

**STATE AGENCY ACTION REPORT**  
**ON APPLICATION FOR CERTIFICATE OF NEED**

**A. PROJECT IDENTIFICATION**

1. Applicant/CON Action Number

**BayCare Long Term Care Hospital, Inc. (CON #9803)**

625 Court Street, Suite 200  
Clearwater, Florida 33756

Authorized Representative: Stephen R. Mason  
(727) 444-1402

**University Community Hospital, Inc. (CON #9804)**

3100 East Fletcher Avenue  
Tampa, Florida 33613-4688

Authorized Representative: Brigitte W. Shaw  
Corporate Chief Operating Officer  
(813) 615-7201

2. Service District/County

District 5 (Pinellas and Pasco Counties )

**B. PUBLIC HEARING**

No public hearing was requested or held regarding the establishment of long-term care hospital beds in District 5. However, letters of support were submitted with the respective applications as follows:

**BayCare Long Term Care Acute Care, Inc. (CON #9803)** submitted 60 unduplicated letters of support with its application to establish a long-term care hospital of 48 beds within Mease Dunedin Hospital in District 5, Pinellas County. The letters consisted of: five letters from the chief executive officers (CEOs) of the five BayCare affiliated hospitals in the area, 33 letters from local area physicians, four letters from registered nurses, five letters from social workers, two letters from case managers, three letters from nursing home administrators, one letter from discharge planner, one letter from a member of the Pinellas County Board of

Commissioners, one letter each from three members of the House of Representatives, Gus M. Bilirakis (District 48), Kimberly Berfield (District 50) and Donald M. Sullivan, M.D. (District 54), one letter from Senator Dennis L. Jones (District 13), one letter from the Bishop of St. Petersburg and one letter from a citizen whose family member had been admitted to the Kindred LTCH in Tampa.

The letters state that there is concern for patients who must transfer out of the area for LTCH services (especially those on ventilators) or who must stay at the ICU units at acute care hospitals. According to the letters, there are 74 skilled nursing homes in Pinellas County and only one skilled nursing facility that accepts ventilator-dependant patients and these patients must have a tracheotomy. Additionally, patients cannot be in need of dialysis and placement to Kindred LTCH in St. Petersburg has been difficult.

At the end of September 2004, there were six patients in the ICU at St. Anthony's Hospital anywhere from 25 to 67 days who were in need of placement. However, there was no mention of placement attempts of these patients to Kindred Bay Area-St. Petersburg.

**University Community Hospital, Inc. (CON #9804)** submitted 10 letters that specifically supported its proposal to establish a long-term care hospital in District 5, Pasco County. Five of the letters were from local physicians. Two of the letters were from the CEOs of Helen Ellis Memorial Hospital and Sun Coast Hospital. The directors of case management at Health Central, Oak Hill and Pasco Regional Hospitals submitted the remaining three letters.

The letters state that there is difficulty placing patients who need LTCH services because there is no LTCH in Pasco County. These patients often have medically complex conditions and either remain in the acute setting or are transferred out of the county for LTCH services. All of the LTCHs in the area are owned by one company (Kindred Healthcare); therefore there is no competition for offering these services.

### **Letters of Opposition**

There were two letters submitted on behalf of Kindred Hospitals-Bay Area-St. Petersburg, Kindred Hospital-Bay Area-Tampa and Kindred Hospital-Central Tampa, by Bud Wurdock opposing the proposed projects for BayCare Long Term Care Inc. (CON #9803) and University Community Hospital, Inc. (CON #9804).

The first letter contends that establishing another LCTH in Pinellas County (**CON #9803**) would result in a duplication of services. More than 16 percent of all patients at Kindred's three Tampa-St. Petersburg

hospitals are residents of Pinellas County. Specifically, 62 percent of the patients at Kindred Hospital-Bay Area-St. Petersburg are from Pinellas County. In 2003 and the first six months of 2004, 705 admissions to the Kindred facilities in St. Petersburg and Tampa came from BayCare affiliated hospitals, producing 35.6 million dollars in revenue that Kindred would lose if BayCare establishes its own LTCH in Pinellas County.

The second letter contends that establishing a LTCH in Pasco County (**CON #9804**) would also result in a duplication of services. Seven percent of the patients at Kindred Hospital-Central Tampa are residents of Pasco County. During 2003 and the first six months of 2004 this equated to 160 admissions to the Kindred facilities in St. Petersburg and Tampa came from University Community Hospital producing over \$7 million in revenue that Kindred would lose if University Community Hospital establishes its own LTCH in Pasco County.

**C. PROJECT SUMMARY**

**BayCare Long Term Care Hospital, Inc. (CON #9803)** is a newly formed not-for-profit corporation that proposes to establish a 48-bed long-term care hospital (LTCH) as a separate licensed facility, at Mease Dunedin Hospital, in District 5, Pinellas County. The applicant is owned by BayCare Health Systems, Inc, which also controls several hospitals through a joint operating agreement in the Bay area of Florida including St. Anthony's Hospital, South Florida Baptist Hospital, Morton Plant Hospital, and Trustees of Mease Hospital. Neither the applicant, nor its parent company, own or operate existing LTCHs.

Mease Dunedin (the host hospital) is a 189-bed not-for-profit hospital located in downtown Dunedin that has been operating since the 1930's. The host hospital is in the process of renovating and this project will be located in the areas left vacant by the relocation of the obstetrics and NICU units of the hospital.

The applicant is requesting that the project be conditioned on the facility's location at 601 Main Street, Dunedin, Florida 34608. Also the applicant has agreed to condition the award of this CON upon providing six percent of total patient days to Medicaid/Medicaid HMO/self-pay/underinsured patients. Additionally the applicant conditions this application for the provision of the delicensing of 10 acute care beds each at Mease Dunedin Hospital and Morton Plant Hospital and 15 acute care beds at St. Anthony's. All three of these BayCare affiliates supplied letters indicating they would delicense the indicated number of beds each

upon approval of this project. As noted above, the applicant is owned by BayCare Health Systems, Inc. Mease Dunedin Hospital (host hospital) is operated by the Trustees of Mease Hospital, Inc., one of the hospitals managed by BayCare Health Systems, Inc.

Renovation and construction costs of \$2,045,471 will be assumed by the host hospital. The applicant's total project cost is estimated at \$363,220. Total cost for the host hospital is estimated at \$3,074,691. The project will involve 24,925 gross square feet (GSF) of new construction at the host hospital.

**University Community Hospital, Inc. (CON #9804)** is a not-for-profit corporation that proposes to establish a freestanding 50-bed long-term care hospital on a 6.5-acre site located on Highway 54 in District 5, in east Pasco County.

The applicant currently operates two acute care hospitals located in District 6, Tampa, Florida. The two facilities, University Community Hospital and University Hospital at Carrollwood, are both Class I general acute care hospitals with licensed bed complements of 374 and 120 respectively.

The applicant is requesting that the project be conditioned for the provision of two percent of its total patient days to Medicaid and 2.4 percent of its total patient days to charity/self-pay/other.

The total project cost is estimated at \$17,239,141. Construction costs are projected at \$9,325,331 and the project will involve 42,000 gross square feet (GSF) of new construction.

#### **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 meets the review criteria.

Section 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, Tina Mazanek, analyzed the application in its entirety with consultation from the Financial Analyst, Ryan Fitch, who evaluated the financial data, and the Architect, Joel Hill, who evaluated the architectural and the schematic drawings.

**E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA**

The following indicate the level of conformity of the proposed project with the criteria and application content requirements found in Sections 408.035 and 408.037, Florida Statutes; applicable rules of the State of Florida, Chapters 59C-1 and 59C-2, Florida Administrative Code.

**1. Fixed Need Pool**

**a. Does the project proposed respond to need as published by a fixed need pool? Ch. 59C-1.008 and Ch. 59C-1.042, 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.

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; seeks exclusion from the acute care Medicare prospective payment system for inpatient hospital services and are usually the most costly post-acute care setting. For example, according to the Medicare Payment Advisory Commission, in fiscal year 2004, for patients with the most common LTCH diagnosis, Medicare rates for LTCHs range from 0.9 to 4.4 times as much as estimated rates for inpatient rehabilitation facilities, and about three to almost 12 times as much as estimated rates for skilled nursing facilities. A long-term care hospital has an average length of stay greater than 25 days for all hospital beds.

The Medicare Payment Advisory Commission (MedPAC) is a commission that makes recommendations to Congress and the Secretary of the federal Department of Health and Human Services regarding reimbursement for long-term hospital services. Medicare is the primary payer for LTCH services, especially in newer LTCHs, and under the current reimbursement system, which although it does account for case-

mix differences between patients, does not account for differences within each case-mix category and therefore provides an incentive to admit patients with the least need for resources among those in the same diagnostic group.

In its June 2004 report to Congress, MedPAC recommended that long-term care hospitals should be defined by patient and facility criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement. Further:

- Facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients.
- Patient-level criteria should identify specific clinical characteristics and treatment modalities.
- Quality improvement organizations should be required to review long-term care hospital admissions for medical necessity and monitor that these facilities are in compliance with defining criteria.

These recommendations were made based on the commission's findings that this type of post-acute care is provided to a small number of medically complex patients and that acute care and skilled nursing facilities are the principle alternatives to LTCHs. Additionally, that LTCH patients cost Medicare more than similar patients using alternative settings, however when LTCH care is targeted to patients of the highest severity, the cost is comparable.

In its June 2004 report, MedPAC also looked at the role long-term care hospitals play in providing care and determined that most LTCH patients are discharged to the LTCH from an acute care facility and that a small number are medically complex, more stable than patients in an acute care intensive care unit, but still have complex medical conditions. These complex conditions typically include need for ventilator support for respiratory problems including tracheostomy diagnosis, failure of two or more major organ systems, neuromuscular damage, contagious infections, or complex wounds that need extended care.

MedPAC also studied where clinically similar patients, who lived in areas with no LTCHs received care and found the following:

- Patients transferred to LTCHs have shorter acute care stays by approximately seven days, suggesting that when there is no LTCH in an area, patients might stay an additional seven days on average in an acute care facility.
- Freestanding skilled nursing facilities are the primary alternative to LTCH care.

- Even when there is no LTCH in an area, some patients needing this service travel to receive it.
- Between seven and eight percent of patients with the highest probability of using LTCHs used rehabilitation hospital services in markets both with and without LTCHs.

Several facility and patient criteria recommendations were made in the report involving clinical characteristics of the patient, minimum staffing levels based on patient characteristics including patient mix and severity levels, admission assessment tools, physician availability, length of stay, and multidisciplinary team requirements. Because these parameters have not been assigned, MedPAC concludes that the role of LTCHs is unclear.

The report further suggests that if its recommendations are developed, that facilities that typically serve one primary hospital will need to broaden its base presumably because it will not have sufficient patient volume otherwise.

In view of these findings, it is important that the determination of specific clinical complexity and severity of conditions of patients 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. It is further important that sufficient appropriate staff be identified and that sufficient patient volume based on need for services be demonstrated.

**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.

**CON Action Numbers: 9803 & 9804**

At present there are 12 long-term care hospitals with 799 beds licensed to operate in the State of Florida. However, only 10 facilities (740 beds) reported utilization for the reporting period. No utilization data is available for Sister Emmanuel Hospital For Continuing Care (29 beds) located in District 11 and SemperCare (30 beds) located in District 2 (Panama City). There are an additional 160 beds approved but not yet operational LTCH beds.

The following new approved LTCHs are: SemperCare (29 beds) in District 2, HealthSouth (40 beds) in District 8, Select Specialty (40 beds) in District 7 and Kindred (31 beds) in District 3. There are 20 CON approved LTCH beds at Kindred Hospital in District 4.

The average occupancy of the operational programs reporting utilization was 68.17 percent for the period January 2003 through December 2003. With regard to the LTCH programs in operation for the total 12-month reporting period, occupancy ranged from a low occupancy rate of 32.67 percent for Select Specialty Hospital-Miami to a high of 90.72 percent for Kindred-North Florida.

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

<b>Florida Long Term Care Hospitals Utilization Experience January 2003-December 2003</b>					
<b>Hospital</b>	<b>District</b>	<b>Beds</b>	<b>Bed Days</b>	<b>Patient Days</b>	<b>Occupancy</b>
Kindred-North Florida	4	60	21,900	19,868	90.72%
Specialty-Jacksonville	4	107	39,055	21,175	54.22%
Kindred Bay Area-St. Petersburg	5	82	27,950	21,703	77.65%
Kindred-Central Tampa	6	102	37,230	26,184	70.33%
Kindred-Bay Area-Tampa	6	73	26,645	17,567	65.93%
*SemperCare Hospital of Orlando	7	35	9,240	2,551	27.61%
Kindred-Hollywood	10	124	45,260	30,876	68.22%
Kindred-Ft. Lauderdale	10	64	23,360	19,184	82.12%
Kindred-Coral Gables	11	53	19,345	16,498	85.28%
Select Specialty-Miami	11	40	14,600	4,770	32.67%
<b>Florida Total</b>		740	64,585	180,376	68.17%

**Source: Florida Hospital Bed Need and Service Utilization by District, Volume II, published 07/23/04.**

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

**\*SemperCare Hospital of Orlando was licensed on 6/12/03 with three quarters of operation shown.**

**A license was also issued for Sister Emmanuel Hospital For Continuing Care (utilization data is not available) in Miami on 7/15/03 for 29 beds, for SemperCare Hospital in Panama City on 1/05/04 for 30 beds.**

As shown above, there are currently 82 LTCH beds in District 5 and 175 LTCH beds in District 6, distributed between three existing Kindred LTCHs, located in Tampa and St. Petersburg, Florida. The two Kindred facilities in Tampa and the one in St. Petersburg experienced average occupancy rates of 70.33 percent, 65.93 percent and 77.65 percent, respectively for the 12-month period ending December 31, 2003.

The current bed complement, patient days and average occupancy of other forms of care in District 5 is presented as follows:

<b>Acute Care and Post-acute Care Providers District 5 Beds and Utilization January 2003-December 2003</b>		
<b>Facility Type</b>	<b>Total Beds</b>	<b>*Average Occupancy</b>
Long-Term Hospital Care	82	77.65%
Acute Care	4,394	50.41%
Comprehensive Medical Rehabilitation	170	65.58%
Hospital-Based Skilled Nursing Unit (HBSNU)	118	78.70%
Skilled Care Community Nursing Homes	10,441	87.72%

**Sources:** Florida Hospital Bed Need Projections by District, published 7/23/04, for LTCH, Acute Care, and CMR beds. Florida Hospital Based Skilled Nursing Unit Utilization by District and Subdistrict July 2003-June 2004, published 10/08/04. Florida Nursing Home Utilization by District and Subdistrict for July 2003-June 2004, published 10/08/04. \*With the exception of the HBSNU and skilled nursing utilization rate, which is July 2003-June 2004.

As stated earlier, the table above illustrates the current bed compliment and number of beds and occupancy rates of the acute care and post-acute care providers in District 5 (Pinellas and Pasco Counties).

The current bed complement, patient days and average occupancy of other forms of care in District 6 is presented as follows:

<b>Acute Care and Post-acute Care Providers District 6 Beds and Utilization January 2003-December 2003</b>		
<b>Facility Type</b>	<b>Total Beds</b>	<b>*Average Occupancy</b>
Long-Term Hospital Care	175	68.13%
Acute Care	5,559	56.76%
Comprehensive Medical Rehabilitation	131	79.08%
Hospital-Based Skilled Nursing	61	68.44%
Skilled Care Community Nursing Homes	9,467	86.72%

**Sources:** Florida Hospital Bed Need Projections by District, published 7/23/04, for LTCH, Acute Care, and CMR beds. Florida Hospital Based Skilled Nursing Unit Utilization by District and Subdistrict July 2003-June 2004, published 10/08/04. Florida Nursing Home Utilization by District and Subdistrict for July 2003-June 2004, published 10/08/04. \*With the exception of the HBSNU and skilled nursing utilization rate, which is July 2003-June 2004.

As stated earlier, the table above illustrates the current bed compliment and number of beds and occupancy rates of the acute care and post-acute care providers in District 6 (Hillsborough, Polk, Hardee, Highlands, and Manatee Counties).

As previously noted, LTCHs are designed to treat patients with medical conditions requiring extended hospital-level services, for a lengthy period of time (generally more than 25 days). Both co-batched applicants state that their respective proposals will provide LTCH services to patients with complex and medically unstable conditions that cannot be adequately addressed by licensed acute care beds, comprehensive medical rehabilitation beds, hospital-based skilled nursing unit beds, and nursing home beds in the service planning area.

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. Applicants for LTCH services must therefore show that there is need based upon the availability, utilization and quality of LTCH, skilled nursing and comprehensive medical rehabilitation services in the district. Although both applicants contend that LTCH services are distinct, neither demonstrated that its proposal addressed a quantifiable distinct population or showed that there was need for additional services regardless of the venue of care, beyond those beds already licensed and operating in the area. A discussion of each applicant’s need analysis is presented below following general findings regarding expected population growth in District 5 and District 6 within the next five years.

Below is a table illustrating the population growth estimates for District 5.

<b>Population Estimates for District 5 Counties and Percent Change by County For Total Population, 65 and over, and 75 and Over Population</b>					
<b>County</b>	<b>Total January 2005</b>	<b>Total January 2010</b>	<b>Percent Change</b>	<b>65+ Percent Change</b>	<b>75+ Percent Change</b>
<b>Pasco</b>	379,738	410,475	8.09%	13.25%	6.51%
<b>Pinellas</b>	949,778	980,674	3.25%	5.26%	-1.80%
<b>Total District 5</b>	1,329,516	1,391,149	4.64%	7.91%	0.90%
<b>State of Florida</b>	17,451,994	18,900,419	8.30%	12.08%	7.60%

Source: AHCA Population Estimates, published March 2004.

As shown above, the overall population in District 5 is expected to increase by 4.64 percent during the next five years, with its 65 and over age cohort increasing by 7.91 percent and its 75 and older age cohort decreasing by .90 percent. The population in Pasco County is expected to increase by 8.09 percent in total population, more than the district average, with their 65 and 75 and older age cohort over population increasing at a rate higher than the district averages. The population in Pinellas County is expected to increase by 3.25 percent in total population, more than the district average, with its 65 and 75 and over population increasing by less than the district average.

Below is a table illustrating the population growth estimates for District 6.

<b>Population Estimates for District 6 Counties and Percent Change by County For Total Population, 65 and over, and 75 and Over Population</b>					
<b>County</b>	<b>Total January 2005</b>	<b>Total January 2010</b>	<b>Percent Change</b>	<b>65+ Percent Change</b>	<b>75+ Percent Change</b>
<b>Hardee</b>	28,248	30,285	7.21%	12.14%	12.18%
<b>Highlands</b>	92,849	100,331	8.06%	11.70%	8.60%
<b>Hillsborough</b>	1,102,850	1,193,188	8.19%	15.86%	10.76%
<b>Manatee</b>	291,383	316,881	8.75%	11.39%	6.45%
<b>Polk</b>	522,554	560,727	7.31%	13.67%	11.72%
<b>Total District 6</b>	2,037,884	2,201,412	8.02%	13.86%	9.89%
<b>State of Florida</b>	17,451,994	18,900,419	8.30%	12.08%	7.60%

Source: AHCA Population Estimates, published March 2004.

As shown above, the overall population in District 6 is expected to increase by 8.02 percent during the next five years, with the 65 and over and 75 and over age cohort increasing by 13.86 percent and 9.89 percent, respectively. Polk County is expected to increase by 7.31 percent in total population, less than the district average. Hillsborough County is expected to increase by 8.19 percent, again, less than the district average. However, the 65 and over population for both counties is expected to increase at a rate higher than the district averages.

**BayCare Long Term Acute Care, Inc. (CON #9803)** is proposing to establish a LTCH of 48 beds in District 5, Pinellas County. It is the intent of the applicant to meet the LTCH needs of BayCare Health System, Inc. related hospitals in Pasco and Pinellas Counties. Those hospitals include Mease Dunedin, Morton Plant and St. Anthony's. Additionally, the applicant states that it will accept patients from non-BayCare referral sources. However, as discussed in detail below, the applicant has not shown that patients needing LTCH services are unable to obtain them at existing area LTC hospitals. Additionally, because the applicant has not give reasonable evidence of the number of patients it can expect to serve, i.e. patients needing services that could not otherwise be served in existing facilities, it appears that the establishment of this project will be accomplished through the loss of patients at existing area LTCHs.

The applicant referenced population growth estimates for District 5 (Pasco and Pinellas Counties) and the State of Florida for the next five years (July 2004-July 2009). According to AHCA data provided by the applicant (and verified by this reviewer), the population of District 5 is expected to grow by 4.3 percent over the five-year period from July 2004-July 2009) and 4.64 percent over the five-year period from January 2005 to January 2010. The population primarily served by the proposed LTCH, the 65 and older cohort, is expected to grow by 5.7 percent for District 5 over the five-year period from July 2004 to July 2009 and 7.91 percent over the five-year period from January 2005 to January 2010.

The applicant referenced the utilization rate for Kindred Hospital-Bay Area-St. Petersburg, the only LTCH in District 5 as 79.71 percent for the 12-month period ending December 2003.

<b>Kindred Hospital-Bay Area-St. Petersburg Annual Utilization 1997-2003</b>	
<b>Year</b>	<b>% Occupancy</b>
<b>1997</b>	46.28%
<b>1998</b>	90.16%
<b>1999</b>	97.24%
<b>2000</b>	98.15%
<b>2001</b>	98.02%
<b>2002</b>	100.15%
<b>2003</b>	77.65%

Source: AHCA Utilization Rates, CON Application #9803, page 43.

As shown in the table above, Kindred Hospital had an occupancy rate of between 46.28 percent and 100.15 percent from 1997 to 2003. However, with a 2003 second quarter 22-bed addition, average occupancy at the Kindred St. Petersburg facility dropped from 99.95 percent to 79.99 percent and subsequent quarters have shown a decline rather than increase. Following illustrates average occupancy by quarter at the Kindred St. Petersburg facility.

<b>Kindred St. Petersburg Facility Occupancy CY 2003 &amp; Quarters 1 and 2 of 2004</b>		
<b>Quarter</b>	<b># Beds</b>	<b>Occupancy</b>
2003 1	60	99.95%
2003 2	82	79.99%
2003 3	82	74.75%
2003 4	82	64.71%*
2004 1	82	69.91%
2004 2	82	71.91%

Source: Florida Hospital Bed and Service Utilization by District July 2004 Batching Cycle and 2004 Local Health Council Reports

\*Note: Bed days were miscalculated in AHCA publication, this is corrected occupancy

Although the applicant contends that the newly added 22 beds to Kindred's St. Petersburg facility will experience a quick and significant increase in occupancy, as did its original 60 beds that does not appear to be the case. As shown above, although some fluctuation has occurred, available beds have not rapidly filled.

The applicant alleges that the ability to pay or complex clinical conditions has constrained certain population's access to the LTCH providers in the District 5. The applicant states that patients referred to a LTCH usually have medically complex conditions that preclude admission to a rehabilitation hospital or nursing facility, but are candidates for post-acute care services. The applicant discussed one of the more difficult

patient populations to place, those on ventilators, especially those with other medical co-morbidities such as renal failure/dialysis. The applicant referenced a survey done by staff at St. Anthony’s Hospital using a list of from the Department of Elder Affairs (DOEA) of facilities in the state facilities that (as of October 13, 2004) accept ventilator patients. According to the applicant several of the skilled nursing facilities will not admit ventilator patients if they are receiving dialysis, or have certain kinds of insurance. However, no copy of the actual survey was provided in the application.

The applicant contends that the LTCHs located in District 5 and District 6, all operated by Kindred, do not accept Medicaid patients. However, as discussed below, Kindred does accept Medicaid patients and the applicant provided no evidence that Medicaid patients referred to Kindred facilities were refused admission. According to the 2003 AHCA Financial Data Report, Kindred’s licensed Florida facilities provided a percent of Medicaid patient days to total patient days, ranging from a low of zero percent (Kindred-North Florida, Kindred-Central Tampa, and Kindred Hospital Coral Gables) to a high of 11.5 percent (Kindred-St. Petersburg). Charity care patient days ranged from a low of zero percent (Kindred-Fort Lauderdale) to a high of 2.5 percent (Kindred Hospital-Coral Gables).

<b>LTCH Provision of Care to the Medically Indigent Calendar Year (CY) 2003</b>			
<b>Hospital</b>	<b>District</b>	<b>% Medicaid</b>	<b>% Charity</b>
Kindred North Florida	4	0.0%	0.5%
Kindred Saint Petersburg	5	11.5%	1.8%
Kindred Central Tampa	6	0.0%	1.0%
Kindred Bay Area Tampa	6	0.3%	1.8%
Kindred Hollywood	10	0.1%	0.8%
Kindred Fort Lauderdale	10	0.4%	0.0%
Kindred Coral Gables	11	0.0%	2.5%
Average Kindred		1.76%	1.20%
Specialty Hospital Jacksonville	4	0.0%	0.0%
Select Specialty Hosp. Miami	11	0.0%	1.0%
Select Specialty Hosp. Orlando	7	0.0%	0.0%
Average State CY 2003		1.24%	.94%

**Source: ACHA Financial Data CY 2003**

**NOTE: Facilities above represent all of the LTCH financial reporting data for CY 2003.**

As noted above, Kindred facilities in the State of Florida averaged 1.76 percent of total patient days to Medicaid and 1.2 percent of total patient days to charity care for calendar year 2003. Although the applicant presented data regarding the payor mix for Kindred-St. Petersburg alleging lack of access, this facility had 11.5 percent of total patient days to Medicaid and 1.8 percent of total patient days to charity care for calendar year 2003.

**CON Action Numbers: 9803 & 9804**

The applicant formulated a need methodology reflecting LTCH potential discharges for St. Anthony's Hospital, Morton Plant Hospital, Mease Dunedin Hospital, Mease Countryside Hospital, and Morton Plant North Bay Hospital and utilizing the actual experience of Florida's LTCH providers. The applicant first identified all patients with a length of stay of 15 days or more, excluding rehabilitation, skilled nursing and psychiatric patients, for the six-month period ending June 2004, for the five BayCare-affiliated hospitals.

<b>BayCare Related Hospitals LTCH Target Patients Patients with a 15 + Length of stay Six Months Ending 6/30/04</b>	
<b>Hospital</b>	<b>Number of Patients</b>
St. Anthony's	232
Morton Plant	347
Mease Dunedin	140
Mease Countryside	188
Morton Plant North Bay	65
<b>Total</b>	<b>972</b>

Source: CON Application #9803, page 68.

As shown in the table above, the applicant identified 972 patients from the five BayCare affiliated hospitals who had a length of stay of 15 days or more for the six-month period ending June 30, 2004. According to the applicant, these patients could potentially benefit from treatment within a LTCH environment verses an acute care setting. However, according to MedPAC, length of stay alone does not address whether or not these were medically complex patients or if they could not have been served in another setting.

The applicant then defined the 174 Diagnosis Related Group (DRG) out of a potential of 520 existing DRGs that were treated by Florida LTCH providers during the 12-month period ending December 2003 (and provided the list in its application) and also included invasive cardiology (both cardiac surgery and angioplasty) as the applicant intends to serve this patient sector. The table below lists the selected hospitals and the results of this analysis.

<b>BayCare Related Hospitals LTCH Target Patients Patients with a 15 + Length of stay plus the Target LTCH Categories Six Months Ending 6/30/04</b>	
<b>Hospital</b>	<b>Number of Patients</b>
St. Anthony's	195
Morton Plant	295
Mease Dunedin	123
Mease Countryside	156
Morton Plant North Bay	54
<b>Total</b>	<b>823</b>

Source: CON Application #9803, page 69.

As shown in the table above, the applicant identified a total of 823 patients at its affiliated hospitals who met the length of stay and DRG categories criteria for its need methodology. As MedPAC points out, the diagnostic related group (DRG) itself or the length of stay in any particular group is not necessarily an indicator of need. MedPAC’s findings indicate that lower acuity patients within any DRG can appropriately be served in a skilled nursing facility (SNF) at a lower cost as LTCHs are usually the most costly post-acute care setting at about three to 12 times that of SNFs. As noted above, SNF utilization in District 5 averaged 87.72 for the most recent reporting period. This utilization rate is below the benchmark for SNF care set in the Florida Statutes at 94 percent.<sup>1</sup>

The applicant took the 15+ length of stay /LTCH DRG pool of potential patients and identified those patients with a length of stay three times the Medicare mean for the DRG. The applicant applied the 2004 DRG-specific Medicare geometric mean length of stay (GMLOS) as an evaluation point. The applicant then consolidated all of the DRG-specific data into their Major Diagnostic Code (MDC) (with the exception of DRGs 475, respiratory system diagnosis and thracheostomy with mechanical ventilator as the applicant contends that DRG 475 and DRG 483 are appropriate for independent review).

The applicant provided the following table summarizing the MDC categories and the number of patients by hospital per MDC category.

<b>BayCare Related Hospital LTCH Target Patients                      Patients with a 15+ Length of Stay/DRG in the Target LTCH Categories/At Least                      Three Times Medicare Geometric Mean Length of Stay                      Six Months Ending 06/30/04</b>		
<b>Hospital</b>	<b>Number of Patients 15+LOS plus LTCH DRG</b>	<b>Number of Patients 15+LOS plus LTCH DRG plus &gt;3XGEO Mean LOS</b>
St. Anthony’s	195	122
Morton Plant	295	157
Mease Dunedin	123	82
Mease Countryside	156	89
Morton Plant North Bay	54	30
<b>Total</b>	<b>823</b>	<b>480</b>

Source: CON #9803 Application, page 70.

According to the applicant, the table above shows that there are a total of 480 potential LTCH patients, based on six-month data ending June 30, 2004. The applicant then converted the data set into a 12-month volume estimate by taking the hospital-specific volumes and annualizing each hospital’s volume by utilizing actual hospital specific CY 2003 data documenting the percentage of total year volume observed during the

<sup>1</sup> Subsection 408.034 (5), Florida Statutes, as amended July 1, 2004, sets the skilled nursing occupancy standard at 94 percent.

first six months of the calendar year. The applicant used Morton Plant Hospital as an example. Fifty-one percent of Morton Plant's full-year volume occurred within the first six months of the year. As a result, the annualization assumed that its six-month data presented represents 51 percent of estimated CY 2004 volume. The 157 target discharges (see table above) would translate into an estimate of 308 total target discharges for the full calendar year ( $157 / .51 = 308$ ). The applicant provided a table on page 73 of the application illustrating the MDC category and application of respective six-month volume percentages for each of the BayCare affiliated hospitals. However, as noted above, the DRG or length of stay is not necessarily an indicator of need as MedPAC findings indicate that lower acuity patients within any DRG can be appropriately served in a skilled nursing facility at a lower cost than LTCHs.

The applicant then applied a "referral factor", using a 33 percent referral source from St. Anthony's, 66 percent for Morton Plant and Morton Plant North Bay, 70 percent for Mease Countryside and 80 percent for East Dunedin for a total forecast of 574 potential LTCH patients. The applicant states that the case managers from each hospital attest to the reasonableness of these referral factors. However, the applicant did not provide supporting documentation that these projections include only patients that cannot be appropriately and less costly served in other post-acute venues.

In order to forecast patient days, the applicant applied AHCA data for the actual length of stays for DRGs 475/483 (approximately 2/3 the total of all the patients). Based on its methodology, the applicant forecasted 18,709 patient days. The applicant converted the patient days and multiplied them times the target rate of 90 percent occupancy level to reach an Average Daily Census (ADC) of 51.3 ( $18,709 / 365 = 51.3$ ). According to the applicant, converting the ADC level of 51.3 utilizing a 90 percent target rate results in a need of 57 beds ( $51.3 \text{ ADC} / 90 \text{ percent target occupancy} = 57 \text{ beds needed}$ ). Based on the fact that there are 12 adult acute care facilities in Pinellas County, a number of nursing homes in the area, and other health care providers, the applicant assumed that 25 percent of patient volume ("in-flow factor") would originate from providers other than BayCare related hospitals.

The applicant states that BayCare-affiliated hospitals provide one-third of the acute care volume within Pinellas and Pasco Counties and feels it is reasonable to expect that the true market demand for LTCH services is three times as large as the BayCare-only need analysis. The applicant took the patients pool of 944 (table on page 73 of the application) times three to reach a Pinellas/Pasco market of 2,832, with 1,888 expected to originate from other sources than BayCare affiliated facilities ( $2,832 \text{ total LTCH patients} - 944 \text{ BayCare LTCH patients} = 1,888$ ).

That applicant contends that by using an alleged true market demand three times larger than the BayCare-only need analysis, the 14,892 patient days forecasted for year two of operation (Schedule five of the application) converts into a total of 44,676 patient days ( $14,892 \times 3 = 44,676$ ). The applicant contends that this converts into a 136-bed need by applying a 90 percent occupancy rate ( $44,676 \text{ patient days} / 365 / 90 \text{ percent} = 136 \text{ beds}$ ). The applicant compared its total market bed need (136 beds) to the current licensed beds in Pinellas County (82 beds) and the proposed beds for this project (48 beds) and contends that the total of 130 beds demonstrates that there is adequate need without impacting the one other existing provider in Pinellas County. The applicant also expects referrals non-BayCare-affiliated providers in Pinellas and Pasco Counties and from the two BayCare-affiliated hospitals in Hillsborough County.

The applicant states that by using the 51.3 ADC/57 beds need base and applying a 25 percent in-flow factor that a total LTCH ADC forecast is 68.4 ( $51.3 / .75 = 68.4$ ), the potential need forecast is 76 LTCH beds. The applicant contends that it will be able to insure that the requirement of less than 25 percent of forecast volume is anticipated to be non-outlier patients referred from Mease Dunedin Hospital.

The applicant has not demonstrated potential access issues. Need for an additional LTCH hospital in District 5 was not demonstrated.

**University Community Hospital, Inc. (CON #9804)** states that the elderly population of District 5 will grow faster than the elderly rate for the state and for Pinellas County within the next five years to explain why a LTCH is needed to be physically located in Pasco rather than Pinellas County where co-batched applicant BayCare plans to establish its LTHC if approved. However, like BayCare, the applicant has failed to show that patients needing this service are unable to obtain it. Additionally, as discussed below, it appears that the establishment of this project will be accomplished through the loss of patients at existing area LTCHs.

Population data was examined as presented by the applicant and verified by the reviewer. The table below indicates that the 65 and older population is 17.8 percent of the state total and this will increase to 18.1 percent by July 2009. The 65 and older population for District 5 is 23.8 percent of its total population and will increase to 28.4 percent by July 2009. The applicant gives data for 2014 indicating that one third of Pasco County's population will be at least age 65. Pinellas County and Florida's elderly will represent 25.1 and 21.5 percent respectively in 2014.

**CON Action Numbers: 9803 & 9804**

<b>District 5 Current and Projected Population Estimates</b>							
District 5	<b>July 2004 Population</b>				<b>Distribution of Elderly</b>		
	Total	65-74	75+	65+	65-74	75+	65+
Pasco County	380,091	48,980	55,415	104,395	12.9%	14.65%	27.5%
Pinellas County	946,942	95,451	115,423	210,874	10.1%	12.2%	22.3%
<b>Total</b>	<b>1,327,033</b>	<b>144,431</b>	<b>170,838</b>	<b>315,269</b>	<b>10.9%</b>	<b>12.9%</b>	<b>23.8%</b>
Florida	17,360,033	1,535,711	1,557,406	3,093,117	8.8%	9.0%	17.8%
District 5	<b>July 2004 Population</b>				<b>Distribution of Elderly</b>		
	Total	65-74	75+	65+	65-74	75+	65+
Pasco County	406,148	57,248	57,952	115,200	14.1%	14.3%	28.4%
Pinellas County	977,524	105,742	112,221	217,963	10.8%	11.5%	22.3%
<b>Total</b>	<b>1,383,672</b>	<b>162,990</b>	<b>170,173</b>	<b>333,163</b>	<b>11.8%</b>	<b>12.3%</b>	<b>24.1%</b>
Florida	18,737,105	1,774,590	1,656,050	3,400,640	9.3%	8.8%	18.1%
District 5	<b>July 2004 Population</b>				<b>Distribution of Elderly</b>		
	Total	65-74	75+	65+	65-74	75+	65+
Pasco County	439,418	74,266	63,304	137,570	18.3%	15.6%	33.9%
Pinellas County	1,007,225	132,562	112,832	245,394	13.6%	11.5%	25.1%
<b>Total</b>	<b>1,446,643</b>	<b>206,828</b>	<b>176,136</b>	<b>382,964</b>	<b>14.9%</b>	<b>12.7%</b>	<b>27.7%</b>
Florida	20,182,917	2,218,032	1,803,416	4,021,448	11.8%	9.6%	21.5%

Source: CON #9804 Application, page 1-6, AHCA Population Estimates, March 2004.

Additionally, as shown in the table above, the Pasco County growth rate for 65 and older population will be greater than that of Pinellas County and the state overall. However, projections beyond five years are speculative primarily because healthcare is a very dynamic field, which experiences dramatic technological developments and frequently changing health modalities.

The applicant contends that the residents of Pasco County do not have access to LTCH services and cites AHCA data for cases admitted to Florida's long term care hospitals for calendar year 2003 by age cohort.

<b>Numbers of Cases at Florida's Long-Term Care Hospitals By Age Cohort, Calendar Year 2003</b>		
<b>Age Group</b>	<b>All Florida LTCHs</b>	
	<b>Cases</b>	<b>Percent</b>
0-44	232	4.8%
45-64	877	18.3%
0-64	1,109	23.1%
65-74	1,242	25.9%
75-84	1,555	32.4%
85+	895	18.6%
65+	3,692	76.9%
<b>Total</b>	<b>4,801</b>	<b>100.0%</b>

Source: CON Application #9804, page 1-9. AHCA hospital patient discharge data, CY 2003

Data indicates that almost 77 percent of the LTCH cases are 65 years of age or older, with the majority of cases between age 65 and 85. The applicant states that with the anticipated growth in Pasco County, need and demand will remain. As noted earlier, the 65+ population in Pasco County is expected to change from 104,395 in July 2004 to 115,200 in July 2009, representing an increase of 9.37 percent.

The applicant states that the district's sole LTCH is not serving the needs of Pasco County as evidenced by the fact that there were two cases from Pasco County for Kindred Hospital Bay Area-St. Petersburg during CY 2003. The applicant contends that residents of Pasco County drive to Tampa (Hillsborough) County in the district for LTCH services. The applicant states that the elderly are most likely to need extended time for recovery following major episodes. The applicant cites AHCA data stating that the use rate for Pasco County residents, with almost the same number of elderly as Pasco has a 12 times less rate use than that of Hillsborough County. The applicant contends that applying the use rate for Hillsborough County to Pasco County, will yield a demand of 611 LTCH admissions for CY 2003 (12 times what actually occurred). According to the applicant, this demonstrates lack of access to those residents in Pasco and Hernando Counties. However, there was no evidence presented that Pasco County residents needing LTCH services were unable to obtain them. Kindred's St. Petersburg facility had a 12-month occupancy rate during calendar year 2003 of 77.65 percent. Additionally, there is evidence that Medicaid patients are accepted at the St. Petersburg facility.

The applicant contends that LTCHs do not compete for the same patients as skilled nursing facilities (SNF); hospital-based skilled nursing facilities (HBSNF) or comprehensive medical rehabilitation (CMR) beds. The applicant provided a table representing data from the Centers for Medicare and Medicaid Services (CMS) listing the average daily census, number of beds, number of Medicare discharges and the case mix index for the hospitals in Pasco County and for hospitals affiliated with the applicant. The case mix ranged from Regional Medical Center Bayonet Point at 2.00 to a low of 1.27 at East Pasco Medical Center. The applicant applied the Medicare acute care relative weight to Kindred Hospital-Bay Area-St. Petersburg's 321 cases for a case mix result of 2.9753. The applicant contends that this indicates that long-term care hospitals have patients who differ and whose needs are greater than those served in the acute care hospitals. Although it is acknowledged that Kindred's average case mix is higher than acute care hospitals, it is noted that acute care hospitals provide care to a varied mix of patients including mothers giving birth. The applicant did not compare patient severity levels with those of skilled nursing facilities or rehabilitation hospitals. A discussion of what another corporation does is not an indication of what the applicant might or might not do. In addition, the MedPAC analysis of LTCHs found that between seven and eight percent of patients with the highest probability of using LTCHs used rehabilitation hospital services in markets both with and without LTCHs. Rehabilitation utilization during the most recent reporting period of 63.63 percent in District 1 is significantly below the benchmark for that

service of 80 percent set forth in the Florida Statutes.<sup>2</sup> MedPAC's findings indicate that a group of lower acuity patients elderly medically complex patients needing post acute care (who, grouped together, would likely have a case mix above that of an acute care hospital) can appropriately be served in a skilled nursing facility at a lower cost as LTCHs are usually the most costly post-acute care setting at about three to 12 times that of SNFs. As noted above, SNF utilization in District 5 averaged 87.72 percent for the most recent reporting period. This utilization rate is below the benchmark for SNF care set in the Florida Statutes at 94 percent.<sup>3</sup>

The applicant states that when acute care hospitals retain long-term care hospital patients, medical complications can arise, the recovery process may be longer, and/or the patients consume resources at much greater rates than acute care patients. According to MedPAC, those acute care hospital patients who use LTCHs have an acute care hospital length of stay (LOS) that is seven days shorter than those who do not. For patients in the top five percent probability of using a LTCH, patients who use LTCHs have an acute care hospital LOS that is nine days shorter. Shorter hospital lengths of stay for similar patients who use LTCHs suggest that LTCH can substitute for at least part of the acute hospital stay. The applicant described the different criterion for admission and reimbursement rates for DRGs at SNF, hospital-based skilled nursing units (HBSNUs) and CMR facilities. The applicant concludes that LTCHs provide a different mix of services for patients who do not qualify for care in other settings, therefore LTCHs are not a substitute for existing providers, rather they are an addition on the continuum of care. However, these statements have not been demonstrated by the applicant. In addition, as noted earlier, the diagnostic related group (DRG) itself or the length of stay in any particular group is not necessarily an indicator of need. MedPAC's findings indicate that lower acuity patients within any DRG can appropriately be served in a skilled nursing facility (SNF) at a lower cost as LTCHs are usually the most costly post-acute care setting at about three to 12 times that of SNFs.

The applicant contends that Kindred Hospital-Bay Area-St. Petersburg has a monopoly, as it is the sole provider of LTCH services in District 5. District 6, Hillsborough County, has two Kindred LTCH hospitals. The applicant alleges that this situation lacks choice for physicians and patients for LTCH services. As is discussed in more detail below, need has not been shown and as is described below, the applicant would be a

---

<sup>2</sup> Subsection 408.034 (3)(i), Florida Statutes, as amended July 1, 2004, sets the occupancy standard for additional comprehensive medical rehabilitation beds through CON exemption at 80 percent. Section 59C-1.039 Florida Administrative Code sets the occupancy standard at 85 percent for fixed need pool calculations.

<sup>3</sup> Subsection 408.034 (5), Florida Statutes, as amended July 1, 2004, sets the skilled nursing occupancy standard at 94 percent.

referring hospital. Kindred, after purchasing existing LTCHs some years ago, is the sole provider in many areas of the state. If the applicant's projections are met, the project is expected to have a positive impact on competition to promote quality assurance and cost-effectiveness. However, it appears the applicant's projections can only be met if it negatively impacts the sole provider of LTCH services in District 5 and possibility also negatively impacts the District 6 Kindred facilities as well.

The applicant states that over 91 percent of LTCH patients come from acute care hospitals. Therefore, according to the applicant, as occupancy rates in acute care hospitals increase, and as additional acute care hospitals are established, LTCH beds must be established to meet the growing need that will be created. The applicant states that because of medical reimbursement policies that it is more cost-efficient to treat medically complex patients at LTCHs rather than acute care facilities. MedPAC points out that LTCHs are usually the most costly post-acute care setting with Medicare rates for LTCHs ranging from three to 12 times as much as estimated rates for SNFs. The findings indicate that lower acuity patients within any DRG can be appropriately served in SNFs at a lower cost than LTCHs. Should MedPAC's recommendations be accepted and Medicare reimbursement change, it is expected that existing LTCH providers will need to serve a larger geographic area to ensure continued operation as currently some portion of LTCH patients could be served at a lower cost in SNFs.

In addition to the factors discussed above, the applicant employed four methodological approaches. In the first method, applicant took the hospital cases that exceeded the geometric mean length of stay plus seven days, GMLOS + 7. Excess days were calculated based on the days in addition to the GMLOS + 7-day criteria. The applicant's calculations yield a need of 91 beds in year one (2008) and 93 beds in year two (2009) for Pasco County (see table 1-10 on page 1-29 of the application). However, as noted earlier, the DRG or length of stay is not necessarily an indicator of need as MedPAC findings indicate that lower acuity patients within any DRG can be appropriately served in a skilled nursing facility at a lower cost than LTCHs. In addition, patients transferred to LTCHs have shorter acute care stays by approximately seven days, suggesting that when there is no LTCH in an area, patients might stay an additional seven days on average in an acute care facility.

Method two uses rates per 1,000 total persons and per 1,000 persons aged 65 and older during CY 2003. As shown earlier, Hillsborough County and Pasco County have similar numbers of elderly persons, but Pasco County residents use LTCH facilities 12 times less than that Hillsborough County residents. According to the applicant, this represents a lack of access to LTCH services and that proximity to a LTCH would result in its use. However, MedPAC states that acute care

hospitals and skilled nursing facilities are the principal substitutes for LTCH in areas without LTCHs and even when there is no LTCH in the area, some patients needing this service will travel to receive it.

The applicant states that by using data from adjacent areas to Pasco County, the bed need is 921 long-term care admissions, 34,906 patient days yielding an average daily census (ADC) of 96, requiring 128 beds to operate at a 75 percent occupancy rate. Applying the Hillsborough County hospital use per 1,000 elderly persons, 5.8793, to the projected Pasco County elderly population 109,442 yields 643 admissions. This equates to 24,370 patient days (using a 37.9 average length of stay for Florida's LTCH) and ADC of 67 persons. At a 75 percent occupancy rate, the need is 89 beds. The applicant did not indicate why a 75 percent occupancy rate was chosen for calculation and has based this methodology on assumptions, as previously discussed, that cannot be made.

For method three, the applicant selected cases from target zip codes in acute care hospitals that exceeded the geometric mean by more than 15 days, GMLOS + 15. According to the applicant's calculations, (see Table 1-11 on page 1-30 of the application), there are 57 beds needed in year one and 58 beds needed in year two at a 75 percent occupancy rate. As stated earlier, length of stay methodologies are not a reliable indicator of need for LTCHs.

The fourth method employs defining the cases and patient days by diagnosis related group (DRG), then selecting acute care hospital cases of residents who live in target areas whose length of stay exceeded 25 days. These cases and patient days were matched by DRG with cases and patient days in LTCHs. According to the applicant, 495 cases were generated from the target areas exceeding the 25-day length of stay. The applicant then matched long stay acute hospital cases with LTCH cases. One hundred seventy-four of the DRGs matched, yielding a rate of 75 percent. The applicant used a 70 percent rate to yield an average length of stay at 54 days ( $495 \times .70 = 347$ ). The applicant used the average length of stay for Florida LTCH patients of 37.9 days times the 347 cases to generate patient days. The patient days were divided by 365 to yield the ADC, and then divided by the target occupancy rate of 75 percent. For year one the bed need was 54 ( $14,652 \text{ patient days} / 365 \text{ days} = 40 \text{ persons} / .75 \text{ occupancy rate} = 53.33$ ) and for the second year, the bed need was 55 ( $15,012 \text{ patient days} / 365 \text{ days} = 41.12 \text{ persons} / .75 \text{ occupancy rate} = 54.83$ ).

All of the need methodologies presented by the applicant make assumptions that, based on 2004 MedPAC findings and as previously discussed, cannot be assumed. Any methodology based on GMLOS or LOS in certain DRGs cannot be considered because it fails to consider

severity of illness. Patients included in the applicant's need analysis might be discharged to a SNF, HBSNU, CMR or directly home with no post-acute care. It was not demonstrated by the applicant that patients needing LTCH services are not currently being placed or that an access problem exists in the district.

**2. Agency Rule Criteria**

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

**3. Statutory Review Criteria**

- a. Is need for the project evidenced by the availability, efficiency, quality of care, 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.**

**BayCare Long Term Acute Care, Inc. (CON #9803)** contends that need is evidenced in District 5 for this project based on utilization in acute care hospitals, by patients with long length of stay and the utilization of long-term care providers in the district. However, as noted earlier, according to MedPAC, the length of stay in any particular diagnostic related group (DRG) is not necessarily an indicator of need. MedPAC's findings indicate that lower acuity patients within any DRG can appropriately be served in a skilled nursing facility at a lower cost as LTCHs are usually the most costly post-acute care setting at about three to 12 times that of SNFs. The applicant contends that patients with limited financial means do not have access to LTCHs in the district because Kindred-St. Petersburg had 0.6 percent of its patients in the Medicaid/Medicaid HMO/self-pay/underinsured/charity category for CY 2003. However, AHCA data for CY 2003 reveals that 11.5 percent of Kindred St. Petersburg's total patient days were provided to Medicaid patients and 1.8 percent were provided to charity care patients.

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 proposed service area.

**University Community Hospital, Inc. (CON #9804)** refers to the need analysis section (Section E.1.b. of this report) for its detailed analysis that Pasco County residents do not have access to LTCH services. However, as discussed above, need was not demonstrated. There is one LTCH in District 5, located in St. Petersburg (Pinellas County).

According to the applicant, this LTCH is too far away to serve the residents of Pasco County and physicians do not transfer patients to that facility. However, the applicant does indicate that patients are transferred to the two LTCHs in adjacent Hillsborough County. The applicant did not show that the residents of Pasco County could not access LTCH services.

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 proposed 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.**

**BayCare Long Term Acute Care, Inc. (CON #9803)** is a newly formed not-for-profit corporation with no operating history. The applicant described the history of its host hospital, Mease Dunedin Hospital, and states that it is accredited by JCAHO, licensed by AHCA, certified to participate in Medicare and Medicaid programs, and has been recognized as giving quality service as evidenced by several awards it has received. The applicant also intends to enlist the services of Acuityhealthcare (consulting firm) to assist in the development of this project and provided a copy of Acuity's policies and procedures.

The complaint summary reports for the six licensed BayCare Health System, Inc. hospitals in the state dated November 5, 2004, indicate a combined listing of 28 complaints, including six without deficiencies. The 22 confirmed allegations involve: EMTALA/ER access (emergency medical treatment & active labor act) (four), discharge planning (three), patient care (two), medical problems/errors/formulary (two), infection control (two), physical plant (two), restraints (one), surgery wrong site (one), dietary (one), falls/injury (one), and lack of assessment (one), plan of care (one).

**University Community Hospital, Inc. (CON #9804)** states that its high quality is evidenced by its accreditation by a variety of local, state, and national organizations including the Joint Commission on Accreditation of Health Care Organizations (JCAHO). The applicant further states that it has developed seven *Centers of Excellence* that provide specialized care to patients. The applicant described its patient safety program, strategic plan, objectives and goals, its process for quality improvement and provided a sample of treatment protocols.

According to AHCA data, the applicant had 20 confirmed complaints at its main campus during the past three years, all with deficiencies. The number of confirmed complaints for each category were as follows: billing/refunds (six), EMTALA/ER access (four), patient care (one), discharge planning (one), lack of assessment (one), medical problems/errors/formulary (one), dietary (one), plan of care (one), medical services (one), untrained/unqualified staff (one), pressure sores (one), staffing (one). The applicant's affiliate, University Community Hospital at Carrollwood had five confirmed complaints during the past three years, all with deficiencies. The number of confirmed complaints for each category were as follows: untrained/unqualified staff (two), discharge planning (one), staffing (one), billing/refunds (one).

- c. 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.**

**BayCare Long Term Acute Care, Inc. (CON #9803):** Audited financial statements of the applicant were analyzed for the purpose of evaluating its ability to provide the capital and operational funding necessary to implement the project.

The applicant is a start up company with \$100,000 in net assets as of March 31, 2004. According to the audit, initial funding of the applicant was provided by BayCare Health Systems, Inc. and Trustees of Mease, Inc. d/b/a Mease Health Care. BayCare Health Systems, Inc. controls, through a Joint Operating Agreement (JOA), several acute care hospitals in the Tampa Bay area as well as nursing homes, life care facilities, home health agencies, ambulatory care centers, and physician practices. The JOA provides for the members to maintain ownership of their assets while agreeing to operate as one organization, with common governance and management.

Included under this agreement are:

- St. Joseph's Hospital, Inc.
- St. Anthony's Hospital, Inc.
- South Florida Baptist Hospital, Inc.
- Morton Plant Hospital, Inc.
- Trustees of Mease Hospital, Inc.

BayCare Long Term Acute Care, Inc. will lease the space required to operate the hospital from Mease Dunedin Hospital. Mease Dunedin Hospital is an affiliate of the Trustees of Mease Hospital, Inc., one of the hospitals managed by BayCare Health Systems, Inc.

**CON Action Numbers: 9803 & 9804**

In **CON #9753**, concerns were raised with this applicant's compliance with 42 CFR section 412.22(e), which prohibits a single entity from controlling both the host hospital and the long-term care hospital within a hospital. In this application, the applicant has addressed these concerns by submitting a copy of the minutes of the board of directors of the applicant. The minutes include a discussion to return the capital contribution of \$14,000 to Mease Health Care, and to approve by-laws of the organization that provide for the organization to be wholly governed by BayCare Health Systems. According to the minutes, these proposals were approved.

BayCare Health Systems, Inc. (sponsor) will be providing funding for the project. Mease Dunedin Hospital (host) will fund the renovation. Audited financial statements were submitted for the period ended December 31, 2003, for both the sponsor and the parent of the host hospital Trustees of Mease Hospital, Inc. Below is an analysis of the financial position of the sponsor and parent of the host hospital:

	<b>SPONSER</b>	<b>HOST'S PARENT</b>
	<u>12/31/2003</u>	<u>12/31/2003</u>
Current Assets	\$ 324,341,000	\$ 43,100,000
Cash and Current Investment	\$ 48,233,000	\$ 555,000
Assets Restricted for Capital Projects	\$ -	\$ -
Total Assets	\$ 2,222,127,000	\$ 325,205,000
Current Liabilities	\$ 217,947,000	\$ 15,637,000
Total Liabilities	\$ 1,050,808,000	\$ 150,820,000
Net Assets	\$ 1,171,319,000	\$ 174,385,000
Total Revenues	\$ 1,444,156,000	\$ 208,723,000
Interest Expense	\$ 32,675,000	\$ 5,499,000
Excess of Revenues over Expenses	\$ 101,467,000	\$ 11,348,000
Cash Flow from Operations	\$ 202,441,000	\$ 37,192,000
Working Capital	\$ 106,394,000	\$ 27,463,000
Current Ratio (CA/CL)	1.5	2.8
Cash Flow to Current Liabilities (CFO/CL)	0.9	2.4
Long-Term Debt to Net Assets (TL-CL/NA)	0.7	0.8
Times Interest Earned (NPO+Int/Int)	4.1	3.1
Net Assets to Total Assets (TE/TA)	52.7%	53.6%
Total Margin (ER/TR)	7.0%	5.4%
Return on Assets (ER/TA)	4.6%	3.5%
Operating Cash Flow to Assets (CFO/TA)	9.1%	11.4%

The sponsor and host's parent's current ratios of 1.5 and 2.8 respectively indicate current assets are in excess of short-term liabilities, an adequate position. The working capital (current assets less current liabilities) of \$106 million and \$27 million are measures of excess liquidity that could be used to fund capital projects. The long-term debt to equity ratio of a 0.7 and 0.8 means long-term debt is less than the net assets of the sponsor and host's parent respectively, an adequate position.

**Capital requirements:**

Total capital costs for this project from Schedule 1 are \$363,220. Schedule 2 indicates the applicant has capital projects totaling \$721,440. The capital costs on Schedule 2 do not include renovation cost (\$2 million) or equipment cost (\$900,000), which will be provided by the host hospital.

**Available capital:**

As discussed above, funding for the proposed project is coming from the sponsor and host hospital. The sponsor submitted a letter committing to fund the applicant until the applicant can become self-sustaining. The host hospital's parent also submitted a letter committing to fund the renovation and equipment costs.

**Conclusion:**

Due to the financial resources of the sponsor and host hospital's parent, funding for this project is likely to be available as needed.

**Staffing:**

According to schedule 6, the proposed project will require a total of 87.6 FTE staff in year one, increasing to 115.2 FTEs in year two. The nursing staff, including aides will fill 51.7 FTE positions in year one, increasing to 70.3 FTEs in year two. Ancillary positions, including therapists will fill 3.2 FTEs in year one increasing to 4.3 positions in year two. The applicant states that it will benefit from the resources of management, finance, operations, engineering, information systems, and facility staff who have already been trained at Mease Dunedin Hospital and will be available to support the proposed LTCH. The applicant provided a copy of the list of policies and procedures from its consulting firm, Acuityhealthcare, which included human resource policies. However, no actual policies pertaining to recruitment and retention were provided.

**University Community Hospital, Inc. (CON #9804):** The audited financial statements for the periods ending September 31, 2003 and 2002 were analyzed for the purpose of evaluating the applicant's ability to provide the capital and operational funding necessary to implement the project. The following is a list of accounts and ratios used in the analysis:

**University Community Hospital, Inc.**

	<u>09/30/2003</u>	<u>09/30/2002</u>
Current Assets	\$ 130,752,895	\$ 94,492,975
Cash and Current Investment	\$ 17,962,583	\$ 17,996,158
Assets Restricted for Capital Projects	\$ 54,711,998	\$ 46,552,032
Total Assets	\$ 384,993,314	\$ 341,044,375
Current Liabilities	\$ 81,458,238	\$ 55,343,873
Total Liabilities	\$ 242,297,963	\$ 217,557,005
Net Assets	\$ 142,695,351	\$ 123,487,370
Total Revenues	\$ 328,976,001	\$ 287,312,689
Interest Expense	\$ 8,398,768	\$ 8,441,121
Excess of Revenues over Expenses	\$ 13,372,552	\$ (3,523,071)
Cash Flow from Operations	\$ 23,665,191	\$ 11,646,292
Working Capital	\$ 49,294,657	\$ 39,149,102
Current Ratio (CA/CL)	1.6	1.7
Cash Flow to Current Liabilities (CFO/CL)	0.3	0.2
Long-Term Debt to Net Assets (TL-CL/NA)	1.1	1.3
Times Interest Earned (NPO+Int/Int)	2.6	0.6
Net Assets to Total Assets (TE/TA)	37.1%	36.2%
Total Margin (ER/TR)	4.1%	-1.2%
Return on Assets (ER/TA)	3.5%	-1.0%
Operating Cash Flow to Assets (CFO/TA)	6.1%	3.4%

**Short-term position:**

The applicant's current ratio of 1.6 and cash flow to current liabilities ratio of 0.3 are both below average and indicate a moderately weak short-term position. The working capital (current assets less current liabilities) of \$49.3 million is a measure of excess liquidity that could be used to fund capital projects. Overall, the applicant has a moderately weak but adequate short-term position.

**Long-term position:**

The ratio of long-term debt to net assets is 1.1 and indicates long-term debt is greater than equity. This is well above average and a weak position. The ratio of cash flow to assets of 6.1 percent is below average and a moderately weak position. The most recent year had \$13.4 million revenues in excess of expenses, which resulted in a total margin of 4.1 percent. Overall, the applicant has a moderately weak but adequate long-term position.

**Capital requirements:**

Schedule 2 indicates the applicant has \$99.5 million in capital projects and maturities of long-term debt due through 2006.

**Available capital:**

Schedule 2 indicates funding for these projects will come from operations and debt financing. Cash flows for the most recent year were \$23.7 million. As discussed above working capital is \$49.3 million. The applicant's reported limited use assets include \$46.5 million in board designated funds for use in capital projects and acquisitions. In addition, the applicant provided a letter from Merrill Lynch stating that the applicant would be able to obtain cost-effective financing for the project.

**Conclusion:**

Funding for this project and all capital projects should be available as needed.

**Staffing:**

According to Schedule 6, the proposed project will require a total of 65.5 FTE staff in year one, increasing to 107 FTEs in year two. The nursing staff, including aides will fill 38 FTE positions in year one, increasing to 63 FTEs in year two. Ancillary positions, including therapists will fill 12.5 FTEs in year one increasing to 23 FTE positions in year two. The applicant listed eight recruitment activities including loan forgiveness, scholarships, providing employment as nurse technicians during training, and working with local, state, and national nursing associations. The applicant listed 15 retention activities including obtaining timely feedback from new employees regarding levels of job satisfaction and utilize. The applicant focused on nursing personnel, listing the director of nursing resources/organizational development as a person who will assist in assuring the recruitment of a qualified workforce for this proposed project. The applicant cites its turnover rates for nurses at two percent, verses the state rate of 16 percent, as per FHA Nurse Staffing Supply Surveys, 1989-2002 and its nursing vacancy rate as eight percent for March 2003.

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

A comparison of the applicants' 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 applicants). In general, projections that approximate the median are the most desirable, and balance the opposing forces of feasibility and efficiency. In other words, as estimates approach the highest in the group, it is more likely that the project is feasible, because fewer economies must be realized to achieve the desired outcome. Conversely, as estimates approach the lowest in the group, it is less likely that the projects are 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 on 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 LTCH-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.

Comparative data were derived from hospitals in peer groups that reported data in 2003; the applicants will be compared to the hospitals in peer group 12. Per diem rates are projected to increase by an average of 3.5 percent per year. Inflation adjustments were based on the new CMS Market Basket, 2<sup>nd</sup> Quarter, 2004.

**BayCare Long Term Acute Care, Inc. (CON #9803):** Projected net revenue per adjusted patient day (NRAPD) of \$974 in year one and \$1,152 in year two are below the group lowest values of \$1,154 in year one and \$1,191 in year two. Values below the lowest value in the range would appear to be unreasonable. (See Comparative Table). This applicant is projecting charity care days of 4 percent. This amount is above the group average charity days of 1.1 percent. Since revenues are not collected for charity days, increasing the level of charity days beyond the group average will result in NRAPD falling at the lower end of the range. However, the level of charity days projected does not appear to be large enough to reduce NRAPD below the lowest value in the range. Therefore, NRAPD is likely understated. It should also be noted that NRAPD increased by 18.3 percent from year one to year two. This drastic increase in revenues is due to the fact that the applicant will be reimbursed at the Medicare acute care rate until it can establish its LTCH credentials (approximately six months). Once established as a LTCH, the applicant will receive the higher LTCH reimbursement rate under the Medicare program.

The estimated revenues submitted by the applicant for the project were developed based on the prospective payment system. In order to qualify for an exemption under 42 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 have no more than 25 percent of its admissions from the host hospital. If the hospital within a hospital does not meet this provision, then the hospital within a hospital will be reimbursed at the lower of the LTCH PPS or the IPPS. The applicant has indicated it will be able to comply with this provision. Failure to comply would have a material negative impact on revenues.

As discussed above, in **CON #9753**, concerns were raised with this applicant's compliance with 42 CFR section 412.22(e), which prohibits a single entity from controlling both the host hospital and the long-term care hospital within a hospital. In this application, the applicant has addressed these concerns by submitting a copy of the minutes of the board of directors of the applicant. Although the applicant has taken steps to comply with 42 CFR section 412.22(e), there still exists a common relationship between the applicant and host hospital. However, this relationship does not necessarily result in common control. If these relationships were found by CMS to result in common control of the host hospital and applicant by BayCare Health Systems, Inc., then the applicant would be prevented from being certified as a LTCH, which would make it ineligible for reimbursement under the LTCH PPS program. The applicant is projecting 66 percent of revenues will come from Medicare.

Projected cost per adjusted patient day (CAPD) of \$1,026 in year one and \$997 in year two is between the control group median and lowest values of \$1,263 and \$1,002 in year one and below the lowest value of \$1,034 in year two. (See Comparative Table). Values below the minimum typically reflect efficiencies that are not achievable by the group and therefore, are unreasonable. A further evaluation of CAPD indicates that both routine and ancillary expenses approximate the median in the group while administrative/overhead and property expense fall well below the lowest value in the group. The majority of the facilities in Group 12 are freestanding facilities while this applicant is going to be operated as a hospital within a hospital. A hospital within a hospital would be

expected to have lower overhead and property costs since it will benefit from an existing facility and economies of scale. With the routine and ancillary cost approximating the median, projected CAPD appears to be reasonable for these costs. Although, overhead and property cost are expected to be less than the control group, it also appears that these cost may have been understated considering the operating margin analysis below.

The year two operating profit for the hospital of \$2,307,335 computes to an operating margin per adjusted patient day of \$155, which falls between the peer group highest and median values of \$333 and \$128 respectively. The operating margin of 13.5 percent indicates that net revenues are not proportional to costs; however, this operating margin is slightly above the group average. As discussed above, revenues appear to be understated. With revenues being understated and the operating margin approximating the median, it is likely that costs are understated as well. With both revenue and cost slightly understated, the operating margin is not expected to be materially different.

This project appears to be financially feasible at LTCH PPS reimbursement rates. However, if the applicant does not meet the Federal eligibility rules for long-term care hospitals within hospitals, then the project is likely to resemble the year one projections, which did not include the LTCH PPS rate for the first six months. Based on the information provided, this project would not be financially feasible if the applicant does not meet the Federal eligibility rules for long-term care hospitals within hospitals.

**CON Action Numbers: 9803 & 9804**

**COMPARATIVE TABLE**

**BAY CARE LONG TERM ACCUTE CARE, INC.**

**CON # 9803**

**2003 DATA Peer Group 12**

	May 2008	YEAR 2	VALUES ADJUSTED		
	YEAR 2	ACTIVITY	FOR INFLATION		
	<u>ACTIVITY</u>	<u>PER DAY</u>	<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
ROUTINE SERVICES	22,287,218	1,497	1,214	997	714
INPATIENT AMBULATORY	0	0	15	0	0
INPATIENT SURGERY	0	0	0	0	0
INPATIENT ANCILLARY SERVICES	31,398,442	2,108	4,165	3,224	2,072
OUTPATIENT SERVICES	0	0	76	0	0
TOTAL PATIENT SERVICES REV.	53,685,660	3,605	5,388	4,155	3,161
OTHER OPERATING REVENUE	0	0	5	2	0
<b>TOTAL REVENUE</b>	<b>53,685,660</b>	<b>3,605</b>	<b>5,391</b>	<b>4,157</b>	<b>3,161</b>
DEDUCTIONS FROM REVENUE	36,533,406	2,453	0	0	0
<b>NET REVENUES</b>	<b>17,152,254</b>	<b>1,152</b>	<b>1,790</b>	<b>1,381</b>	<b>1,191</b>
<b>EXPENSES</b>					
ROUTINE	4,969,758	334	477	339	226
ANCILLARY	6,100,192	410	552	365	236
AMBULATORY	0	0	0	0	0
TOTAL PATIENT CARE COST	11,069,950	743	0	0	0
ADMIN. AND OVERHEAD	2,242,226	151	0	0	0
PROPERTY	1,532,743	103	0	0	0
TOTAL HOSPITAL EXPENSE	3,774,969	253	880	592	511
OTHER OPERATING EXPENSE	0	0	0	0	0
<b>TOTAL EXPENSES</b>	<b>14,844,919</b>	<b>997</b>	<b>1,865</b>	<b>1,303</b>	<b>1,034</b>
OPERATING INCOME	2,307,335	155	333	128	-456
		13.5%			
PATIENT DAYS	14,892				
ADJUSTED PATIENT DAYS	14,892				
TOTAL BED DAYS AVAILABLE	17,520		VALUES NOT ADJUSTED		
ADJ. FACTOR	1.0000		FOR INFLATION		
TOTAL NUMBER OF BEDS	48		<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
PERCENT OCCUPANCY	85.00%		90.7%	69.3%	30.4%
PAYER TYPE	<u>PATIENT DAYS</u>	<u>% TOTAL</u>			
SELF PAY	615	4.1%			
MEDICAID	665	4.5%	11.5%	0.0%	0.0%
MEDICAID HMO	154	1.0%			
MEDICARE	9,877	66.3%	97.0%	79.5%	65.0%
MEDICARE HMO	1,399	9.4%			
INSURANCE	0	0.0%			
HMO/PPO	1,843	12.4%	27.2%	11.0%	0.0%
OTHER	339	2.3%			
TOTAL	14,892	100%			

**University Community Hospital, Inc. (CON #9804):** Projected net revenue per adjusted patient day (NRAPD) of \$1,091 in year one is below the control group lowest value of \$1,196. Projected NRAPD of \$1,306 in year two is between the control group lowest and median values of \$1,234 and \$1,431. The lowest value is generally viewed as the practical lower limit on economies of operation. With NRAPD falling between the median and lowest values in year two, the facility is expected to consume health care resources in proportion to the services provided. (See Comparative Table). It should be noted that NRAPD increased by 19.7 percent from year one to year two. This drastic increase in revenues is due to the fact that the applicant will be reimbursed at the Medicare acute care rate until it can establish its LTCH credentials (approximately six months). Once established as a LTCH, the applicant will receive the higher LTCH reimbursement rate under the Medicare program.

Projected cost per adjusted patient day of \$1,470 in year one and \$1,268 in year two is between the control group highest and median values of \$1,873 and \$1,309 in year one and between the control group lowest and median values of \$1,071 and \$1,351 in year two. CAPD in year two is between the lowest and median values indicate projected costs are efficient when compared to the control group. (See Comparative Table). It should be noted that CAPD decreased by 13.7 percent from year one to year two. This decrease is likely due to the doubling of occupancy from year one to year two. Generally, as patient days increase, fixed cost per patient day decrease.

The year two operating profit for the hospital of \$515,623 computes to an operating margin per adjusted patient day of \$38, which falls between the peer group lowest and median values of \$-456 and \$128 respectively. The operating margin of 2.9 percent indicates that net revenues are slightly greater than costs. With such a small operating margin, the applicant will have to maintain the projected cost-efficiencies in order to remain profitable.

Based on the above, financial feasibility of this project appears likely.

**CON Action Numbers: 9803 & 9804**

**COMPARATIVE TABLE**

**UNIVERSITY COMMUNITY HOSPITAL, INC.**

**CON # 9804**

**2003 DATA Peer Group 12**

	JUNE 2009	YEAR 2	VALUES ADJUSTED		
	YEAR 2	ACTIVITY	FOR INFLATION		
	<u>ACTIVITY</u>	<u>PER DAY</u>	<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
ROUTINE SERVICES	68,502,289	5,060	1,258	1,033	740
INPATIENT AMBULATORY		0	15	0	0
INPATIENT SURGERY		0	0	0	0
INPATIENT ANCILLARY SERVICES		0	4,317	3,341	2,148
OUTPATIENT SERVICES		0	79	0	0
TOTAL PATIENT SERVICES REV.	<u>68,502,289</u>	<u>5,060</u>	<u>5,585</u>	<u>4,306</u>	<u>3,276</u>
OTHER OPERATING REVENUE		0	5	2	0
<b>TOTAL REVENUE</b>	<u><u>68,502,289</u></u>	<u><u>5,060</u></u>	<u><u>5,587</u></u>	<u><u>4,309</u></u>	<u><u>3,276</u></u>
DEDUCTIONS FROM REVENUE	50,815,019	3,754	0	0	0
<b>NET REVENUES</b>	<u><u>17,687,270</u></u>	<u><u>1,306</u></u>	<u><u>1,855</u></u>	<u><u>1,431</u></u>	<u><u>1,234</u></u>
<b>EXPENSES</b>					
ROUTINE	4,332,793	320	494	351	234
ANCILLARY	4,914,219	363	573	378	244
AMBULATORY		0	0	0	0
TOTAL PATIENT CARE COST	<u>9,247,012</u>	<u>683</u>	<u>0</u>	<u>0</u>	<u>0</u>
ADMIN. AND OVERHEAD	5,914,779	437	0	0	0
PROPERTY	2,009,856	148	0	0	0
TOTAL HOSPITAL EXPENSE	<u>7,924,635</u>	<u>585</u>	<u>912</u>	<u>614</u>	<u>529</u>
OTHER OPERATING EXPENSE		0	0	0	0
<b>TOTAL EXPENSES</b>	<u><u>17,171,647</u></u>	<u><u>1,268</u></u>	<u><u>1,933</u></u>	<u><u>1,351</u></u>	<u><u>1,071</u></u>
OPERATING INCOME	515,623	38	333	128	-456
		2.9%			
PATIENT DAYS	13,538				
ADJUSTED PATIENT DAYS	13,538				
TOTAL BED DAYS AVAILABLE	18,250		VALUES NOT ADJUSTED		
ADJ. FACTOR	1.0000		FOR INFLATION		
TOTAL NUMBER OF BEDS	50		<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
PERCENT OCCUPANCY	74.18%		90.7%	69.3%	30.4%
PAYER TYPE	<u>PATIENT DAYS</u>	<u>% TOTAL</u>			
SELF PAY	948	7.0%			
MEDICAID	271	2.0%	11.5%	0.0%	0.0%
MEDICAID HMO	0	0.0%			
MEDICARE	9,476	70.0%	97.0%	79.5%	65.0%
MEDICARE HMO	0	0.0%			
INSURANCE	406	3.0%			
HMO/PPO	2,437	18.0%	27.2%	11.0%	0.0%
OTHER	0	0.0%			
TOTAL	<u><u>13,538</u></u>	<u><u>100%</u></u>			

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

<b>District 5 LTCH Projects Project in June 2009 Dollars</b>		
	<b>*BayCare Long Term Acute</b>	<b>University Community Hospital, Inc.</b>
	<b>Care, Inc.</b>	
CON Number	9803	9804
Net Revenue per adjusted patient day	\$1,192	\$1,306
Cost per adjusted patient day	\$1,032	\$1,268
Operating profit per patient day	\$ 160	\$ 38
Estimated Managed Care level	22.8%	18.0%
Estimated Medicaid level	5.5%	2.0%

**\*Project values inflated to June 2009 dollars for comparison purposes.**

**BayCare Long Term Acute Care, Inc. (CON #9803)** projects managed care to represent 22.8 percent of its patient days, which is between the control group median and highest values of 27.2 percent and 11 percent. The projected levels, if realized, will have a positive impact on competition to promote quality assurance and cost-effectiveness.

**University Community Hospital, Inc. (CON #9804)** projects managed care to represent 18.0 percent of its patient days, which is between the control group highest and median values of 27.2 percent and 11.0 percent. The projected levels, if realized, will have a positive impact on competition to promote quality assurance and cost-effectiveness.

- f. **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 these proposals 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 application 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.

**BayCare Long Term Acute Care, Inc. (CON #9803):** This CON application is basically a resubmission of the one for **CON #9753** reviewed in June of 2004. The floor plan is almost exactly the same and a demolition plan has been added.

The applicant proposes to establish a 48-bed long-term care hospital within Mease Dunedin Hospital. The new hospital will occupy a portion of the first floor. Three facilities will delicense beds to create the new long-term care hospital. The AHCA Office of Plans and Construction will have to know the disposition of the bed space that will be vacated in those facilities.

The project area is all existing, but about 40 percent is shown to be renovated and 60 percent will be refurbished. Most of the patient rooms will be private and their toilet rooms include a shower, most of them sized for a patient in a wheelchair. There is also a shower for the five rooms without one. Quite a few patient toilet rooms are part of the renovation since the plans show them as new.

All the patient rooms are shown to have the requisite square footage, but the method of calculating the square footage does not take into account the size requirements of The Guidelines in Paragraph 7.2.A2, Page 19. The applicant needs to verify that the calculations are correct. If the windows are intended to be located in the new patient rooms, then the budget takes them into account. If they are not, the costs will be impacted.

The code list is essentially, except for the reference to Chapter 59A-5 of the Florida Administrative Code, which should read 59A-3.

The patient rooms that will be located in the former obstetric Department and nursery areas will have to meet code requirements for new construction since they were not patient rooms previously. The most important item that these rooms are lacking is the lavatory within the rooms in addition to the ones in the toilet rooms. Patient rooms that were existing are not required to have the second lavatory.

The applicant presented cost information that shows that the host hospital will be doing the renovation at no initial cost to BayCare. These costs seem reasonable, unless the addition of the lavatories increases the budget.

Whereas the previous application did not include a demolition plan, the new submission provides this information. Many toilet rooms are going to be renovated as stated above and this is an expensive proposition as always with plumbing changes. Some of the windows are going to be replaced, but the narrative does not say how many or where they will be located.

Again, no pharmacy is shown in the new hospital and must be added within the confines of the LTCH. The space for basic radiographic equipment has been so labeled. This equipment must belong to the new facility and cannot be leased from the host hospital.

It is required that schematic drawings be submitted as part of the CON application. Although the drawings for this 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 application 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.

**University Community Hospital, Inc. (CON #9804)** proposes a new 50-bed 42,000 square foot hospital in Pasco County. This application is almost an exact duplicate of the one submitted and reviewed in May of this year. The costs have risen slightly, adding several dollars to the costs per square foot. This is to be expected due to inflation and other higher costs that impact the building industry.

A 6.5-acre site for the new facility has been chosen. Again, it cannot be determined if a building on this site could meet the disaster preparedness requirements of the Florida Building Code, Section 419.4.56 regarding the flood plain elevation and the Category 3 surge inundation. If included, this information is not readily apparent in the application. It is required that the site and the new facility meet these code requirements. This will have to be addressed if the project progresses.

The application included a floor plan of the single-story building and larger scaled plans of typical patient rooms. Part of the plan has only single-line walls, which is acceptable at the schematic phase. The corridor system is not fully developed, but appears to be workable. Attention should be drawn to The Guidelines, Section 7.2.B, for all the required ancillary spaces within each patient wing. Most of them seem to have been provided, but some items such as handwashing stations are not shown on the floor plan, although they are on the large scaled patient room plans.

There are two patient wings that project from the main hospital area. Half of each wing has the typical “race track” layout with ancillary support spaces in the center and patient rooms on the exterior walls. In each wing, the nurse station might be better placed at the end the center core where the clean room and equipment storage are located. This would give the staff clear views down the corridor, particularly in smoke compartment 1. This was mentioned in the previous review and is unchanged.

The other patient wing has two smoke compartments. Smoke compartment 4 is the intensive care unit with its own nurse station. This ICU does not have the required isolation space. Additionally, each patient space must be 200 square feet and the headwall width must be at least 13 feet. These are deficiencies that can be corrected, but will increase the budget somewhat.

On the front of the facility, there is a projecting surgery suite with one operating room. The OR is not dimensioned and must be at least 400 square feet. There is a recovery/holding room that could be made into another OR in the future. This suite does not have is the required nurse station. The hospital also must have a space for emergency services to provide care for any emergency medical condition that is within the service capability of the hospital. Since the plan is schematic, some of the doors are not shown. For instance, the only door to the kitchen is through medical records, which must be a drafting error. These issues can be corrected if the CON is granted design progresses. The pharmacy seems a bit small.

The patient rooms and their toilet rooms appear to meet codes. Some 5’ turning space circles for disabled patients are indicated on the plans. The patient rooms also have the required lavatory within the room as well as the one in the toilet room.

Other than the deficiencies listed above, the overall project is straightforward and the layout is good. The ancillary spaces, in general, seem to be adequately sized and conveniently arranged for the functions that they support. For an entirely new facility, more details about the spaces would have been helpful to determine if all the required spaces are provided and their relations to each other. One 16” floor plan and 1/4” patient room plans are not quite enough to thoroughly evaluate the physical plant for a new facility, but this is all that is required for a CON application.

**CON Action Numbers: 9803 & 9804**

There are multiple lists of applicable codes on the drawings that are all somewhat incorrect. The information from Schedule 10 indicates that sufficient time has been allowed for construction and the budget is probably sufficient with the possible qualifications listed above.

- g. 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 2003 Hospital financial Data Report, LTCHs in the state averaged 1.24 percent Medicaid patient days and 0.94 percent charity care patient days as shown in the chart below.

<b>LTCH Provision of Care to the Medically Indigent Calendar Year (CY) 2003</b>			
<b>Hospital</b>	<b>District</b>	<b>Medicaid %</b>	<b>Charity %</b>
Kindred North FL	4	0.0%	0.5%
Kindred St. Petersburg	5	11.5%	1.8%
Kindred Central Tampa	6	0.0%	1.0%
Kindred Bay Area Tampa	6	0.3%	1.8%
Kindred Hollywood	10	0.1%	0.8%
Kindred Ft. Lauderdale	10	0.4%	0.0%
Kindred Coral Gables	11	0.0%	2.5%
Specialty Hosp. Jacksonville	4	0.0%	0.0%
Select Specialty Hosp. Miami	11	0.0%	1.0%
Select Specialty Hosp. Orlando	7	0.0%	0.0%
<b>Average State CY 2003</b>		<b>1.24%</b>	<b>.94%</b>

**Source: ACHA Financial Data CY 2003**

**NOTE: Facilities above represent all of the LTCH reporting financial data for CY 2003.**

Below is a table comparing the projected percentage of charity care and Medicaid patient days to the charity care and Medicaid days provided by the Kindred-St. Petersburg facility in CY 2003.

<b>Comparison of Percentage of Medicaid and Charity Patient Days to Kindred-St. Petersburg</b>		
	<b>Medicaid %</b>	<b>Charity Care %</b>
BayCare Long Term Acute Care*	4.0 %	3.09 %
University Community Hospital, Inc.*	2%	1.25 %
Kindred St. Petersburg**	11.5 %	1.8 %

**Source: Projected Financial Schedule 7 information from CON #9803 and 9804 Applications.\*\*AHCA Financial Data CY 2003.**

As shown in the table above, BayCare and University project 1.29 percent and 0.45 percent more charity care patient days on their applications than the Kindred-St. Petersburg provided in CY 2003. However, Kindred St. Petersburg provided 7.5 percent and 9.5 percent more patient days to Medicaid than BayCare or University are projecting respectively.

**BayCare Long Term Acute Care, Inc. (CON #9803)** is a newly formed not-for-profit corporation with no operating history.

The applicant is proposing to condition the proposed project on the provision of six percent Medicaid/Medicaid HMO/charity/self-pay patients. Schedule 7B indicates that the applicant expects to deliver up to four percent of its total patient days to Medicaid, exceeding the state average of 1.24 percent by 2.76 percent. The applicant projects 3.09 percent of total patient days to charity care, exceeding the state average of 0.94 percent by 2.15 percent.

**University Community Hospital, Inc. (CON #9804)** provided 5.3 percent of its total patient days to Medicaid patients for CY 2003, according to AHCA data. According to the applicant, it provided 7.2 percent of its patient days to Medicaid patients for its fiscal year ending September 2003.

The applicant is proposing to condition the proposed project on the provision of 2.0 percent Medicaid and 2.4 percent charity/self-pay/other. Schedule 7 indicates that the applicant intends to provide 2.0 percent of total patient days to Medicaid, exceeding the state average of 1.24 percent by 0.76 percent. The applicant projects 1.25 percent of its total patient days to charity care, exceeding the state average of 0.94 percent by 0.31 percent.

## **F. SUMMARY**

**BayCare Long Term Acute Care, Inc. (CON #9803)** is a newly formed not-for-profit corporation that proposes the establishment of a 48-bed LTCH within Mease Dunedin in District 5, Pinellas County.

Renovation and construction costs of \$2,045,471 will be assumed by the host hospital. The applicant's total project cost is estimated at \$363,220. Total cost for the host hospital is estimated at \$3,074,691. The project will involve 24,925 gross square feet (GSF) of new construction at the host hospital.

The applicant agrees to condition this certificate of need on the provision of six percent of total patient days to Medicaid/Medicaid HMO/self-pay/underinsured patients. Two BayCare-affiliated hospitals have agreed to delicense 10 beds each, and an additional one agreed to delicense 15 beds in order to accommodate this project.

**University Community Hospital, Inc. (CON #9804)** proposes to establish a freestanding 50-bed long-term care hospital in District 5, Pasco County.

The total project cost is estimated at \$17,239,141. Construction costs are projected at \$9,325,331 and the project will involve 42,000 gross square feet (GSF) of new construction.

The applicant is requesting that the project be conditioned for the provision of two percent of its total patient day to Medicaid and 2.4 percent of its total patients days to charity/self-pay/other.

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

**Need**

*Need in not published by the agency for long-term care hospital beds. It is the applicant's responsibility to demonstrate need.*

**BayCare Long Term Acute Care, Inc. (CON #9803)** contends that area LTCH providers have denied certain patients in Pinellas and Pasco Counties access to LTCH care, however, the applicant did not demonstrate that access was denied. There are two licensed LTCHs with an average occupancy rate, for the 12-month period ending June 2003, below 70 percent located in District 6 (Hillsborough County) and one licensed LTCH located in District 5 (Pinellas County) with a utilization rate of 77.65 percent. Travel distances to existing LTCHs, skilled nursing facilities, comprehensive medical rehabilitation facilities, or any appropriate provider of post-acute care were not demonstrated to be unreasonable. Need for a 48-bed LTCH was not shown.

**University Community Hospital, Inc. (CON #9804)** contends that the residents of Pasco County do not have access to LTCH services, as there is no LTCH located in Pasco County. However, the applicant did not demonstrate that Pasco County residents are being denied access to existing post-acute care services, including LTCH services at any of the three LTCH hospitals located in Districts 5 and 6. There is one LTCH with an average occupancy rate, for the 12-month period ending December 2003, located in District 5 (Pinellas County) of 77.65 and an average of below 70 percent for the two LTCHs located in adjacent Hillsborough County. Travel distances to the existing LTCHs, skilled nursing facilities, comprehensive medical rehabilitation facilities, or any appropriate provider of post-acute care were not demonstrated to be unreasonable.

**Quality of Care:**

**BayCare Long Term Acute Care, Inc. (CON #9803)** is a new development stage corporation with no significant operating experience. The host hospital, Mease Dunedin is JCHAO accredited, licensed by AHCA and certified to participate in Medicaid and Medicare programs. AHCA data reveal that in the past three years BayCare affiliated hospitals had a combined listing of 22 confirmed complaints with deficiencies, Mease Dunedin Hospital accounted for three of those complaints with deficiencies.

**University Community Hospital, Inc. (CON #9804)** states that it has a history of providing quality care as evidenced by its being licensed by AHCA, accredited by JCAHO and certified by a variety of other professional organizations and its being a full participant in the Medicaid and Medicaid programs. It is a Class I general acute care hospital that provides tertiary services. AHCA data reveals that in the past three years the applicant had 20 confirmed complaints while its affiliate had five confirmed complaints.

**Medicaid/Indigent Care:**

**BayCare Long Term Acute Care, Inc. (CON #9803)** agrees to condition this certificate of need on the provision of six percent of total patient days to Medicaid/Medicaid HMO/self-pay/underinsured patients.

**University Community Hospital, Inc. (CON #9804)** is requesting that the project be conditioned for the provision of two percent of its total patient day to Medicaid and 2.4 percent of its total patients days to charity/self-pay/other.

**Financial/Cost:**

**BayCare Long Term Acute Care, Inc. (CON #9803)** is a newly formed corporation that proposes to establish a LTCH in District 6, Hillsborough County. Its sponsor and parent, BayCare Health System Inc. appears to be financially capable of financing his project. Funding for the proposed project is coming from the sponsor and host hospital (Mease Dunedin). Both the sponsor and the host hospital submitted letters committing to fund the applicant until the applicant can become self-sustaining. Due to the financial resources of the sponsor and host hospital, funding for this project is likely to be available as needed.

The applicant projects managed care to represent 22.8 percent of its patient days, which approaches the control group median and highest value of 27.2 percent and 11 percent. The project levels, if realized, will have a positive impact on competition to promote quality assurance and cost-effectiveness.

**University Community Hospital, Inc. (CON #9804)** is a not-for-profit corporation that proposes to establish a 50-bed freestanding LTCH in District 5, Pasco County. The applicant indicates funding for these projects will come from operations and debt financing. In addition, the applicant provided a letter from Merrill Lynch stating that the applicant would be able to obtain cost-effective financing for the project. Funding should be available for this project as needed.

The applicant projects managed care to represent 18.0 percent of its patient days, which is between the control group highest and median values of 27.2 percent and 11.0 percent. Therefore, the projected levels, if realized, will have a positive impact on competition to promote quality assurance and cost-effectiveness.

**Architectural:**

**BayCare Long Term Acute Care, Inc. (CON #9803):** There were several notable architectural concerns including:

- No pharmacy was included in the new hospital and must be added.
- There are several spaces that are labeled for radiographic equipment as required. This equipment must belong to the new facility and cannot be leased from the host hospital.

Cost renovation information shows that the host hospital will be doing the renovation at no cost to BayCare. These costs seem reasonable, unless the addition of the lavatories increases the budget.

**University Community Hospital, Inc. (CON #9804):** It could not be determined if a building on this site could meet the disaster preparedness requirements regarding flood plain elevation and surge inundation. However, other than the deficiencies listed earlier, the overall project is straightforward and the layout is good.

There are multiple lists of applicable codes on the drawings that are all somewhat incorrect. The information from Schedule 10 indicates that sufficient time has been allowed for construction and the budget is probably sufficient with the possible qualifications listed earlier.

**G. RECOMMENDATION**

Deny CON #9803 and CON #9804.

**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**