

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

SemperCare Hospital of Pensacola, Inc. (CON #9745)

2745 North Dallas Parkway
Plano, Texas 75093

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Select Specialty Hospital-Escambia, Inc. (CON #9746)

2021 Church Street, Suite 202
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Authorized Representative: Greg Sassman, Vice President
(615) 284-6716

2. Service District

District 1

B. PUBLIC HEARING

A public hearing was not held or requested with regard to the establishment of new long-term care hospital beds in District 1. However, letters of support were submitted for the respective applications as follows:

SemperCare Hospital of Pensacola, Inc. (CON #9745) submitted 42 letters of support from various health care providers; government officials; churches and private businesses. The letters include support from representatives of the Baptist Healthcare System including several of its hospitals as well as Baptist Manor (nursing home) and Baptist Home Health Care; West Florida Hospital; Azalea Trace (Nursing Home); Pensacola Health Care Facility; Delta Health Group, Inc.; City of

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Pensacola; the Council for Aging of West Florida, Inc., and 15 letters from area physicians.

The letters of support from Baptist Healthcare System affiliates, local businesses and community groups basically state that the location of a LTCH in Baptist Hospital (District 1) will enhance services and accessibility for residents of the Pensacola area. Several of the letters addressed the inability to place acute care patients that qualify for LTCH services. West Florida Hospital's letter indicates that it had 172 patient discharges during calendar year 2002 that were appropriate for long-term care hospital placement. The applicant also includes a summary of the physician support letters which states that utilizing its length of stay methodology, Baptist Hospital discharged 336 patients that were appropriate for long-term hospital care during 2002 and that 15 of the physicians who included letters of support for the project accounted for seven or more of these discharges. A listing of these physicians and the number each discharged was provided for 2002. An updated number of potential LTCH discharges by West Florida Hospital as well as the physician discharges listed were not provided for 2003.

Letters of support from three area nursing homes contend that they have patients whose level of care is higher than they can provide given the prospective payment system's reimbursement and that the long-term hospital reimbursement allows the long-term care hospital to provide the most effective treatment. All express their willingness to enter into a written transfer agreement with SemperCare upon approval of the project. The nursing homes do not provide the numbers of their patients who need long-term hospital care.

Janice Gilley, Escambia County Commissioner, submitted a letter of support for the project indicating that there are currently no facilities in the area providing this care and if the project is not approved patients and families will have to travel to Mobile, which is over 60 miles away or to Panama City, over 100 miles, to assess this care. She concludes that the project will be of great benefit to caregivers, friends and family members.

While some of the letters of support quantified the actual number of patients who could be discharged for LTCH services; the emphasis is on the long-term care hospital being more appropriate for prospective payment system reimbursement. There was no documentation provided to indicate that these patients did not receive appropriate care in other settings.

Select Specialty Hospital-Escambia, Inc. (CON #9746) submitted approximately 150 letters in support of the proposed Escambia County

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LTCH and 11 letters from providers outside the county generally attesting to the quality of care provided by Select Specialty. Letters of support were received from the following local providers and organizations: Sacred Heart Healthcare System includes affiliated hospitals (Northwest Florida Community Hospital, North Okaloosa Medical Center, Sacred Heart Hospital-Pensacola, Sacred Heart-Emerald Coast); NovaCare Rehabilitation; Healthmark Corporation; Council for Aging of West Florida, Inc. and several physician groups representing a total of 37 physicians in the immediate Escambia County area. The physician letters indicate that care was given to a total of 129 patients who would likely be candidates for LTCH services during 2002. Letters of support were also submitted by the City of Pensacola Deputy Mayor and one City Council member.

The letters of support basically state that the location of a LTCH in District 1 will enhance services and accessibility for residents. Several of the letters addressed the inability to place acute care patients that qualify for LTCH services. The majority of support letters are comprised of "form" letters on Sacred Heart Health System letterhead and signed by individuals whose affiliation with Sacred Heart is largely unclear. It is assumed that the signees are employees within the Sacred Heart Health System. Approximately half of these letters indicate support for specialized services for the Pensacola area and the remaining letters state that without a LTCH, seriously ill patients are remaining in the hospital for three or more weeks as they are too sick to go to a skilled nursing facility, rehab unit, or home with home health.

The applicant also included 11 letters of support from various Select Specialty affiliates from around the country. Three of these were from representatives of the new Miami Select Specialty Hospital. In addition, there was one letter from a mother of a Select Specialty Hospital Miami patient. These basically support the long-term care hospital concept and compliment the care given at Select Specialty Corporation Hospitals.

C. PROJECT SUMMARY

SemperCare Hospital of Pensacola, Inc. (CON #9745), a wholly owned subsidiary of SemperCare, Inc., proposes to establish a 36-bed LTCH within Baptist Hospital in Pensacola, Escambia County. The parent, SemperCare, Inc. currently operates 17 LTCHs with eight others in the process of start-up. In Florida, SemperCare has received a license for a 30-bed LTCH in Panama City and is approved for a 29-bed LTCH in Tallahassee, both in District 2. The applicant also has a 35-bed LTCH located within Florida Hospital in Orlando (District 7). SemperCare has submitted two separate proposals during the current review cycle to

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develop LTCHs in the state of Florida. These involve new LTCHs in Districts 1 and 6.

The proposed LTCH will be located on the fourth floor of Baptist Hospital and will contain 16,825 square feet, which encompasses 22 one-bed rooms and seven semi-private rooms at a renovation construction cost of \$1,109,770. Total project cost is estimated to be \$2,125,730. SemperCare, Inc will provide the funding for the proposed project.

The applicant proposes to condition award of the certificate of need on the provision of 2.0 percent of the facility's annual patient days to Medicaid patients and one percent of gross revenue to indigent/charity care. Though not proposed as a condition, the applicant indicates that following approval of this CON, Baptist Hospital will delicense 30 skilled nursing beds and six acute care beds.

Select Specialty Hospital-Escambia, Inc. (CON #9746), a wholly owned subsidiary of Select Medical Corporation, proposes to establish a 54-bed freestanding LTCH to be located at 5203 North Ninth Avenue in Pensacola, Escambia County. The applicant proposes to lease the building formerly used as the Haven of Our Lady of Peace, a licensed community nursing home that was replaced at a new location. The parent, Select Medical Corporation, currently has 72 LTCHs nationwide, including one operational LTCH in Miami that was licensed on December 23, 2002. Select also has CON approval to develop a 40 bed LTCH located within Lucerne Medical Center in District 7. Select Specialty has submitted six proposals in the current review cycle to develop LTCHs within the State of Florida. These involve proposals in Districts 1, 3, 4, 6, 8 and 9.

The proposed hospital will consist of 58,590 gross square feet of renovation and 273 GSF of new construction with construction costs of \$5,423,478. Total project cost is estimated to be \$7,762,645. Select Medical Corporation will provide the funding for the proposed project.

The applicant proposes to condition award of the certificate of need on the provision of 2.0 percent of the facility's total annual patient days to Medicaid patients and 0.8 percent to charity care patients.

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.

Chapter 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, M. Riley Gibson, analyzed the application in its entirety with consultation from the Financial Analyst, Douglas Pierce, 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 Florida Statutes, Sections 408.035, and 408.037; applicable rules of the State of Florida, Chapter 59C-1 and 59C-2, Florida Administrative Code; 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 acute care hospital (LTCH) beds. It is the applicant's responsibility to demonstrate need based on the topics provided in rule and listed in Item b below.

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A long-term care hospital is defined as a hospital licensed under Chapter 395, Florida Statutes, which meets the requirements of Part 412, subpart B, paragraph 412.23(e), Code of Federal Regulations; and, where applicable, also meets the requirements for a hospital within a hospital specified under paragraph 412.22(e) of that subpart. A long-term care hospital has an average length of inpatient stay greater than 25 days for all hospital beds. Long-term care hospitals are designed to provide extended care to patients who are clinically complex and have multiple acute or chronic conditions. Long-term care hospitals typically provide programs in one or more of the following areas: respiratory care, particularly for ventilator-dependent patients; treatment of patients with multiple illnesses or multiple systems failure; treatment of wounds caused by disease or accident; and treatment for patients requiring interdisciplinary rehabilitation services who are unable to tolerate the more intensive treatments provided in a comprehensive medical rehabilitation hospital.

According to the June 2003 Medicare Payment Advisory Commission (MedPAC) Report to Congress, there has been substantial growth in the number of LTCHs over the past decade. Corresponding with the increase in the number of facilities is a rapid increase in Medicare spending on LTCHs. The MedPAC report suggests that skilled nursing facilities (SNFs) and LTCHs may be clinical substitutes for each other. In addition, there may be other overlaps between LTCH services and other health care venues. This potential for LTCHs to substitute for less costly SNF care is exacerbated by the fact that there are currently no clinical patient admission criteria for LTCHs except for the anticipated 25-day length of stay.

According to the June 2003 *MedPAC* report to Congress:

“LTCHs are the post-acute setting least used by beneficiaries and are not available in many areas. In general, policymakers regard rapid growth in any sector as a phenomenon that requires examination. As the number of LTCHs has almost doubled since 1993 and Medicare spending for such care has also quintupled from 1993 – 2001, questions have arisen about whether beneficiaries using LTCHs are different from patients using other settings. Our analysis found patients in market areas with LTCHs had

similar acute hospital lengths of stay regardless of whether they used LTC hospitals or not. Patients who used these hospitals were three to five times less likely to use SNF care, suggesting that SNFs and LTCHs may be substitutes. Compared with similar patients who did not use LTCHs, total payments and mortality rates for LTCH patients were considerably higher.”¹

In view of these findings, it is important that the determination of specific clinical conditions being served in LTCHs be identified and that the establishment of a LTCH does not represent a more costly and possibly duplicative post-acute care option.

b. Determination of Need.

In the absence of agency policy regarding long term care hospital beds and services, Chapter 59C-1.008 (2)(e), Florida Administrative Code, provides 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:

- a. Population demographics and dynamics;
- b. Availability, utilization and quality of like services in the district, subdistrict or both;
- c. Medical treatment trends; and
- d. Market conditions.

The existence of unmet need will not be based solely on the absence of a health service, health care facility, or beds in the district, subdistrict, region or proposed service area.

Note: The Centers for Medicare and Medicaid Services (CMS) have established a prospective payment system for short-stay acute care providers to include limited "outlier" payments for long-stay acute care patients in short-stay acute care hospitals. Effective October 1, 2002, CMS implemented a new prospective payment system for long-term care hospital providers. Through this system, termed LTC DRGs, CMS is recognizing the patient population of LTCHs as separate and distinct from the populations treated by short-term acute care and post-acute care providers that each have their own prospective payment system in recognition of the material differences in patient populations, cost of care, and health care delivery.

¹ June 2003 MedPac Report to Congress: *Variations and Innovation in Medicare*, page 72.

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Under this system, each patient admitted to a LTCH is assigned a DRG with a corresponding payment rate that is weighted based upon the patient's diagnosis and acuity. The LTCH will be reimbursed the pre-determined payment rate for that DRG, regardless of the cost of care. A proposed rule updating the LTCH annual payment rate and providing for certain policy changes was published in the Federal Register on January 30, 2004 (Vol. 69, No. 20).

Federal Regulations, 42 CFR Parts 412, 413 and 476 regarding prospective payment for long-term care hospitals published in Volume 67, Number 169 of the Federal Register describe the universe of LTCHs on page 55960 as:

“LTCHs typically furnish extended medical and rehabilitation care for patients who are clinically complex and have multiple acute or chronic conditions. Generally, Medicare patients in LTCHs have been transferred from acute care hospitals and received a range of “postacute care” services at LTCHs, including comprehensive rehabilitation, cancer treatment, head trauma treatment and pain management.”

CMS further draws parallels and distinctions among post-acute care providers, most notably rehabilitation providers (page 55965):

- Most patients in LTCHs had several diagnosis codes on their Medicare claims, indicating that they had multiple co-morbidities and are probably less stable upon admission than patients admitted to other postacute care settings. Relative to intensive rehabilitation facilities (IRFs), LTCHs had a higher proportion of patient costs attributable to ancillary services (for example, pharmacy, laboratory, and radiology charges).
- LTCHs provide care to a disproportionately large number of Medicare beneficiaries who are eligible because of disability. While individuals with disabilities make up about 10 percent of the Medicare population, they make up 17 percent of the LTCH patients.
- LTCH admissions typically come from outlier acute care hospitals, nonoutlier acute care hospitals, and other (indicating direct admissions without acute stay).
- In terms of age, those without prior acute care stays were younger and about twice as many were under the age of 65, with a mean age about five or three years lower than those with prior acute care stays (whether outlier or nonoutlier). When compared to intensive rehabilitation facilities (IRFs) the proportion of LTCH patients who are under 65 years of age (18 percent) was twice that of IRF patients (nine percent).
- About 1/3 of the LTCH Medicare stays were beneficiaries who are also eligible for Medicaid, compared to fewer Medicaid-eligible beneficiary

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stays at IRFs. CMS states that it is widely documented that dually eligible beneficiaries are generally much sicker than non-Medicaid eligible Medicare beneficiaries.

Rehabilitation facilities are currently required to have 75 percent of their admissions in one of 10 specific diagnoses related to conditions requiring rehabilitation services. The only condition of participation for LTCHs in addition to those required of all hospitals is to have an average Medicare length of stay greater than 25 days.

In addition to similarities to rehabilitation providers noted above, as previously stated, the *MedPAC Report to Congress* indicated that data suggests that care provided in LTCHs is similar to that provided in skilled nursing facilities and that care in LTCHs is becoming a substitute for skilled nursing care rather than a different or higher level of care. However, despite similarities in care suggested by the data, payments for LTCH patients were higher as were mortality rates.

At present there are 11 licensed long-term care hospitals with a total of 769 beds licensed to operate in the state of Florida. However, only 10 facilities (740 beds) reported utilization for the reporting period with Sister Emmanuel Hospital For Continuing Care (29 beds) located in District 11 (Miami) and SemperCare (30 beds) located in District 2 (Panama City), licensed, but not yet operational. There are an additional 166 beds approved but not yet operational LTCH beds. Sixty-six of these beds are approved for LTCHs in districts with existing facilities: Districts 4, 7, and 10. The remaining 100 beds will establish new LTCHs in District's 2, 3 and 8. The following are the CON approved, but not yet licensed LTCH beds: 20 beds at Kindred Hospital in District 4, six beds at Kindred in Ft. Lauderdale in District 10 and the following approved new LTCH hospitals: SemperCare (29 beds) in Tallahassee, in District 2, Kindred Hospitals East, L.L.C. (31 beds) in District 3 at Munroe Regional in Ocala, HealthSouth (40 beds) in Sarasota in District 8; and Select Specialty (40 beds) in Orlando in District 7.

The average occupancy of the operational programs reporting utilization was 73.23 percent for the period July 2002 through June 2003. With regard to the LTCH programs in operation for the total 12-month reporting period, occupancy ranged from a low occupancy rate of 52.59 percent for Specialty LTCH-Jacksonville to a high of 93.79 percent for Kindred LTCH-St. Petersburg.

The following table shows the beds, patient days and occupancy of Florida's operational LTCHs for the July 2002 through June 2003 reporting period:

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**Florida Long Term Care Hospitals
Utilization Experience July 2002-June 2003**

Hospital	District	Beds	Bed Days	Patient Days	Occupancy
*Kindred-North Florida	4	60	22,080	19,848	89.89%
Specialty-Jacksonville	4	107	39,376	20,706	52.59%
Kindred-St. Petersburg	5	82	23,642	22,174	93.79%
Kindred-Central Tampa	6	102	37,536	28,913	77.03%
Kindred-Tampa	6	73	26,864	18,038	67.15%
**SemperCare Hospital of Orlando	7	35	665	-0-	-0-
Kindred-Hollywood	10	124	45,632	31,523	69.08%
***Kindred-Ft. Lauderdale	10	64	23,552	21,102	89.60%
Kindred-Coral Gables	11	53	19,504	17,469	89.57%
****Select Specialty-Miami	11	40	7,720	782	10.13%
Florida Total		740	246,571	180,555	73.23%

Source: Florida Hospital Bed Need and Service Utilization, 1/23/04

***Kindred-North Florida approved under CON 9650 to add 20 LTCH beds**

****SemperCare Hospital of Orlando licensed 06/12/03 with one quarter of operation shown.**

*****Kindred-Ft. Lauderdale approved under CON 9621 to add 6 LTCH beds**

******Select Specialty-Miami was licensed 12/23/02, thus only six months of utilization is shown. A license was also issued on 07/15/03 for 29 beds for Sister Emmanuel Hospital For Continuing Care in Miami and on 1/05/04 for 30 beds for SemperCare Hospital in Panama City. No utilization data is available for the latter two LTCHs.**

There are currently no long term care hospital beds in District 1. However, in District 2 a 30-bed LTCH in Panama City was recently licensed and a 29-bed LTCH in Tallahassee has CON approval. Once fully operational, the Panama City facility located in Bay County will be the closest in-state accessible LTCH for District 1 residents with an approximate travel time of two hours and 30 minutes. The Tallahassee based LTCH will approximate a three-hour travel time for Escambia County residents using Interstate 10 between Tallahassee and Pensacola. Both applicants contend that it is unreasonable to require LTCH appropriate patients to travel in excess of 100 miles to receive LTCH services. However, as noted in letters of support provided by applicants, LTCH care is available within 60 miles in Mobile, Alabama.

The current bed complement, patient days and average occupancy of other forms of care in District 1 is presented as follows:

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**Acute Care and Post-acute Care Providers
District 1 Beds and Utilization**

Facility Type	Total Beds District 1	District 6 Average Occupancy
Acute Care	1,813	53.21%
Comprehensive Med. Rehab	78	61.76%
Hospital Based Skilled Nursing	94	58.49%
Skilled Care Community Nursing Homes	3,243	84.79%

Source: Acute care, CMR beds for July 1, 2002 through June 30, 2003. Skilled care community nursing home, and HBSNU beds by district for July 2002-June 2003.

As previously noted, LTCHs are designed to treat patients with medical conditions requiring extended hospital-level services, for a period of time of at least 25 days on average. Both co-batched applicants state that its respective proposals will provide LTCH services to patients with complex and medically unstable conditions that cannot be adequately addressed in licensed acute care beds, comprehensive medical rehabilitation beds, hospital-based skilled nursing unit beds, and nursing home beds in the service planning area. However, the MedPAC report states that patients may have different levels of functional limitation, differences in severity of illness within a given DRG, or personal preferences. The supply of providers, Medicare's eligibility requirements, and local practice patterns also may influence what type of post-acute care patients receive. The MedPAC analysis of LTCHs found that patients in market areas with LTCHs had similar acute hospital lengths of stay regardless of whether they used LTCHs or not. Patients who used these hospitals were three to five times less likely to use skilled nursing care, suggesting that skilled nursing facilities and LTCHs may be substitutes. In other words, the MedPAC report suggests that the potential exists for substitution of services among alternative settings. Although the Medicare payment system now specifically recognizes the LTCH patient population as being distinct from the patient populations treated by traditional acute care hospitals and post-acute care providers, there may be overlap between patient populations served, especially between the diagnoses and services provided to lower acuity LTCH patients.

As noted earlier, when no need methodology exists, it is the applicant's responsibility to demonstrate need based upon the availability, utilization and quality of like services in the district. The Centers for Medicare and Medicaid, based on several studies, has determined that LTCH services are similar to home health services, skilled nursing services and comprehensive medical rehabilitation services. Applicants for LTCH services must therefore show that there is need based upon the availability, utilization and quality of LTCH, home health, skilled nursing and comprehensive medical rehabilitation services in the district.

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Although both applicants contend that LTCHs serve a distinct population and do not represent a substitute for other post-acute care options, neither demonstrated this contention. A discussion of each applicant's need analysis is presented below following general findings regarding expected population growth in the district within the next five years.

Population Estimates for District 1 Counties and Percent Change by County For Total Population, 65 and over, and 75 and Over Population

County	Total July 2004	Total July 2009	Percent Change	65+ Percent Change	75+ Percent Change
Escambia	303,870	315,476	3.82%	5.16%	5.60%
Okaloosa	181,505	193,933	6.85%	7.81%	17.17%
Santa Rosa	131,745	147,996	12.34%	25.96%	29.56%
Walton	46,602	52,726	13.14%	29.88%	32.82%
Total District	663,722	710,131	6.99%	12.02%	14.84%

Source: AHCA Pop. Projections, published June 2003.

As shown above, the overall population in District 1 is expected to increase by 6.99 percent during the next five years, with the 65 and over and 75 and over age cohort increasing by 12.02 percent and 14.84 percent, respectively. Escambia County, the most populous county in the district and the proposed site of both LTCHs, is expected to have the smallest percent increase in total population as well as in the 65 and over and 75 and over population categories for the five-year projection period. As noted earlier, there are LTCHs approved in District 2 nearer Walton County, the county with the highest expected rate of growth overall, age 65 and over and age 75 and over, and nearer Okaloosa county, the second largest county in the district with a high rate of expected growth in the 75 and older population.

SemperCare Hospital of Pensacola, Inc. (CON #9745) proposes LTCH services to primarily serve Escambia County residents and residents of the surrounding counties discharged from acute care facilities. The applicant contends that the proposed relationship between SemperCare and Baptist Hospital will provide the optimal situation for the majority of the potential LTCH patients in District 1 and represents a cost-effective approach.

The applicant states that based on hospital discharge data for the period July 2002 through June 2003, 1,209 patients in District 1 met the utilization screening criteria indicating they might have benefited from a LTCH. According to the applicant, for the same time period, at least 528 patients at Baptist Hospital and West Florida Hospital would have benefited from LTCH services. The applicant states that these patients represented 15,363 patient days over the GMLOS for their respective DRGs.

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SemperCare contends that other post-acute care providers are not appropriate sites for the delivery of the type and intensity of long-term care services it proposes. The applicant states that the intensity of care provided by LTCHs is generally much greater than care delivered by other post-acute care providers such as medical rehabilitation, hospital-based skilled units, or nursing homes. The applicant further contends that LTCH patients can receive restorative care, such as aggressive ventilator weaning, and restorative care, such as rehabilitation, that other providers are ill-suited to provide or cannot provide. However, as previously noted, the June 2003 MedPAC Report to Congress indicates that patients in market areas with LTCHs had similar acute hospital lengths of stay regardless of whether they used LTCHs or not and that patients who used these hospitals were found to be three to five times less likely to use skilled nursing facility (SNF) care, suggesting that SNFs and LTCHs may be substitutes. Although the applicant states its intention to generally serve medically complex patients, especially ventilator dependent patients, there are no clinical patient criteria under Medicare for entrance into a LTCH except the 25 day average length of stay required for Medicare reimbursement. In response to this lack of clinical criteria, the applicant references guidelines developed by McKesson Health Solutions, LLC's to recognize the characteristics that distinguish short-term acute care patients from LTCH patients. The applicant states that the severity of patients was measured by applying this patient refinement classification system to SNF and LTCH patient data, purported to be a more complex system than the CMS DRG patient classification system. Based on this system of identifying four levels of severity, the applicant contends that its patients fall into the two most severe categories, while the majority of SNF patients fall into the two least severe categories. The applicant states that it does treat a relatively high volume of respiratory-ventilator-dependent patients and that on average, long-stay patients treated in a SemperCare Hospital experience an average of 7.5 co-morbidities with multi-system complications. However, charts submitted by SemperCare (Exhibit 13, page 57 of the application) show that approximately 30 percent of its patient population's severity levels were considered "minor" or "moderate". While the majority of its patients may be considered "major" or "extreme" severity levels, it is clear that a significant percentage (30 percent) of its patient population could have received care in another post-acute venue. Additionally, the applicant provided no information to demonstrate that lengths of stay in acute care beds decreased for LTCH patients when it provided LTCH services in the same planning area.

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The applicant discusses venues of post-acute care that include: comprehensive medical rehabilitation (CMR), community skilled nursing beds, and home health services indicating that none are appropriate for the patients it intends to serve. The applicant does not specifically address hospital based skilled nursing unit beds (HBSNU), of which 94 are currently licensed in District 1 with a reported average utilization of 59.49 percent. Although CMS recognizes the differences in the clinical milieus through distinctly separate payment and certification systems for other forms of post-acute care, data used to define the number of LTCH patients the applicant indicates need LTCH services does not clearly show that these patients, or a large portion thereof, could not be appropriately treated in other post-acute settings.

The applicant took exception to several issues raised in a previous review regarding agency concerns as a result of the findings contained in the June 2003 MedPAC Report. However, in view of the lack of any specific clinical patient criteria for LTCH admittance, the MedPAC Report raises genuine concerns regarding LTCHs as a possible clinical substitution for other forms of post-acute care. The MedPAC Report recognizes that more research is needed to determine the role that LTCHs play for Medicare patients and to understand quality outcomes in this setting. As part of its follow-up March 2004 meeting, MedPAC is recommending that LTCH and patient criteria be developed in order to define LTCHs and their patients. AHCA would be remiss not to consider the concerns and recommendations of the MedPAC Report. And as noted above, the applicant has provided information that substantiates concerns expressed in the MedPAC Report and failed to address some of the larger concerns in the report which were that acute care stays remained the same even when LTCH beds were available in an area and mortality rates of post-acute patients were not improved. Claims have long been made, but never demonstrated by LTCHs that patients are inappropriately held in acute care beds and not receiving the best care as a result. LTCHs have also claimed that if LTCH care were available, the acute care length of stay would be reduced and the patient would receive more appropriate care. Neither of these was demonstrated by the applicant even though it operates several LTCHs in the United States and one in Florida.

The applicant is proposing to locate within Baptist Hospital as well as work with West Florida Hospital, a second area acute care hospital. The applicant anticipates that the majority of its admissions will come from these two hospitals. The applicant chose to use a Length of Stay (LOS) methodology to project the need for LTCH services at Baptist Hospital.

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This methodology is based upon utilization data from the second half of 2002 and the first half of 2003 for the hospitals within District 1. The LOS methodology targets patients whose lengths of stay are well above national averages for that DRG. This approach uses the GMLOS for each DRG provided as a part of the Medicare Prospective Payment System for acute care hospitals and applies the GMLOS to all potential discharges from the host hospital (Baptist) and other area hospitals. Since all DRGs are not appropriate for admission to a LTCH, the applicant provides a listing of inappropriate DRGs as well as individual patient utilization data with a length of stay less than the Medicare GMLOS plus 15 days. Based on this approach, the applicant arrived at 1,187 potentially appropriate LTCH patients representing a total of 30,092 LTCH appropriate patient days for hospitals in District 1. This approach assumes that patients will not be held in acute care beds for this extended time, but rather discharged to its LTCH. As noted earlier, the MedPAC Report found that this was not the case in the areas it studied and the applicant provided no documentation from areas where it currently operates to show that it was reasonable to expect these days beyond the GMLOS would be reduced. If days are not reduced, there is no reason to assume that these patients might be LTCH patients. They could easily be SNF or SNU or CMR patients or not be candidates for any post-acute care and be discharged directly home after an extended acute care stay.

These potential referral hospitals are shown as follows with the number of patients and aggregate number of patient days shown that represent a stay in acute care beds beyond the average for their particular diagnosis:

Potential LTCH Referrals From Area Acute Care Hospitals

Facility	Patients	Patient Days
Baptist Hospital	352	9,456
West Florida Hospital	166	4,301
Sacred Heart Hospital	351	8,895
Fort Walton Beach Medical Center	213	5,304
*All other Okaloosa & Santa Rosa County Acute Care Hospitals	105	2,136
District 1 Total	1,187	30,092

Source: CON Application, Exhibit 25. *All other above includes North Okaloosa Medical Center, Twin Cities Hospital, Gulf Breeze Hospital, Jay Hospital, Santa Rosa Medical Center, and Healthmark Regional Medical Center. Note: Walton County residents are not included in the projections because these patients are closer to Panama City and will be served by SemperCare Hospital of Panama City in Bay County.

Based on the above caseload of patients and projected patient days, the applicant is projecting a referral rate of 35 percent (10,532 patient days) which is actually less than the total LTCH appropriate days shown above for both Baptist Hospital and West Florida Hospital, the two primary referral sources for the proposed LTCH (13,757 patient days). Based on an 80 percent occupancy rate and an average length of stay of 25.35 days, the applicant arrived at a need for 36 LTCH beds. The applicant

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states that based on the parent company's experience, the proposed LTCH will have an average daily census of 18 patients during the DRG demonstration period (50 percent occupancy), 25 patients during year one (69 percent occupancy), and 29 patients during year two (81 percent occupancy).

With regard to the LOS methodological approach, the applicant's projections are based on assumed capture rates. It was not demonstrated by the applicant that patients that may meet the definition of a LTCH patient are not currently being placed or that an access problem exists in the district. The subsequent placement of these patients was not disclosed although it is stated in hospital letters that the patient's condition was such that transfer to an existing post-acute facility was not a reasonable option. With only three patients leaving the area for LTCH services in Florida, it is assumed that these patients remained in an acute care bed or were treated in other post-acute settings either in Florida or Alabama. Discharge data is shown for the period July 2002 through June 2003, reflecting the 1,209 patients in District 1 that met the utilization screening criteria indicating they might have benefited from a LTCH. The letters of support submitted by Baptist Hospital and West Florida Hospital, reflect a total of 508 patients meeting LTCH criteria and discharged by these two hospitals in CY 2002. It is unclear if the totals shown by the hospitals and area physicians reflect the same patient refinement classification system for identifying LTCH appropriate patients (McKesson Health Solutions guidelines) as previously addressed by the applicant.

In response to AHCA comments in a previous SAAR regarding the LTCH appropriateness of identified patient data, the applicant states that it commissioned a study (Morrison Informatics, Inc.) to determine the proportion of current short-term acute care patients who are clinically appropriate for the proposed LTCH. The applicant states that the research project was based on an initial pilot study on two patients conducted at Baptist Hospital to confirm need for the LTCH based on clinical admission criteria. It appears that in the later research project, Baptist Hospital's discharge planners reviewed patient charts for one month and identified 52 patients who were clinically appropriate for LTCH services. The applicant states that of these 52 patients, 11 patients continued to be denied post-acute care in skilled nursing or rehabilitation facilities due to their clinical needs. On an annualized basis, the chart reviews indicate approximately 624 potential LTCH patients and 132 possible denials for post-acute care. The applicant states that LTCH appropriate case summaries were presented to clinical admissions staff at SNF and CMR facilities to determine whether the identified case studies would be appropriate candidates for admission to these post-acute care venues. The result was that the majority of these

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cases were rejected by the contacted facilities (three SNFs and three CMRFs). The actual commissioned research document was not provided for review. It was further not disclosed how many of these identified patients were eligible for hospital-based skilled nursing care, or the subsequent disposition of these patients. As previously noted, the applicant states that Baptist Hospital will delicense 30 of its existing 57 SNU beds and six acute care beds subsequent to the approval of this project. Baptist Hospital's 57-bed HBSNU provided 9,770 days of care and an average occupancy of 46.96 percent for the July 2002 through June 2003 reporting period. It is noted that basing projections for LTCH need on data from one month is not reasonable.

In summary: the applicant's hospital within a hospital projections are based on the potential LTCH patient base of between 508 and 528 patients as identified by the length of stay methodology and summary of potential patients discharged from physicians as shown in the letters of support from Baptist Hospital and West Florida Hospital. The subsequent placement of these patients was not disclosed although it is stated in hospital letters that the patient's condition was such that transfer to an existing post-acute facility was not a reasonable option. However, it was not disclosed how many of these patients met the criteria and were eligible for hospital-based skilled nursing care. It was further not demonstrated that patients that qualify for LTCH services are not currently being served or that any substantial access problem exists for residents in District 1.

Select Specialty Hospital-Escambia, Inc. (CON #9746) indicates that the proposed 54-bed LTCH will primarily serve Escambia County and surrounding area residents. The applicant contends that District 1 residents have no access to long-term care hospital services, pointing out that patient origin data show that just three persons (two from Okaloosa County and one from Santa Rosa County) received care at any of the state's LTCHs during the 12-month period, October 1, 2002 through September 30, 2003. The applicant presents an analysis of discharges for the reporting period from the eleven LTCHs in the state to demonstrate that the majority of patients served by LTCHs reside in the same county in which the LTCH is located. The notable exception is Kindred Hospital-North Florida in Clay County, a largely rural area serving surrounding counties. The applicant also discussed the use of other post-acute care options and the distinguishing criteria for each to demonstrate that LTCHs do not represent a substitute for other forms of post-acute care services. However, as previously discussed, the June 2003 MedPAC Report to Congress does suggest that SNFs and LTCHs may be clinical substitutes for each other and that an overlap exists between the types of patients being treated in each venue. This issue

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may only be resolved if and when clinical criteria is developed for LTCH services.

The applicant states that rather than employ a methodology for generalizing LTCH demand, the demand is demonstrated by matching DRGs treated in Florida's LTCHs with those long-stay patients in acute care hospitals in District 1. The applicant identified LTCH cases by DRG for the period October 2002 through September 2003 and for the same time period identified acute care patients with a length of stay of 25 days or longer in acute care hospitals in District 1. There were certain exclusions made (newborns, mental diseases, alcohol/drug abuse, etc.) to ensure comparability. The result was the identification of 355 acute care cases from acute care hospitals that had a length of stay of 25 days or longer and that matched the DRGs treated at Florida's LTCHs. The top 25 DRGs were associated with 41 percent of District 1's long-stay cases and represent 75 percent of the cases in LTCHs in Florida. The applicant increased the 355 cases by 25 percent to complete the comparison using the statewide experience. A length of stay of 43.9 days (average for Florida LTCHs) was used to generate patient days for 2004. For subsequent years, the cases were increased at the compounded annual growth rate of the elderly population. The results of the applicant's computation is shown in the following table:

Forecast of the Demand for LTCH Services in District One and Escambia County by Year 2004-2008

Year	Forecasted LTCH Cases	Forecasted LTCH Days	Average Daily Census, ADC	Beds Needed @ 75 Percent
District One				
2004	444	19,484	53	71
2005	453	19,903	55	73
2006	463	20,331	56	74
2007	473	20,768	57	76
2008	483	21,215	58	77
Escambia County				
2004	334	14,671	40	54
2005	337	14,799	41	54
2006	340	14,928	41	55
2007	343	15,057	41	55
2008	346	15,188	42	55

Source: CON Application, Page 1-31

The applicant contends that the above results indicate that sufficient demand will occur to establish a LTCH in District 1. The applicant anticipates that the average daily census in 2006 will actually correspond to the year within which the 54-bed facility is expected to open. As shown above, the applicant expects that the majority of patients (ADC of 41 in 2006) will originate from residents of Escambia County. However, the above results show anticipated demand without imposing patient, family, or physician preferences. These factors will have an influence on the decisions made to access LTCH services and

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impact the use of the hospital. Additionally, even though the applicant begins with a projection in 2004, this is based on presumed existing need and if there were really hundreds of patients needing LTCH services in District 1, there would most likely be numerous letters of complaint to the agency about lack of access from citizens, government groups, activist's groups, physician's groups, and hospitals citing real cases, not suspected ones. As an example, the applicant also discussed area support for the project providing sample excerpts from letters indicating how beneficial a LTCH would be to the area. If there were hundreds of actual cases, letters would be much stronger and based on real examples of need. The physician letters provided in support of the project indicate a total of 129 of their patients would have likely been candidates for LTCH services during 2002. There is no indication given that hospital case workers in the area were contacted with regard to potential cases, especially from within the Sacred Heart Healthcare System, comprised of Northwest Florida Community Hospital, North Okaloosa Medical Center, Sacred Heart Hospital-Pensacola, and Sacred Heart-Emerald Coast.

In addition to the need assumption made above, the applicant also presented two methodological approaches for consideration. The first methodology utilizes a length of stay methodology to identify acute care patients with lengths of stay in acute care hospitals that exceed the acceptable DRG stay. The second method involves statewide age-specific LTCH use rates applied to population projections for July 2006 to predict the number of LTCH patient days in District 1.

Select Specialty states that both methods have the same objectives. These include the calculation of the number of long-term care patient days that the district would generate, conversion of the patient days to an average daily census, calculation of the number of LTCH beds needed at an 80 percent occupancy, inflation of the forecast to calendar year 2006 using July 2006 population estimates and among the options in the models, finding the option that is most consistent with the district's utilization of health care resources for CMR, HBSNU and community nursing homes.

The length of stay methodology projects patient days for a new LTCH using the ALOS for LTCH appropriate patients in acute care hospitals to calculate an estimated number of patient days that may be generated by area hospitals. The applicant used Florida's hospital discharge data for calendar year 2002 for hospitals within its proposed service area to identify patient days appropriate for LTCH services.

The applicant contends that the Major Diagnostic Code (MDC) that creates the longest length of stays is not associated with DRGs but the DRGs that appear are tracheotomies of head, neck and throat with or

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without complications, that are assigned the MDC is “ALL” meaning that the result can occur within any of the MDCs. Likewise, DRGs 468 and 477, extensive operating room procedure related/unrelated to principle diagnosis, are assigned the MDC “PRE” meaning that it is a pre-event that can occur across all the MDCs. Since not all diagnoses are appropriate for the services offered at a LTCH (neonates with complications or their mothers with complications in delivery, psychiatric and substance abuse diagnoses), the applicant has deleted these DRGs from inclusion in the analysis. The applicant provided two options under the length of stay methodology: (1) patients with a length of stay greater than 25 days and (2) patients with a geometric mean plus seven days which adds seven days to each of the 527 DRGs’ GMLOS. *(Note: The GMLOS represents an adjusted value for all cases for a given DRG, assigned by the CMS).* It is therefore assumed that if patients stayed in the acute care hospital more than a few days beyond the GMLOS, they are potential candidates for a LTCH.

The applicant indicates that an analysis of District 1 Florida hospital discharge data for CY 2002 for patients with a length of stay over 25 days identified 1,345 cases and of those 919 were selected after including only adults, aged 18 and older and excluding psychiatric and substance abuse cases. These 919 cases had an ALOS of 39.3 days, which is approaching the statewide LTCH ALOS of 42.7. Option two, the geometric mean plus seven days produced 281 cases, having an average length of stay of 54.3 days, higher than the statewide LTCH ALOS.

The patient days for both categories were divided by 365 days to yield an average daily census (ADC) and the value of the ADC was divided to 0.8, to obtain the number of beds needed if the ADC corresponded to an 80 percent occupancy rate. The 919 cases accounted for 36,159 patient days or an average stay of 39.3 days. The applicant divides 36,159/365, which results in an ADC of 99. Therefore, 124 beds would be needed at 80 percent occupancy. The use of the GMLS plus seven-day method yielded 281 cases and a total of 15,391 patient days. This results in an ALOS of 54.8 days and an average daily census of 41.14. Therefore, to reach 80 percent occupancy, 53 beds would be needed utilizing this method.

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The following chart shows the applicant's calculated number of LTCH discharges for the acute care hospitals in District 1 for CY 2002 and the projected discharges for CY 2006. The applicant indicates that the population increase to July 2006 for District 1 is applied and a compound annual growth rate of 0.0132 is utilized in the projections below.

Long-term Hospital Patient Days District 1 Service Area Hospitals July 2003 - July 2006

	Discharges LOS > 25 days	Discharges GMSOS + 7 days
ALOS	39.3	54.8
ADC July 2003	99	42
ADC July 2006	103	44
Beds Needed @ 80% Occupancy	129	56

Source: CON Application page 1-37. July 2003 figures are based on CY 2002 Hospital Discharge Data.

Based on the above discharges, the applicant states that the two options yield different results, one for 129 beds and one for 56 beds based on extended acute care lengths of stay. The applicant contends that the two estimates provide a reasonable upper and lower range of projected LTCH patient days but the 56 beds represent the "best fit" for the forecast of LTCH beds in District 1. As with any LOS methodology, certain variations in patient characteristics can alter assumptions of need. These include the patient's functional ability, availability of caregivers at home, ethnicity, age, socio-demographics, and dependence on technology. The applicant's Exhibit 1-1 provided supporting data, including MDC data by hospital for District 1 (as well as the remaining districts in the state). This documentation indicated that a total of 876 cases were patients with a length of stay over 25 days within District 1. Sacred Heart Hospital accounted for 305 out of 681 total cases for Escambia County alone. However, there was no documentation presented from area hospital discharge planners with regard to discharges of potential LTCH patients. Further, no evidence has been presented by the applicant indicating that area residents who need LTCH services have been unable to obtain post-acute care them from one of the several venues of post-acute services currently available within District 1. Additionally, as noted above in co-batched applicant SemperCare's discussion, this assumption means that the applicant intends to reduce the length of stay at the acute care facility if the project is approved and the MedPAC Report's findings indicate that is not the case. Neither applicant demonstrated that acute care length of stays were shortened

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when it operated a LTCH in the area. Therefore any methodology based on the GMLOS or LOS cannot be considered if the applicant does not demonstrate there is reason to believe it will reduce the length of stay at the acute care hospital. These patients might be discharged to a SNU, SNF, CMR or even directly home with no post-acute care.

The applicant also presented a "Use Rate Model", calculating a statewide utilization rate to be applied in District 1 utilizing data from other Districts with LTCH beds. This approach uses varying use rates and is not considered a valid method of calculating need. In the Recommended Order arising out of Case No. 03-2484CON (Select Specialty Hospital-Sarasota, Inc. versus AHCA), the judge found that *"a use rate methodology is not necessarily a reliable indicator of bed need because the existing LTCHs are not evenly distributed statewide and the utilization rates for the existing LTCHs vary significantly."*

In summary, the applicant's need analysis does not take into consideration other influencing factors including patient, family, or physician preferences. These factors will have an influence on the decisions made to access LTCH services and impact the use of the hospital. The physician letters provided in support of the project indicate a total of 129 of their patients would have likely been candidates for LTCH services during 2002. There is no indication given that hospital case workers in the area were contacted with regard to potential cases, especially from within the Sacred Heart Healthcare System. Also for consideration, the applicant also presented two methodological approaches to need. With regard to the LOS methodology, the applicant's projections are also based on assumed capture rates of LTCH appropriate referrals from area hospitals. However, as with any LOS methodology, certain variations in patient characteristics can alter assumptions of need. These include the patient's functional ability, availability of caregivers at home, ethnicity, age, socio-demographics, and dependence on technology. The applicant's use rate approach is based on the experience of other LTCHs in other parts of the state and relies on assumptions that may or may not occur in the proposed service area. This approach was recently dismissed by a law judge as not necessarily a reliable indicator of need due to varying utilization rates for existing LTCHs in the state. Although the applicant purports an access problem for area residents, it was not sufficiently demonstrated by the applicant that patients that may meet the definition of a LTCH patient are not currently being placed or that an access problem exists in the district. If access was of a severe nature, there would be complaints to the agency and the letters of support would have been stronger and based on real examples of need.

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It was not demonstrated by either applicant that patients are being denied access to LTCH services offered outside of District 1 or that other post-acute care options are not being utilized efficiently. Access to LTCH care will be available to residents on the western side of the district with the implementation of an approved LTCH in that area and is currently available to residents on the eastern side of the district within reasonable travel times.

2. Local Health Plan Preferences

Is need for the project evidenced by the applicable district health plans? Applicants shall provide evidence in their applications that a proposed long-term care hospital is consistent with the needs of the community and other criteria contained in Local Health Council Plans. ss. 408.035(1) and 408.037(1), Florida Statutes, and Ch. 59C-1.030(2)(c), Florida Administrative Code.

The October 2003 District 1 CON Allocation Factors Report does not have preferences for the development of long-term care hospital beds.

3. Agency Rule Criteria

The Agency does not currently have adopted preferences relating to LTCHs.

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.**

SemperCare Hospital of Pensacola, Inc. (CON #9745) basically refers to the previous discussion in Item E1 "Fixed Need Pool" regarding the lack of LTCH services from the continuum of care at Baptist Hospital and within District 1. As previously stated, the applicant states that the proposed project will increase the availability and accessibility to care in District 1 due to the lack of any LTCH services in the district and the distance that residents must travel for these services. However, agency Rule 59C-1.008(2)(e)(3), indicates that the existence of unmet need will not be based solely on the absence of a health service, health care facility, or beds in the district, subdistrict, region or proposed service area. The closest approved provider of LTCH services is in Panama City

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(District 2/Bay County), in excess of 100 miles from Pensacola. The applicant identifies the primary service area for its project to be Escambia County and surrounding counties in District 1 with the exception of Walton County; which is more accessibly served by the Bay County LTCH. As noted earlier, support letters submitted indicate that LTCH services are located within 60 miles of this area in Mobile, Alabama.

The applicant proposes to develop a hospital-within-a-hospital concept in conjunction with Baptist Hospital. However, the applicant did not discuss improved efficiency within the current continuum of care or specify what efficiencies will occur with Baptist Hospital (e.g. centralized sharing and purchasing, management, clinical and quality management, etc.). These centralized benefits were not outlined, specifically with regard to financial cost savings to the applicant, Baptist Health Care System or Baptist Hospital.

As previously discussed, the applicant provided a letter from Baptist and other hospitals indicating a potential caseload of LTCH patients based on length of stay. The applicant also provided a summary of supporting documentation from area hospitals and physicians regarding potential LTCH referrals. Specific documentation from area providers with regard to delays in care would have been supportive and beneficial in showing an access problem to long-term care in the area.

The applicant did not demonstrate need for the project as evidenced by the availability, quality of care, accessibility, and extent of utilization of existing health care facilities and health services in the applicant's service area.

Select Specialty Hospital-Escambia, Inc. (CON #9746) states that the proposed LTCH will result in improved access to all persons, not just those traditionally underserved. The applicant further states that due to the location of the existing LTCHs, few residents of District 1 use long-term acute care hospital services because of the lack of availability and accessibility of LTCH services.

The applicant proposes to develop a freestanding hospital on the campus of Sacred Heart Hospital. However, other than a sample Purchased Services Agreement and a non-committal letter of support, any efficiencies that might result from this collaboration was not disclosed (e.g. centralized sharing and purchasing, management, clinical and quality management, etc.). These centralized benefits were not outlined, specifically with regard to financial cost savings to the applicant, the health care system or Sacred Heart Hospital.

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As previously discussed, the applicant provided numerous letters of support for the project but only local physicians in the area provided any specific numbers regarding potential LTCH referrals. Documentation from area providers/case workers with regard to specific delays in care would have been supportive and beneficial in showing an access problem to long-term care in the area.

The applicant did not demonstrate need for the project as evidenced by the availability, quality of care, accessibility, and extent of utilization of existing health care facilities and health services in the applicant's service area.

- 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.**

SemperCare Hospital of Pensacola, Inc. (CON #9745) is a new, development stage corporation with no operating history. 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. 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. The applicant included the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) survey results for nine currently operational SemperCare facilities.

The applicant points out that the facility will be separately licensed and responsible for securing and completing all appropriate state licensure requirements, Medicare and Medicaid certification, and JCAHO accreditation. The applicant states that Baptist Hospital, the host hospital, is currently fully licensed and accredited.

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Select Specialty Hospital-Escambia, Inc. (CON #9746) is a new, development stage corporation, and as such has no operating history. The applicant is a controlled entity of Select Medical Corporation, an existing provider of LTCH services nationwide with 72 existing LTCHs, including one in Miami, Florida that was licensed on December 23, 2002, and an approved 40-bed LTCH in Orlando. The applicant states that the proposed Escambia County LTCH will be JCAHO accredited like other Select hospitals. The JCAHO accreditation is an indication that quality of care is being delivered and that the components are in place to ensure the delivery of quality of care.

The applicant states that Quality Improvement Programs already in place at other Select locations nationwide will be implemented in the proposed facility. The applicant states its commitment to implementing an effective quality improvement program and described the various elements of the QI Program.

AHCA data reveals that its facility in Miami had four confirmed complaints from January 28, 2004 to April 5, 2004. There was one confirmed complaint in each of the following categories: Restraints, Medicine Problems/Errors/Formulatory, Infection Control and Patient Abuse/Neglect.

- 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.**

The co-batched applicants are not proposing special health care services that are not reasonably and economically accessible in adjacent service 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.**

Neither of the proposed projects will be located in a statutorily defined teaching hospital nor will the primary purpose of the proposed projects involve research or physician education.

- 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.**

The audited financial statements were reviewed to assess the financial position of the two co-batched applicants as of the balance sheet date

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and the financial strength of the operations for the applicants for the applicable period presented.

SemperCare Hospital of Pensacola, Inc. (CON #9745) is a start-up company with \$100 in assets as of October 14, 2003. SemperCare, Inc., the parent, was formed in 1999 for the purpose of developing a network of facilities providing long-term hospital care. The parent company had, at June 30, 2002, \$13.7 million in cash on hand, \$20.1 million in current assets and \$23.3 million in total assets. Capital has been raised through the issuance of stock and long-term debt. The company has a shareholders' deficit of \$13.6 million, a net operating loss for the period of \$3.1 million with negative cash flows from operations of \$4.7 million. The first long-term care hospital owned by SemperCare opened in April 2000 with 12 facilities operational as of the date of the balance sheet. These 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. On August 8, 2003 the company established a \$55 million credit facility with General Electric Capital Corporation (GECC) to support its development strategy and ongoing working capital requirements. 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.

SemperCare Hospital of Pensacola, Inc. will lease the space required to operate the hospital from Baptist Health Care Corporation with SemperCare paying no rent for the first six months and \$1,000 per month per licensed long-term care bed thereafter. The initial term of the lease is for five years, with options to extend.

Baptist Health Care Corporation will contribute approximately \$750,247 in funding for the proposed project. Audited financial statements were submitted for the period ended September 30, 2002. Those statements reported cash and short-term investments of \$52.2 million, current assets of \$122.5 million, with a operating profit of \$8.4 million and operating cash flows of \$22.9 million.

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Capital requirements:

Total capital costs for this project from Schedule 1 are \$2.1 million. Schedule 1 did not include the estimated loss during the initial six months of operation of \$1,353,444, bringing the total project costs for the applicant to \$3,479,174. Schedule 2 indicates the applicant has no other capital projects.

Available capital:

Funding for the proposed project is coming from the parent, SemperCare, Inc. and Baptist Health Care Corporation. Each provided a letter in support of their commitment to fund the project. Baptist Healthcare Corporation and SemperCare, Inc.'s financial resources were previously discussed above.

Staffing:

According to Schedule 6, the proposed project will require 90.8 FTE staff for the proposed operating year ending November 2006. Nursing staff including aides will fill 49 FTE positions, with ancillary staff filling 25.5 FTE positions. The applicant provided position descriptions of various department personnel required as well as a table describing the hospital's recruitment strategy implementation. The applicant did not discuss any retention incentives for staff.

Conclusion:

Funding for this project is likely to be available as needed.

Select Specialty Hospital-Escambia, Inc. (CON #9746), a wholly-owned subsidiary of Select Medical, Inc., is a development stage company with \$10 in assets as of February 4, 2003. The applicant submitted Form 10K for Select Medical, Inc. for the period ended December 31, 2002. *(Note: Since the financial statements presented for Select Medical Corporation are the same as those submitted for a previous review, the financial reviewer accessed the parent's latest publicly available 10-K report).* The parent company had, at December 31, 2003, \$165.5 million in cash on hand, \$485.1 million in current assets and \$1.1 billion in total assets. Reported net operating revenue increased by 24 percent to 1.4 billion, producing cash flows from operations of \$246.3 million, which is an increase of 104 percent over the previous year. The parent company is considered financially strong.

Capital requirements:

Total capital costs for this project from Schedule 1 are \$7.9 million. Schedule 2 indicates the applicant has no other capital projects. Although no other capital projects are listed by the applicant, the parent, in their 10-K filing, stated that they are committed to developing eight to 10 projects a year as part of their expansion strategy. No dollar figure was attached to the projected development plan, however in previous applications the estimated cost per hospital project was in the \$2 to \$3 million range.

Available capital:

Funding for the proposed project is coming from the parent, Select Medical, Inc. A letter was provided in support of their commitment to fund the project.

Staffing:

According to Schedule 6, the proposed project will require a total of 80 FTE staff in year one, increasing to 108.5 FTE staff in year two. The nursing staff, including aides will fill 40 FTE positions in year one, increasing to 61 FTE positions in year two. Ancillary positions, including therapists will fill 20 positions in year one, increasing to 22.5 positions in year two. The applicant states that the staffing models are based upon the anticipated occupancy and programs to be provided at the LTCH, and that salaries are based on an evaluation of the area and its own experience in staff recruitment. The applicant states that it is confident it will be able to effectively recruit and maintain appropriately qualified staff to meet the needs of its patients. Benefits are calculated at 26 percent of employee's annual salary. The applicant provided a reasonable discussion of recruitment and staff retention plans to be utilized.

Conclusion:

Funding for this project, with the support of its parent, should be available as needed.

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

A comparison of each of the co-batched 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 management skills 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

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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 prospective payment system (PPS) rule for long-term care hospitals (LTCH) effective for cost reporting periods beginning or after October 1, 2002. Under the 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 applicants' 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 both *SemperCare (CON #9745)* and *Select Specialty (CON #9746)* were developed based on the prospective payment system. However, with regard to the *SemperCare* proposal, in order to qualify for an exemption under CFR Part 412.23 for reimbursement under the prospective payment system a long-term acute care facility, operating as a hospital within a hospital, must not exceed more than 15 percent of its total 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. *SemperCare (CON #9709)* states they intend to comply with this provision. Failure to comply would have a material negative impact on revenues.

Medicare requires a six-month period (demonstration period) before a hospital is eligible for reimbursement under the LTCH PPS. This period is required to demonstrate a minimum 25-day average length of stay.

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During the demonstration period the hospital is reimbursed at the acute care rate. *SemperCare* (CON #9745) submitted schedules for this six-month demonstration period, whereas *Select Specialty* (CON #9746) did not disclose how this period was accounted for in their financial projections.

Comparative data for both applicants were derived from hospitals in peer group 12 that reported data in 2002. Per Diem rates are projected to increase by an average of 3.3 percent per year. Inflation adjustments were based on the 2003 2nd Quarter Health Care Cost Review, New CMS Hospital Market Basket Index.

SemperCare Hospital of Escambia (CON #9745): Projected net revenue per adjusted patient day (NRAPD) of \$1,083 in year one and \$1,104 in year two is between the control group median and lowest values of \$1,106 and \$843 in year one and \$1,143 and \$871 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 \$1,029 in year one and \$1,025 in year two is between the control group median of \$1,029 and between the control mean and lowest values of \$1,063 and \$747 in year two. Compared to the control group these costs are efficient. (See Comparative Table).

The year two operating profit for the hospital of \$842,857 computes to an operating margin per adjusted patient day of \$80, which falls between the peer group median and lowest values of \$125 and \$-31 respectively. The operating margin of 7.2 percent indicates that net revenues are proportional to costs.

This application appears to be financially feasible.

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Select Specialty Hospital-Escambia, Inc. (CON #9746): Projected net revenue per adjusted patient day (NRAPD) of \$1,074 in year two is between the control group lowest and median values of \$890 and \$1,168. 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 \$978 in year two is between the control group lowest and median values of \$763 and \$1,087. Compared to the control group these costs are efficient. (See Comparative Table).

The year two operating profit for the hospital of \$1,468,401 computes to an operating margin per adjusted patient day of \$96, which falls between the peer group lowest and median values of \$-31 and \$125 respectively. The operating margin of 8.9 percent indicates that net revenues are proportional to costs.

With the support of the parent, Select Medical, Inc., the project is considered financially feasible.

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Select Specialty Hospital-Escambia, Inc (CON #9746)

**TABLE TWO
PEER GROUP 12**

	2007 YEAR 2 ACTIVITY	YEAR 2 ACTIVITY PER DAY	INFLATION ADJ. VALUES		
			Highest	Median	Lowest
ROUTINE SERVICES	14,563,500	950	1,199	890	655
INPATIENT AMBULATORY	31,690,173	2,067	12	0	0
INPATIENT SURGERY	320,327	21	0	0	0
INPATIENT ANCILLARY SERVICES	0	0	3,738	2,863	2,327
OUTPATIENT SERVICES	0	0	221	1	0
TOTAL PATIENT SERVICES REV.	46,574,000	3,038	4,684	3,774	2,984
OTHER OPERATING REVENUE	0	0	4	2	0
TOTAL REVENUE	46,574,000	3,038	4,688	3,776	2,984
DEDUCTIONS FROM REVENUE	30,108,076	1,964	*	*	*
NET REVENUES	16,465,924	1,074	2,168	1,168	890
EXPENSES					
ROUTINE	4,277,688	279	556	314	190
ANCILLARY	5,572,695	364	636	295	201
AMBULATORY	0	0	0	0	0
TOTAL PATIENT CARE COST	9,850,383	643	1,192	609	391
ADMINISTRATIVE & OVERHEAD	2,738,249	336	932	501	367
PROPERTY	2,408,891	*	*	*	*
TOTAL HOSPITAL EXPENSE	14,997,523	978	2,182	1,067	749
OTHER OPERATING EXPENSE	0	0	0	0	0
TOTAL EXPENSE	14,997,523	978	2,224	1,087	763
OPERATING INCOME (MARGIN)	1,468,401	96	280	125	-31
PERCENT OPERATING MARGIN	8.9%				

PERCENTAGES NOT INFLATION ADJUSTED

PATIENT DAYS	15,330			
ADJUSTED PATIENT DAYS	15,330			
TOTAL BED DAYS AVAILABLE	19,710			
ADJ. FACTOR	1.0000			
TOTAL NUMBER OF BEDS	54			
PERCENT OCCUPANCY	77.8%	100.2%	84.2%	52.2%

PAYER CLASS					
	PATIENT DAYS	PERCENT OF TOTAL			
SELF-PAY	123	0.8%	4.1%	0.9%	0.0%
MEDICAID	307	2.0%	13.3%	0.2%	0.0%
MEDICAID HMO	0	0.0%			
MEDICARE	11,934	77.8%	97.3%	75.4%	67.4%
MEDICARE HMO	0	0.0%			
INSURANCE	2,225	14.5%			
HMO/PPO	741	4.8%	23.4%	10.5%	0.0%
OTHER	0	0.0%			
TOTAL	15,330	100.0%			

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

A comparison of the co-batched applicants is presented as follows:

**Comparison Chart For Proposed Long-Term Care Hospital
Projects in District 6 for the Second Year of Operation**

	SemperCare (CON #9745)	Select Specialty (CON #9746)
Net Revenue per adjusted patient day	\$1,104	\$1,074
Cost per adjusted patient day	\$1,025	\$ 978
Operating profit per patient day	\$ 80	\$ 96
Estimated Managed Care level	11.5%	4.8%
Estimated Medicaid level	2.0%	2.0%

SemperCare Hospital of Pensacola, Inc. (CON #9745) projects managed care to represent 11.5 percent of its patient days. This is between the control group median and highest level of activity of 10.5 and 23.4 percent. The projected levels, if realized, will have a positive impact on competition to promote quality assurance and cost-effectiveness.

Select Specialty Hospital-Escambia, Inc. (CON #9746) projects managed care to represent 4.8 percent of its patient days. This is between the control group lowest and median level of activity of 0.0 and 10.5 percent. The projected levels, if realized, will have a slight positive impact on competition to promote quality assurance and cost-effectiveness.

- 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.**

It is required that schematic drawings be submitted as part of the CON application. Although the drawings for the proposal may be more advanced than required, they have been reviewed as schematics with the expectation that they will necessarily be revised and refined during the design development (preliminary) and contract document stages. The architectural review of the applications shall not be construed as an in-depth effort to determine complete compliance with all applicable codes and standards. The final responsibility for facility compliance ultimately rests with the owner.

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SemperCare Hospital of Pensacola, Inc. (CON #9745) proposes the conversion of space on the fourth floor of Baptist Hospital to a 36-bed long-term care hospital. Baptist Hospital will delicense 36 beds to accommodate the new facility. There will be 22 private and seven semi-private rooms. Two rooms are designed as isolation rooms and four as handicapped accessible rooms. An almost identical scenario was reviewed for CON #9702 in October of 2003. The areas of concern identified in the previous architectural review have been resolved with the new plan.

The codes listed are essentially correct except that the Florida Building Code has revisions dated 2002 and 2003 which are not mentioned. There is no specific reference to the guidelines which are almost totally included by reference in the Florida Building Code.

Most of the patient rooms show a hand washing station within the room itself in addition to the lavatory in the bathroom. This is required for new construction and may be existing. None of the handicapped accessible rooms appear to have showers large enough to accommodate a patient on a stretcher. This is not required, but desirable.

All the patient rooms are existing as patient rooms, so they will only be required to meet existing construction standards. However, some of the semi-private rooms are very small.

The costs and schedules appear to be reasonable for a project of this scope.

The new facility has the requisite pharmacy and a space for basic radiographic equipment. It was not readily apparent from the narrative that the facility will have its own radiographic equipment. This equipment must belong to the new facility and may not be leased from the host hospital.

Select Specialty Hospital-Escambia, Inc. (CON #9746) is proposing to convert an existing unoccupied nursing home to a 54-bed freestanding long-term care hospital on the campus of Sacred Heart Hospital in Pensacola. The building was never a hospital, so it will be considered new construction by the Agency. An almost identical scenario was reviewed as CON #9701 in October of 2003. There were many problems with the layout of the previous submittal, but they have been mostly corrected for this new application.

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New hospital construction must meet the requirements of disaster preparedness in the Florida Building Code, Section 419.4. These provisions not only prescribe the protection of the exterior shell of the facility, but also affect the location of the generator and other mechanical and electrical systems. The planned use of the existing basement will have to be considered based on its elevation relative to the flood plain. No information specific to the disaster preparedness was readily apparent in the application. This information will have to be provided when and if the project is submitted to the AHCA Office of Plans and Construction for review.

There is a list of applicable building codes, and it is mostly correct. The design professional is obviously aware of the provisions in the Florida Building Code since the firm has extensive health care experience. There were extensive outline specifications included in the application.

The surgical suite has been relocated to the second floor and provides spaces that were lacking in the previous plan. The circulation paths and space relationships, while providing for the various restrictive areas, could benefit from further study. There are extensive corridors and the entire suite is quite linear, due to the footprint of the existing building. The nurse station does not have very good views of the two pre-op and post-op stations. However, due to the nature of the procedures that will take place here, the surgical suite will probably be used less frequently than comparable facilities in a full service acute care hospital. The operating room must have a minimum of 400 square feet exclusive of fixed cabinetry, and the one provided does not appear to be quite large enough by scaling the plan.

Various services will be contracted out, such as laundry and cooking, but ancillary spaces have been provided to receive and distribute linen, meals and other items. Space for radiographic equipment has been provided and there is a small laboratory in the proposed facility. Any part of the existing building that will not be utilized for the new hospital will have to be fire-rated as if it were storage. There also must be space for emergency services to provide care for any emergency medical condition that which is within the service capability of the hospital.

Out swinging patient toilet rooms have been provided on the new plan, but in the case of patient rooms E and F, an in swinging door with breakaway hardware would be a better and acceptable solution. All patient rooms have a hand washing station within the room itself in addition to the lavatory in the bathroom as required.

There are extensive mechanical and electrical systems which will be updated or totally replaced. Examples are a new generator and a nurse

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call system. Most of these represent major expenditures. The estimated project budget of more than \$ 7.7 million appears to be adequate based on the scope of the project. The project schedule is also reasonable.

- 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.**

According to the 2002 Hospital Financial Data Report, LTCHs in the state averaged 1.8 percent Medicaid patient days and 1.7 percent charity care patient days.

SemperCare Hospital of Pensacola, Inc. (CON #9745) is a new development stage company with no historical operating history to demonstrate its experience of providing services to Medicaid or medically indigent patients.

The applicant agrees to condition award of the certificate of need on the provision of two percent of its patient days to Medicaid and a ratio of indigent/charity care to gross revenue that will average one percent. According to Financial Schedule 7A, the applicant does project that two percent of total patient days will be provided to Medicaid patients and that one percent of total patient days will be provided to charity care patients in each of the first two years of operation. The applicant's Medicaid provision exceeds the state average but the charity care provision is lower than the state average of 1.7 percent.

Select Specialty Hospital-Escambia, Inc. (CON #9746) is a new development stage company with no operating history.

The applicant proposes to condition award of the certificate of need on the provision of 2.0 percent of the facility's total annual patient days to Medicaid patients and 0.8 percent to charity care patients. Schedule 7A indicates that the applicant expects to deliver up to two percent of its total patient days to Medicaid patients and 0.8 percent for charity care in both the first and second year of operation. The applicant's Medicaid provision exceeds the state average but the charity care provision is lower than the state average of 1.7 percent.

F. SUMMARY

SemperCare Hospital of Pensacola, Inc. (CON #9745) proposes to establish a 36-bed LTCH within Baptist Hospital in Pensacola, Escambia County.

The proposed LTCH will be located on the fourth floor of Baptist Hospital and will contain 16,825 square feet, which encompasses 22 one-bed rooms and seven semi-private rooms at a renovation construction cost of \$1,109,770. Total project cost is estimated to be \$2,125,730. SemperCare, Inc will provide the funding for the proposed project.

The applicant proposes to condition award of the certificate of need on the provision of 2.0 percent of the facility's annual patient days to Medicaid patients and one percent of gross revenue to indigent/charity care. Though not proposed as a condition, the applicant indicates that following approval of this CON, Baptist Hospital will delicense 30 skilled nursing beds and six acute care beds for a total of 36 beds.

Select Specialty Hospital-Escambia, Inc. (CON #9746) proposes to establish a 54-bed freestanding LTCH to be located within the building formerly used as the Haven of Our Lady of Peace, a licensed community nursing home that was replaced at a new location.

The proposed hospital will consist of 58,590 gross square feet of renovation and 273 GSF of new construction with construction costs of \$5,423,478. Total project cost is estimated to be \$7,762,645. Select Medical Corporation will provide the funding for the proposed project.

The applicant proposes to condition award of the certificate of need on the provision of 2.0 percent of the facility's total annual patient days to Medicaid patients and 0.8 percent to charity care patients.

After weighing and balancing all applicable review criteria, the following relevant factors are summarized below:

Need

Need is not published by the agency for long-term care hospital beds. It is the applicant's responsibility to demonstrate need. There are presently no LTCH beds located in District 1. It was not demonstrated by either applicant that patients are being denied access to LTCH services offered outside of District 1 or that other post-acute care options are not being utilized effectively.

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SemperCare Hospital of Pensacola, Inc. (CON #9745)

- The applicant contends that accessibility to LTCH services in Panama City and Tallahassee is unreasonable, especially for residents of Escambia, Okaloosa and Santa Rosa Counties. The applicant's need methodologies were based on assumptions called into question by recent federal studies and access to LTCH care will be available to residents on the western side of the district and is currently available to residents on the eastern side of the district within reasonable travel times. The applicant did not demonstrate that District 1 residents are being denied access to existing appropriate post-acute care services.

Select Specialty Hospital-Escambia, Inc. (CON #9746)

- The applicant contends that District 1 LTCH appropriate patients are remaining in acute care hospitals within the county as no appropriate or available alternatives exist within an acceptable distance. The applicant's need methodologies were based on assumptions called into question by recent federal studies and access to LTCH care will be available to residents on the western side of the district and is currently available to residents on the eastern side of the district within reasonable travel times. The applicant did not demonstrate that patients that may meet the definition of a LTCH patient are not currently being placed or that an access problem exists in the area.

Quality of Care:

SemperCare Hospital of Pensacola, Inc. (CON #9745)

- The applicant is a new development stage corporation with no significant operating experience. The applicant intends to use the parent company's performance improvement system currently in place to ensure and maintain quality care. The applicant included the JCAHO survey results for nine currently operational SemperCare facilities. The applicant provided a reasonable description of its performance improvement plan.

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Select Specialty Hospital-Escambia, Inc. (CON #9746)

- The applicant is a new development stage corporation with no significant operating experience. The applicant provided a reasonable description of its performance improvement plan for monitoring and improving care delivery.

Cost/Financial Analysis:

SemperCare Hospital of Pensacola, Inc. (CON #9745)

- The applicant is a start-up company with limited assets. The parent, SemperCare, Inc. has total assets of 23.3 million. However, the company had a net operating loss of \$3.1 million with negative cash flows from operations of \$4.7 million. The financial strength of the applicant depends on the continued ability to raise capital to support operating losses. The funding for the proposed project is likely to be available as needed.
- With net revenues falling between the lowest and median level, the facility is expected to consume health care resources in proportion to the services provided. Projected cost per adjusted patient day is between the control group median and lowest values and considered efficient. The projected operating margin falls between the peer group median and lowest values indicating that net revenues are proportional to costs. The project appears to be financially feasible.
- The applicant projects managed care to represent 11.5 percent of its patient days. This is between the control group median and highest level of activity of 10.5 and 23.4 percent. The projected levels, if realized, will have a positive impact on competition to promote quality assurance and cost-effectiveness.

Select Specialty Hospital-Escambia, Inc. (CON #9746)

- The applicant is a start-up company with limited assets. However, the parent, Select Medical, Inc. is a financially strong company with total assets of \$1.1 billion, revenue from operations of \$1.4 billion, and cash flows of \$246.3 million. The funding for the proposed project should be available, with the support of the parent company.

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- The applicant did not disclose how the demonstration period (six months) reimbursement was accounted for in the financial projections.
- With net revenues per adjusted patient day falling between the lowest and median values, the facility is expected to consume health care resources in proportion to the services provided. Projected cost per adjusted patient day is considered efficient in comparison to the control group. The projected operating margin of 8.9 percent indicates that net revenues are proportional to costs. With the support of the parent company, the proposed project is considered to be financially feasible.
- The applicant projects managed care to represent 4.8 percent of its patient days. This is between the control group lowest and median level of activity of 0.0 and 10.5 percent. The projected levels, if realized, will have a slight positive impact on competition to promote quality assurance and cost-effectiveness.

Architectural Analysis:

SemperCare Hospital of Pensacola, Inc. (CON #9745)

- The project proposes to establish a 36-bed long-term care hospital on the fourth floor of Baptist Hospital. The hospital will delicense 36 beds to accommodate the new facility.
- The architectural review reveals that the applicable building codes are essentially correct with the exception of revisions to the Florida Building Code that were not addressed. All the patient rooms are existing so they will only be required to meet existing construction standards. This leaves some of the semi-private rooms undersized for its proposed use. The new facility has the requisite pharmacy and a space for basic radiographic equipment. Based on the information presented, the projected costs and schedules appear reasonable.

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Select Specialty Hospital-Escambia, Inc. (CON #9746)

- The project involves the conversion of an existing unoccupied nursing home to a 54-bed LTCH on the campus of Sacred Heart Hospital. No information specific relative to disaster preparedness was found in the application. The planned use of the existing basement of the building will have to be considered based on its elevation relative to the flood plain. The applicable building codes appear to be mostly correct and architectural concerns noted with previous proposals submitted by the applicant appear to be mostly addressed by this project. However, the circulation paths and space relationships could benefit from further study and the required operating rooms appears to be slightly undersized.
- The schedule for project completion and costs appear acceptable.

G. RECOMMENDATION

Deny CON #9745 and CON #9746.

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