LTCH Use Rate in Florida

<i>Area</i>	<i>Beds</i>	<i>65+ pop</i>	<i>Patient Days</i>	<i>Use Rate for LTCH Services per 1000 Population 65+</i>
District 4	167	240,241	40,146	167
District 5	60	299,751	21,073	70
District 6	175	311,863	46,070*	148**
District 10	188	260,725	51,865	199
District 11	53	314,900	16,502	52
Total	643	1,427,480	175,656**	124
Florida Use Rate for LTCH				123**

Source: CON Application 9544; *Florida Hospital Bed and Service Utilization by District, January 2002 Batching Cycle; **AHCA calculation.

Chart 3 of the application has an apparent typographical error for the District 6 patient days (48,070 vs. 46,070), which is corrected in the foregoing table. The Florida Use Rate for LTCH for July 2000-June 2001, using January 1, 2001, population estimates, is 123 patient days per 1,000 population 65 and older. Applying the corrected use rate to the 2002 District 7 65 and older population results in a population-based need in District 7 for 107 beds, pursuant to the applicant’s methodology (see Chart 4 of the application):

Projected LTCH Use in District 7

<i>Area</i>	<i>2002 65+ Population</i>	<i>Average Use Rate for LTCH</i>	<i>Projected Patient Days</i>	<i>Average Daily Census</i>	<i>Bed Need At 80%</i>
District 7	254,821	123*	31,343*	86*	107*

Source: AHCA Population Estimates; *AHCA calculation.

The 107-bed need calculated from the applicant’s statewide use rate formula is slightly below the 112 in Chart 4 of the application. AHCA data shows that 120 patients from District 7 were admitted to LTCHs in Florida between July 1, 2000, and June 30, 2001. Of those patients, 55 were to Jacksonville facilities, 47 were to Tampa facilities, two were to the St. Petersburg facility, and 16 were to the Ft. Lauderdale facility. The applicant states that its Length of Stay (LOS) methodology is more conservative than the population-based need methodology discussed above but the population-based one is nevertheless valid and helpful in determining the need in an area. However, the applicant’s use rate is based on existing patient days in existing Florida LTCHs and the applicant admits that it will not be serving the same patient population as served by all but one LTCH in Florida. (Refer to discussion below in this section). Therefore, any need methodology based on this use rate is not valid for this applicant.

Further, the applicant says that the existing LTCHs are freestanding and that no hospital-within-hospital LTCHs are yet operating in Florida. The applicant asserts that the hospital-within-a-hospital model proposed by SemperCare Hospital of Orlando typically serves a different population, that is, high acuity patients with case weights greater than 2.0, many of which are transferred directly from the host hospital’s ICU, who often would not be transferred to a freestanding LTCH, particularly for a long distance, due to the risk involved in transferring the patients. Also, the applicant states that it projects to serve a patient population with a length of stay of approximately 28 days rather than the typical 30 to 58 day lengths of stay of the existing LTCHs in Florida, due to a more diverse case mix than freestanding LTCHs. In addition to ventilator patients, the applicant proposes to serve the following categories of patients: cardio-pulmonary conditions; medically complex conditions; stage III and IV wounds; and neurological and musculoskeletal disorders, which typically average shorter lengths of stay than ventilator patients. The applicant contends that it anticipates higher referral rates than those for

freestanding LTCHs because operating a hospital-within-a-hospital model increases the integration of the LTCH services within the existing health care environment, specifically, physicians at the host hospital do not have to change their rounds to see their patients and families are comforted by knowing that the hospital services are immediately available.

b.2. Availability, utilization and quality of like services in the district, subdistrict, or both:

At the present time there are eight long-term care hospitals with 643 beds licensed to operate in the State of Florida. These facilities are concentrated in five of the 11 health planning areas: District 4 (Jacksonville and Clay County), District 5 (St. Petersburg), District 6 (Tampa), District 10 (Ft. Lauderdale and Hollywood), and District 11 (Miami). The applicant included a map (Graphic 6), which shows the locations of the existing LTCHs and their approximate distances from Orlando. There are two CON approved LTCHs: Mercy Medical Development, Inc. (29 beds) in District 11, and HealthSouth LTAC of Sarasota, Inc. (40 beds) in District 8. Additionally, there are 22 LTCH beds approved at Kindred Hospital’s St. Petersburg facility.

The utilization for the state LTCHs for July 2000-June 2001 is as follows:

Florida LTCH Utilization July 2000-June 2001

<i>Area</i>	<i>Hospital</i>	<i>LTCH Beds</i>	<i>Occupancy</i>
District 4	Kindred Hospital-North Florida	60	88.39%
District 4	Specialty Hospital Jacksonville	107	53.23%
District 5	Kindred Hospital-Bay Area-St. Petersburg	60	96.22%*
District 6	Kindred Hospital-Central Tampa	102	78.33%
District 6	Kindred Hospital-Bay Area-Tampa	73	63.45%
District 10	Kindred Hospital-South Florida-Hollywood	124	70.15%
District 10	Kindred Hospital-S. Florida-Ft. Lauderdale	64	86.11%
District 11	Kindred Hospital S. Florida Coral Gables	53	85.30%
Total		643	74.84%

Source: *Florida Hospital Bed and Service Utilization by District, January 2002 Batching Cycle*

*CON #9488 was issued to Kindred to add 22 LTCH beds to its existing 60 beds and are expected to be on-line by December 31, 2002.

As indicated, there are no licensed or approved LTCHs in District 7. The closest licensed LTCHs to Orlando are in Tampa (approximately 90 miles). According to the applicant, it is not reasonable to assume that the patients the applicant is proposing to serve have access to similar services in adjacent districts or the more distant existing LTCHs. The reasons given were summarized in the letters of support (Section B above),

and include disruption of continuity of care, hardship to patients and their families, and unnecessary transfer risks. However, the applicant fails to discuss how its proposed patient population is currently accessing care. For example, in exhibits provided by the applicant, many of the patients the applicant appears to consider as candidates for these proposed beds are adult open heart surgery patients, who typically do not require LTCH services in Florida. As the applicant notes in its population discussion (above), it plans to serve shorter stay patients, so that its average length of stay (ALOS), unlike all but one LTCH in Florida, will be approximately 28 days.

Although letters of support suggest that patients may not be receiving the most appropriate care, none quantify the number of patients. The applicant has not shown that access to needed care is denied in District 7 nor discussed the types of programs or venues of care that might provide extended care to patients it proposes to serve, such as adult open heart surgery patients, to delineate why those programs are inappropriate for the patients it proposes to serve.

b.3 Medical treatment trends:

The applicant states that hospital-within-a-hospital LTCHs have resulted from the need to treat acutely ill patients, often presenting with multiple symptoms, in a specialized environment. Many patients are admitted to general hospitals that have multiple diagnoses requiring complex and multi-specialty intervention. These patients require a significantly longer than average length of stay before discharge to home or a post-acute setting, such as home health, skilled nursing, or rehabilitation, and they often remain in ICUs because they are too acutely ill to be sent to a general medical unit. The patients may have multiple body system complications and failures that require daily physician visits and significant ancillary and nursing services (which are not specified in the application). They may also have respiratory problems and be ventilator-dependent. However, of the 35 proposed beds, the applicant proposes to provide ventilator services in only four beds. Although stable enough to receive restorative rehabilitative therapies that would expedite their recovery, these therapies cannot be as effectively or efficiently provided in the ICU setting.

Therefore, the applicant contends that these patients are best served by LTCHs. Unfortunately, information provided by the applicant does not clearly show that the patients identified as potential candidates for this LTCH present multiple symptoms and therefore need a specialized environment. As noted earlier, the applicant has included a large number (121 in DRGs 104-110, 112, and 115-118) of adult heart patients in Tab 4 as possible candidates for this LTCH (see Length of Stay Methodology discussed below).

b.4. Market conditions:

The applicant described the market conditions established by CMS's exemption from the Prospective Payment System (PPS). When Medicare PPS was introduced in 1983, HCFA (now CMS) realized that the DRG-based PPS did not adequately address the patient care delivery anomalies associated with specialized patient populations including those of long-term care. Most of the long-term acute patients remain hospitalized well beyond the Medicare geometric mean length of stay (GMLOS). Medicare cost-based exemption for LTCHs was a tool used by CMS to address the specialized needs of patients and providers until a more equitable system could be implemented. The applicant also notes that the Balanced Budget Act of 1997 included many substantial changes in the Medicare cost-based reimbursement methodology for LTCHs and required CMS to develop a PPS for LTCHs, proposed rules for which were published in the Federal Register on March 22, 2002. CMS established the PPS exemption because of the need for the specialized level of care of LTCHs. Under these conditions, the hospital-within-a-hospital LTCH model has proven successful in providing patient care, managing costs, and freeing necessary acute care space in hospitals without unnecessarily duplicating services. It is noted that CMS has funded research to study LTCHs on several occasions both prior to and after the Balance Budget Act of 1997, to better understand the growth being experienced in this type of care. That growth has been both in number of facilities and in Medicare expenditures. According to a recent study, the rate of growth has been "rapid in recent years"².

² Korbin Liu, SC.D., et al "Long-Term Care Hospitals Under Medicare: Facility-Level Characteristics", *Health Care Financing Review*, Volume 23, Number 2, Winter 2001, page 1.

The applicant states that approval of the proposed project will not increase competition because there are no LTCH providers in District 7, but it will increase competition statewide, especially since one provider, Kindred Hospitals, operates seven of the eight LTCHs in Florida. The applicant concludes that introducing another provider into the state, particularly one that utilizes the hospital-within-a-hospital LTCH model, will provide the citizens of Florida increased access to progressive, convenient, and high quality clinical services.

Length of Stay Methodology:

The applicant states that it examined the patient base at Florida Hospital Orlando and determined that a significant need for a LTCH exists within Florida Hospital Orlando. Florida Hospital Orlando is a major tertiary care provider for residents of District 7. In the length of stay methodology presented in the application, the applicant used calendar year 2001 utilization data for Florida Hospital Orlando and states that the methodology uses the geometric mean length of stay (GMLOS) for each DRG provided as a part of the Medicare Prospective Payment System and applies the GMLOS to all potential discharges from the host hospital regardless of payer source. After deleting all patients with lengths of stay less than 15 days, the applicant states that it removed all patients from the individual patient utilization data with DRGs identified by the applicant as “clinically inappropriate” for LTCH services, which are listed behind Tab 5 of the application. No other explanation was given for the inclusion of the 777 patients reflected in the DRG information behind Tab 4 of the application. The applicant then removed individual discharges for patients whose length of stay was less than the GMLOS for the specific DRG plus 15 days. The remaining patient data was adjusted to reflect days assumed to be spent in the host hospital by subtracting the GMLOS for each patient from the total length of stay to determine each patient’s LTCH length of stay. The days assumed to be spent in the host hospital for each patient were summed and resulted in 22,238 LTCH-appropriate patient days.

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The applicant notes that it would usually adjust the LTCH-appropriate patient days for market share and referrals from other hospitals but did not do so in this application because the referrals from Florida Hospital Orlando alone would support the need for the proposed project.

The final two steps of the length of stay methodology in the application are determining the average daily census and projecting need based upon a defined planning occupancy rate. The applicant determined the average daily census to be 60.9 ($22,238 \div 365$), and used an 80 percent target occupancy to project a bed need of 76 ($61 \div 0.8$), as shown in Chart 5 of the application. As stated by the applicant, this projection of need is based solely on discharges from Florida Hospital Orlando and an 80 percent occupancy rate.

AHCA reviewed detailed patient discharge data for all LTCHs in Florida for the period July 2000-June 2001. While not every DRG referenced behind Tab 4 of the application appeared in the AHCA data for LTCHs, it is significant that zero discharges for DRGs 104-110, 112, and 115-118 were reported in LTCHs statewide. However, these DRGs are not listed among those deemed clinically inappropriate for LTCHs behind Tab 5 of the application but are not described in the Proposed Clinical Programs section of the application. In any event, removal of DRGs 104-110, 112, and 115-118 from the individual patient utilization data (4,122 patient days for 121 patients) and applying the applicant's length of stay methodology results in a projected bed need well in excess of the number of beds requested in the application:

Patient Days:	$22,238 - 4,122 = 18,116$
Average Daily Census:	$18,116 \div 365 = 49.6$
Beds Needed at 80% Occupancy:	$49.6 \div 0.8 = 62$

The average length of stay associated with the foregoing revision is 27.6 days ($(22,238 - 4,122) \div (777 - 121)$).

It is again noted that the applicant failed to discuss the District 7 population demographics and dynamics as they relate to the availability, utilization and quality of like services in the district to clearly demonstrate that patients are either unable to access needed services or are being cared for in an inappropriate setting. Based on the number of days patients that remained in acute care beds, it is likely that some portion of those patients identified by the applicant would have benefited from LTCH services. However, the applicant did not demonstrate that more than 120 District 7 patients needed LTCH services during the period July 1, 2000 through June 30, 2001. These patients were treated in LTCHs outside of the district.

2. Local Health Plan Preferences

Is need for the project evidenced by the applicable district health plan? ss. 408.035(1) and 408.037(1), Florida Statutes, and Ch. 59C-1.030(2)(c), Florida Administrative Code.

There are no local health plan preferences for long-term care hospitals.

3. Agency Rule Preferences

Please indicate how each applicable preference for the type of service proposed is met. Ch. 59C-1.031-.044, Florida Administrative Code.

There are no agency rule criteria for long-term care hospitals.

4. Statutory Review Criteria

- a. Is need for the project evidenced by the availability, quality of care, efficiency, accessibility, and extent of utilization of existing health care facilities and health services in the applicant's service area? ss. 408.035(2) and 408.035(7), Florida Statutes.**

The applicant states that long-term acute care services are currently missing from the continuum of care at Florida Hospital and within District 7. The proposed LTCH will benefit long-stay acute care patients by providing a higher number of

nursing hours per patient day than a general nursing unit, combined with a number of therapy hours per day that significantly exceeds what is typically provided in an intensive care setting. As distinguished from skilled nursing facility care, the LTCH will provide a high level of nursing care for high acuity patients suffering from multiple conditions.

Please refer to Section E.1.b.2. above for further discussion.

The applicant provided evidence that it will be able to provide some of the needed care for its patients even though it intends to locate on the campus of another hospital. The lease agreement provided in Tab 1 of the application discusses patient care and termination of the lease with an option to extend. Common areas are discussed, as are maintenance and repair of the hospital. However, food service was not specifically addressed. It is not clear how the applicant plans to address the dietary needs of its patients. Additionally, as discussed above, assuming the applicant will be serving a medically complex patient population, its ability to provide adequate staff is a critical element of this proposal. Because the applicant failed to discuss recruitment and retention policies, it is not clear that adequate staff will be available.

As discussed earlier, 120 District 7 residents received LTCH services are LTCH outside of the district. This indicates that the project will improve the availability and accessibility of LTCH services to District 7 residents.

- b. Does the applicant have a history of providing quality of care? Has the applicant demonstrated the ability to provide quality care? ss. 408.035(3), Florida Statutes.**

The applicant, SemperCare Hospital of Orlando, Inc., does not have an operational history of providing quality of care. The applicant states that its parent, SemperCare, Inc., has a variety of mechanisms that have been used to ensure and maintain quality care in its other facilities, which will be implemented by the applicant. It is noted that the applicant did not provide evidence of its parent's certification or licensure history in other states so that it was clear that these mechanisms are appropriately and adequately applied by SemperCare. These mechanisms include a comprehensive performance improvement system called QualMax™, constant maintenance of regulatory compliance and readiness, outcomes

measurement systems, utilization and risk management programs, credentialing and privileging systems, a corporate compliance program, and a customer satisfaction system. All of the foregoing are described in the application. Exhibit 6 of the application contains copies of SemperCare's Performance Improvement Plan, Utilization Management Program, and Risk Management Policies and Procedures. Exhibit 7 of the application contains SemperCare's Corporate Compliance Program Guide. The applicant also addressed licensure history, again noting that as a new entity, it does not have one. The applicant included the Joint Commission on Accreditation of Healthcare Organization (JCAHO) survey results for the four currently operational SemperCare facilities. The applicant points out that it will be separately licensed and included copies of its Certificate of Incorporation and authorization to operate in Florida as Exhibit 8 of the application. Copies of Florida Hospital's licenses are included in Exhibit 9 of the application.

- c. Is the applicant proposing special health care services for its service area that are not reasonably and economically accessible in adjacent service areas? ss. 408.035(4), Florida Statutes.**

Currently, there are no LTCH providers in District 7. There are LTCHs in adjacent Districts 4 and 6, however, as discussed above, the applicant contends that they are not reasonably accessible due to distance considerations. Assuming that the patients being served are elderly multi-complex patients this is likely the case, at least to some extent. However, the applicant has not clearly demonstrated this and LTCHs in Florida have historically served large areas.

- d. Is this project to be located in a research or teaching hospital? Will the program affect the clinical needs of health professional training programs in the service area? ss. 408.035(5), Florida Statutes.**

The proposed project is not to be located in a statutorily defined teaching hospital nor will the primary purpose of the project involve research or physician education. The applicant states that Florida Hospital is a statutory Family Practice Teaching Hospital, operates one of the largest family practice residency programs in the country, and has several clinical training agreements. The applicant also states that Florida Hospital is qualified as a research hospital under the Florida Statutes. The

applicant lists Florida Hospital's numerous affiliations with colleges and universities. The applicant says that it is committed to supporting the clinical needs of health professionals and anticipates that some of the health professional training programs that currently use Florida Hospital Orlando as a clinical training site will also use SemperCare Hospital once it is operational. The applicant also says that the Departments of Nursing and of Occupational Therapy Assistance at Florida Hospital College of Health Sciences have expressed interest in using SemperCare Hospital of Orlando as a training site. The applicant did not provide copies of any documentation relating to the referenced agreements, affiliations, or training programs.

- e. What resources, including health manpower, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? ss. 408.035(6), Florida Statutes.**

Schedule 6 of the application contains the proposed staffing for the facility. While the applicant states that staff for the facility will be hired and trained prior to opening, recruitment and retention are not discussed.

The audited financial statements of the applicant were reviewed to assess the financial position as of the balance sheet date and the financial strength of its operations for the period presented.

The applicant is a start up company with \$100 in assets as of April 16, 2002. SemperCare, Inc., the parent, was formed in 1999 for the purpose of developing a network of facilities providing long-term acute care. The company had, at June 30, 2001, \$3.8 million in cash on hand, \$6.6 million in current assets and \$9.8 million in total assets. Capital has been raised through the issuance of stock. The company has a shareholders' deficit of \$8.3 million, a net operating loss for the period of \$3.6 million with negative cash flows from operations of \$3.9 million. However, the first LTAC hospital owned by SemperCare opened in April 2000 with four facilities operational as of the date of the balance sheet.

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The facilities are too new to judge the financial strength of the parent based on their revenue. The short-term financial position of the company depends on its continued ability to raise sufficient capital to support its operating losses. In October 2001 the company issued an additional \$5.05 million in preferred stock. The long-term future of the company will depend on its being able to operate the facilities at a profit level that will support the company's debt. It is too early to determine the long-term financial strength of the parent.

Capital requirements:

SemperCare Hospital of Orlando, Inc. will lease the space required to operate the hospital from Florida Hospital Medical Center, with SemperCare paying no rent for the first six-months of operation and \$1,056 per month per licensed LTAC bed thereafter. Total capital costs for this project from Schedule 1 are \$1.3 million, with \$904,718 the responsibility of the applicant and the remainder provided by Florida Hospital Medical Center. Schedule 1 did not include the estimated loss during the initial six months of operation of \$257,539, bringing the total project costs for the applicant to \$1,162,257. Schedule 2 indicates the parent has a total of \$4.9 million in capital projects.

Available capital:

Funding for the proposed project is coming from the parent, SemperCare, Inc., for its portion, and from Florida Hospital Medical Center for its share. A letter was provided from each in support of their commitment to fund their part of the project. SemperCare, Inc.'s financial resources are discussed above; Florida Hospital had \$156.0 million in cash as of December 31, 2000.

Conclusion:

The applicant, with the support of its parent, may be able to raise sufficient capital to fund the project under review; however funding for this and all other capital projects is not fully assured.

f. What is the immediate and long-term financial feasibility of the proposal? ss. 408.035(8), Florida Statutes.

A comparison of the applicant's estimates to the control group values provides for an objective evaluation of financial feasibility, (the likelihood that the services can be provided under the parameters and conditions contained in Schedules 7 and 8), and efficiency, (the degree of economies achievable through the skill and management of the applicant). In general, projections that approximate the median are the most desirable, and balance the opposing forces of feasibility and efficiency. In other words, as estimates approach the highest in the group, it is more likely that the project is feasible, because fewer economies must be realized to achieve the desired outcome. Conversely, as estimates approach the lowest in the group, it is less likely that the project is feasible, because a much higher level of economies must be realized to achieve the desired outcome. These relationships hold true for a constant intensity of service through the relevant range of outcomes. As these relationships go beyond the relevant range of outcomes, revenues and expenses may, either go beyond what the market will tolerate, or may decrease to levels where activities are no longer sustainable.

The Centers for Medicare and Medicaid Services (CMS) published a proposed prospective payment system (PPS) rule in March 2002 for long-term care hospitals (LTCH). Under the proposed PPS for LTCH a payment for a Medicare patient will be made at a predetermined, per discharge amount for each LTC-DRG. The law requires that the LTCH PPS be budget neutral, which means that total payments must equal the amount that would have been paid if the PPS had not been implemented. Therefore, a comparison of the applicant's revenue estimates to the control group values, based on the reasonable cost-based reimbursement system, provide a rational basis for evaluating estimated revenues.

The estimated revenues submitted by the applicant for the project were developed based on the existing reasonable cost-based reimbursement system. In order to qualify for an exemption under CFR Part 412.23 for reimbursement under the existing prospective payment system a long-term acute care facility, operating as a hospital within a hospital, must, according to CMS's State Operations Manual interpretive guidelines, not exceed more than 15 percent of its total

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inpatient operating costs in services obtained under contract with the host hospital *or* at least 75 percent of the hospital's inpatient population must be referred from a source other than the host facility. The applicant states that they anticipate more than 25 percent of their patients to be referred from Florida Hospital; they will meet the requirements by having less than 15 percent of their inpatient operating costs in services purchased from Florida Hospital.

Comparative data were derived from hospitals in peer groups that reported data in 2000; the applicant will be compared to the hospitals in peer group 12. Per diem rates are projected to increase by an average of 3.3 percent per year. Inflation adjustments were based on the most current Florida Hospital Input Price Index.

Projected net revenue per adjusted patient day (NRAPD) of \$845 in year one and \$840 in year two is between the control group lowest and median values of \$712 and \$916 in year one and \$733 and \$944 in year two. The lowest value is generally viewed as the practical lower limit on economies of operation. With net revenues per adjusted patient day falling between the lowest and median the facility is expected to consume health care resources in proportion to the services provided. (See Comparative Table).

Projected cost per adjusted patient day of \$762 in year one and \$750 in year two is between the control group lowest and median values of \$737 and \$796 in year one and slightly below the lowest level of \$759 in year two. The lowest cost is considered the lower limit of cost-efficiency. Costs below this threshold would describe efficiencies that no other facility has been able to achieve. However, examining the various expense categories discloses that estimated overhead costs of \$215 in year one and \$194 in year two are significantly lower than the control group overhead cost per adjusted patient day of \$309 in year one and \$319 in year two. The applicant proposes to operate a hospital within a hospital, leasing space from Florida Hospital Medical Center; this results in savings in overhead expenses compared to the freestanding hospitals that comprise the control group. (See Comparative Table). Compared to the control group these costs are efficient.

g. Will the proposal foster competition to promote quality and cost-effectiveness? ss. 408.035(9), Florida Statutes.

The applicant projects managed care to represent 32.2 percent of its patient days. This is above the control group highest level of activity of 19.6 percent. The projected levels, if realized, will have a positive impact on competition to promote quality assurance and cost-effectiveness. Also, although the proposed project may lower costs for the discharging acute care hospital, the proposed project is unlikely to lower costs for third party payers.

h. Are the proposed costs and methods of construction reasonable? Do they comply with statutory and rule requirements? ss. 408.035(10), Florida Statutes; Ch. 59A-3 or 59A-4, Florida Administrative Code.

The application is to establish a long-term care hospital within a hospital. SemperCare Hospital proposes to lease a building on Florida Hospital Orlando's main campus to establish a long-term care facility.

The proposed hospital will have 35 patient rooms. Six rooms will be private, 14 semi-private rooms and there will be one isolation room. The requirements for accessibility are met and the minimum allowable square footages are acceptable.

Since the existing space is currently being used as a skilled nursing facility, most of the renovation will be done to ancillary spaces, and not to the actual patient rooms. There will be renovations to certain HVAC and electrical systems to upgrade them to meet current codes. There are two nurse stations centrally located on the floor. One has an adjacent staff toilet, but it is not accessible.

However, there is an accessible toilet directly across the corridor from both nurse stations, and this should be sufficient although it does not meet the exact wording of the code.

The two nurse stations also share some ancillary spaces, and their location, size and layout are acceptable. The two major additions to the support spaces are a new pharmacy and a medical records room. A new family waiting room will also be created.

The renovation cost of \$176 per square foot appears to be reasonable. Many ancillary spaces and hospital services will be leased from or be billed to the new hospital.

The applicant provided a list of most common applicable codes, but is not accurate and will have to be revised if this project should proceed.

- i. Does the applicant have a history of providing health services to Medicaid patients and the medically indigent? Does the applicant propose to provide health services to Medicaid patients and the medically indigent? ss. 408.035(11), Florida Statutes.**

The applicant does not currently own or operate LTCHs in Florida. The applicant agrees to condition award of the certificate of need on the following: a minimum of two percent of total annual patients days will be provided to Medicaid patients and a minimum of one percent of total annual patient days will be provided to indigent/charity care patients. According to AHCA Fiscal Year 2000 data, LTCHs in Florida provided 2.5 percent Medicaid days and 2.3 percent charity days.

F. SUMMARY

SemperCare Hospital of Orlando, Inc., proposes the establishment of a new 35-bed long-term care hospital. The proposed long-term care hospital will be located at the Orlando campus of Florida Hospital in District 7, Orange County. The proposed project cost is \$1,305,983 and will involve 14,190 GSF (3,200 GSF of renovation and \$562,000 in renovation cost).

Need:

Need is not published by the agency for long-term care hospital beds. It is the applicant's responsibility to demonstrate need, pursuant to Ch. 59C-1.008(2)(e), Florida Administrative Code. The applicant demonstrated numeric need based on a population-based need methodology that considered utilization of LTCH services in Florida. However, the applicant is not proposing to serve the same patient population as served by all but one of the LTCHs whose utilization it used to determine additional need. Therefore, this need methodology is not valid

for the patient population it proposes to serve. Additionally, the applicant failed to clearly show that area residents were unable to access needed care or, other than through its proposed staffing, that the patients it states it will serve are actually multi-complex and need the level of care provided in a LTCH.

Quality of Care:

The applicant does not currently own or operate long-term care hospitals in the State of Florida. However, the applicant reasonably demonstrated the potential to provide quality of care based on their experience and existing policies in place at other facilities. The applicant included the JCAHO survey results for the four currently operational SemperCare facilities. The applicant did not discuss how it would recruit or retain the staff proposed in the application.

Financial/Cost:

The applicant is a start up company with \$100 in assets as of April 16, 2002. SemperCare, Inc., the parent, was formed in 1999 for the purpose of developing a network of facilities providing long-term acute care. The company had, at June 30, 2001, \$3.8 million in cash on hand, \$6.6 million in current assets and \$9.8 million in total assets. The facilities are too new to judge the financial strength of the parent based on their revenue. The short-term financial position of the company depends on its continued ability to raise sufficient capital to support its operating losses. The long-term future of the company will depend on its being able to operate the facilities at a profit level that will support the company's debt. It is too early to determine the long-term financial strength of the parent. The applicant, with the support of its parent, may be able to raise sufficient capital to fund the project under review; however, funding for this and all other capital projects is not fully assured.

The applicant projects managed care to represent 32.2 percent of its patient days. This is above the control group highest level of activity of 19.6 percent. The projected levels, if realized, will have a positive impact on competition to promote quality assurance and cost-effectiveness.

Medicaid/Indigent Care:

The applicant has agreed to provide two percent of its total annual patient days to Medicaid patients and one percent of its total annual patient days to indigent/charity patients. The applicant does not have a history in Florida of providing Medicaid and/or indigent care.

Architectural Analysis:

The applicant proposes to lease a building on Florida Hospital Orlando's main campus to establish a long-term care facility in existing space currently being used as a skilled nursing facility. The proposed hospital will have 35 patient rooms. Six rooms will be private, 14 semi-private, and there will be one isolation room. The requirements for accessibility are met and the minimum allowable square footages are acceptable. The renovation cost of \$176 per square foot appears to be reasonable. Many ancillary spaces and hospital services will be leased from or be billed to the new hospital.

The applicant provided a list of most common applicable codes, but is not accurate and will have to be revised if this project should proceed.

G. RECOMMENDATION

Deny CON #9544.

AUTHORIZATION FOR AGENCY ACTION

Authorized representatives of the Agency for Health Care Administration adopted the recommendation contained herein and released the State Agency Action Report.

DATE: _____

Karen Rivera
Health Services and Facilities Consultant Supervisor
Certificate of Need

Jeffrey N. Gregg
Chief, Bureau of Health Facility Regulation