

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Kindred Hospital East, L.L.C. (CON #9831)
680 South Fourth Street
Louisville, Kentucky 40202

Authorized Representative: Bud Wurdock
(502) 596-7718

2. Service District

District 4

B. PUBLIC HEARING

A public hearing was not held or requested with regard to the establishment of the proposed long-term care hospital in District 4. However, letters of support were submitted as follows:

Kindred Hospitals East, L.L.C. (CON #9831) submitted 22 letters of support with its application. In addition, the agency received seven letters of support, five of which were duplicative, for a total of 24 unduplicated letters of letters of support. The 24 letters submitted consisted of: 15 letters from physicians, one letter each from the CEOs of Halifax Community Health System, Florida Hospital-Deland, and the executive director of Volusia Health Network, one letter each from Senators Carey L. Baker (District 20) and Evelyn J. Lynn (District 7), State Representatives; Joyce Cusack (District 27), Pat Patterson (District 26), Joe E. Pickens (District 21), and one letter from Frank T. Bruno, Jr., Volusia County Council Chair. The majority of physicians state that they have seen many long-stay patients that would have benefited from care provided at a long-term care facility if one were available in the Daytona

area. One physician stated that in the past year he had 12 patients in this category. Another physician identified 10 patients in his practice in this category, but did not specify a time frame. The remaining letters from physicians were not specific as to the number of patients involved nor did they specify a time period.

The majority of letters from elected officials state that the process for arranging continued care for medically complex patients who need a wide variety of health services is difficult. They state that these patients in Volusia County do not go to other existing long-term care facilities because of the distance, reluctance to change physicians or medical instability that makes transport difficult. However, no specific data or examples were offered.

Mr. Bud Wurdock, Director of Market Planning for Kindred Healthcare and Authorized Representative for the Kindred North Florida, provided a letter of opposition dated April 12, 2004 to a 2004 proposal by Select Specialty Hospital-Duval, Inc. (CON #9752) to establish a 40-bed long-term care hospital (LTCH) in Duval County also in District 4. The letter states that “approval of an application for an additional long term care hospital in District 4 will have a significantly adverse impact on the future of Kindred Hospital North Florida and will result in a wasteful duplication of services in District 4”. The letter goes on to state “the occupancies of existing providers in the district clearly indicate there is not a need for an additional long term care hospital in District 4”. Kindred also states that “clearly the addition of up to 40 long term hospital beds would have a serious negative effect on the utilization and financial stability of Kindred Hospital North Florida”.

Kindred also filed a letter of opposition to SemperCare of Volusia, Inc.’s CON #9706 to establish a 43-bed LTCH in Volusia County. This letter was dated October 31, and received on November 10, 2003, late after the batch review omissions deadline and therefore was not considered at that time. However, this letter contains the first two quotes in the paragraph above and specifically states “reducing patient admissions from Volusia County would threaten the financial stability of Kindred Hospital North Florida”.

During calendar year 2004, Kindred North Florida discharged 54 Volusia County residents of its total 441 discharges or 12.25 percent of its total (the facility's second highest county of patient origin). Volusia County had a total of 85 long-term care facility discharges, with Kindred North Florida providing the most with 54, Select Specialty Hospital - Orlando 21 and Specialty Hospital Jacksonville five. No other facility had more four discharges.

In reference to the above data it is interesting to note just what Kindred Hospital North Florida documents has changed since their April 12, 2004 and October 31, 2003 letters. However, the applicant does not appear to acknowledge that there are any differences. At the time of Select Specialty Hospital-Duval, Inc. (CON #9752) and SemperCare of Volusia, Inc.'s proposals to establish a 40-bed long-term care hospital (LTCH) in Duval County and 43-bed LTCH in Volusia, the district's two LTCHs utilization was approximately one percentage point lower. At the time of the April 12 letter there were 20 additional beds approved. However, the applicant now contends there is a need for a 60-bed hospital in the district. It appears that essentially the same circumstances that existed in the 2004 and 2003 letters are still operative today, and Kindred proposes 60 beds, 20 more than CON #9752; 17 more than CON #9706, which they so vehemently opposed.

C. PROJECT SUMMARY

Kindred Hospitals East, L.L.C. (CON #9831) proposes to construct a freestanding 60-bed LTCH to be located in Volusia County. Kindred Hospitals East is currently the licensee and operator of 22 LTCHs across the United States and its parent company, Kindred HealthCare, Inc., operates 73 health care facilities nationwide. Kindred also owns seven of the 12 licensed LTCHs in Florida and is approved to add 20 beds to Kindred Hospital-North Florida (District 4, Clay County) and develop a 31-bed LTCH in District 3. The applicant has concurrently submitted an application to establish a LTCH in District 7 in Brevard County.

The proposed project involves 74,326 gross square feet (GSF) of new construction, comprised of an eight-bed intensive care unit and 52 private rooms, including three isolation rooms. The total construction cost is estimated to be \$12,641,565 with total project costs of \$20,884,061.

As a condition of approval, the applicant agrees to a combined provision of 2.2 percent of its total patient days to Medicaid and charity care patients beginning with the second year of operation.

D. REVIEW PROCEDURE

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

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

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

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

E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA

The following indicate the level of conformity of the proposed project with the criteria and application content requirements found in Florida Statutes, Sections 408.035, and 408.037 and applicable rules of the State of Florida, Chapter 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, Florida Administrative Code.

Need is not published by the Agency for long-term 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.

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. Kindred proposes to provide 78.6 percent of its services to Medicare and Medicare HMO patients in its second year of operation.

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 tracheotomy 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 that 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 a March 29, 2005, letter to the Centers for Medicare and Medicaid Services (CMS) encouraging reimbursement changes for LTCHs based on MedPac's 2003 and 2004 reports to Congress, Glenn M. Hackbarth, MedPac's chairman made six comments on the then proposed, now effective rule entitled *Medicare Program; Prospective Payment System for Long-Term Hospitals; Proposed Annual Payment Rate Updates. Policy Changes, and clarification; Proposed Rule 70 Fed. Reg 5724* (February 3, 2005). First among them was a note about the rapid growth of LTCHs and the consequent rapid growth in Medicare spending. LTCHs more than tripled from 1993 to 2004 with Medicare spending for care increased almost eight-fold from \$398 million in 1993 to an estimated \$3 billion for rate year 2006.

Mr. Hackbarth highlighted five other comments from MedPac reports including:

- Uneven geographic distributions which suggests that Medicare patients are served in alternative settings such as acute care hospitals and skilled nursing facilities.
- Patients treated in LTHCs cost Medicare more on average, but the difference is not statistically significant if focused on patients that are medically complex with a good chance of improvement.
- Need for further study particularly in the following areas, which Mr. Hackbarth indicates CMS is in agreement with:
 - Comparison of LTCH patients and outlier patients in acute care hospitals;
 - Examination of LTCH patients and diagnoses typically seen in inpatient rehabilitation facilities;
 - Medical record reviews to monitor changes in service use over time;
 - Evaluation of long-term LTCH patients to determine whether they should be treated in skilled nursing facilities; and
 - Examination of LTCHs' patients to determine whether they are being retained in LTCHs beyond their need for LTCH-level care.

The two other comments dealt with LTCH hospitals within hospitals and suggestions for perspective payment reimbursements.

In consideration of these comments and 2003 and 2004 MedPac reports, CMS announced that, although unable to make changes with the final rule appearing in the May 6, 2005, Federal Register, it plans to revise the relative weights for DRGs to LTCHs this fall with other updates planned for October 1, 2005.

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.

At present there are 12 long-term care hospitals (LTCHs) with 805 beds licensed to operate in the State of Florida. There are an additional 290 beds approved, but not yet licensed, LTCH beds.

The following table illustrates the distribution of approved, but not yet licensed LTCH beds in Florida.

Florida Approved-Not Yet Licensed Long Term Care Hospital Beds		
Hospital	District	Beds
SemperCare Hospital of Tallahassee	2	29
Kindred Hospitals East-LLC	3	31
Kindred Hospital-North Florida	4	20
Select Specialty Hospital-Orange	7	40
HealthSouth LTAC of Sarasota, Inc.	8	40
Kindred Hospitals East -LLC	9	70
Select Specialty Hospital – Palm Beach	9	60
Total		290

Source: *Florida Hospital Bed Need Projections by District, Volume I*, published 01/28/05.

As shown in the table above, there are 290 approved, but not yet licensed LTCH beds distributed throughout Florida in Districts 2, 3, 4, 7, 8 and 9.

The applicant states that it intends to locate this LTCH in Volusia County to more effectively meet the needs of the residents in District 4. However as discussed below, the applicant did not demonstrate that patients needing LTCH services were unable to obtain them.

The average occupancy of the operational programs reporting utilization was 66.34 percent for the period July 2003-June 2004. LTCH programs in operation for the total 12-month reporting period ranged in occupancy from a low occupancy rate of 55.63 percent for Specialty Hospital Jacksonville to a high of 90.24 percent for Kindred Hospital-North Florida, a hospital approved for an additional 20 beds.

The following table shows the beds, patient days and occupancy of Florida's operational LTCHs for the July 2003 through June 2004 reporting period:

Florida Long-Term Care Hospitals Utilization Experience July 2003-June 2004					
Hospital	Dist.	# Beds	Bed Days	Patient Days	Occupancy
SemperCare Hospital of Panama City*	2	30	5,340	999	18.71%
Kindred Hospital-North Florida	4	60	21,960	19,817	90.24%
Specialty Hospital Jacksonville	4	107	39,162	21,786	55.63%
Kindred Hospital-Bay Area-St. Petersburg	5	82	30,012	21,104	70.32%
Kindred Hospital-Central Tampa	6	102	37,332	25,306	67.79%
Kindred Hospital-Bay Area-Tampa	6	73	26,718	17,071	63.89%
Select Specialty Hospital-Orlando, Inc.	7	35	12,320	6,995	56.45%
Kindred Hospital-South Florida-Hollywood	10	124	45,384	29,111	64.14%
Kindred Hospital-South Florida-Ft. Lauderdale**	10	70	23,880	16,840	70.52%
Kindred Hospital-Coral Gables	11	53	19,398	16,449	84.80%
Select Specialty-Miami	11	40	14,640	10,101	69.00%
Sister Emanuel Hospital for Continuing Care***	11	29	10,179	4,411	43.33%
Florida Total		805	286,325	189,950	66.34%

Source: *Florida Hospital Bed Need and Service Utilization by District, Volume II*, published 01/28/05.

*SemperCare Hospital of Panama City was issued a license on 1/5/04 with two quarters of operation shown. **Kindred-Fort Lauderdale was initially licensed for 64 beds and on 4/16/04 was licensed for 6

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additional beds per CON #9621. ***Sister Emanuel Hospital for Continuing Care was issued a license on 7/15/03 with two quarters of operation shown.

As shown above, there was a 66.34 percent average occupancy rate for the LTCHs in the State of Florida for the 12-month period ending June 2004.

The following table illustrates the bed compliment in District 4 and the occupancy rates for the 12-month period ending June 2004.

District 4 Acute Care and Postacute Care Providers Bed Count & Utilization July 2003-June 2004		
Facility Type	Total Beds	Average Occupancy
Long-Term Care Hospital	167	68.07%
Acute Care	4,207	64.29%
Comprehensive Medical Rehabilitation	183	83.83%
Hospital Based Skilled Nursing	54	74.49%
Community Nursing Homes	9,241	92.27%

Sources: *Florida Hospital Bed Need Projections by District, Volume II, published 1/28/05 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 July 2003-June 2004, published 10/08/05.*

The following table illustrates the population estimates for the next five years for District 4 and the state.

Population Estimates for District 4 Counties and Percent Change by County For Total Population, 65 and over, and 75 and Over Population					
County	Total July 2005	Total July 2010	Percent Change	65+ Percent Change	75+ Percent Change
Baker	24,083	25,892	7.51%	17.75%	20.76%
Clay	165,877	186,941	12.70%	29.59%	24.49%
Duval	854,145	913,436	6.94%	12.55%	5.37%
Flagler	68,345	83,037	21.50%	29.72%	29.41%
Nassau	66,923	75,212	12.39%	20.85%	21.54%
St. Johns	151,136	175,299	15.99%	27.13%	21.04%
Volusia	489,445	529,157	8.11%	11.33%	5.18%
Total District 4	1,819,954	1,988,974	9.29%	16.20%	10.18%
State of Florida	17,844	19,478,414	9.16%	14.21%	8.73%

Source: *AHCA Population Estimates, published March 2005.*

As shown above, the overall population in District 4 is expected to increase by 9.29 percent during the next five years, with the 65 and over and 75 and over age cohort increasing by 16.20 percent and 10.18 percent, respectively. Duval County is the most populous county in the district and by the year 2010 is projected to have 46 percent of the total population, 32 percent of both the 65 and over population and 75 and over population in the district. Volusia County is the second most populous county in the district and by the year 2010 is projected to have 26.6 percent of the total population, 37.46 percent of the 65 and over population and 39.05 percent of the 75 and over population in the district. The applicant contends that as a result of the increase in the

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senior population in Volusia County, the financial and capacity burdens on short-term hospitals from long-term patients will continue to increase creating an unmet need unless a LTCH is made available in the county. However, the applicant did not demonstrate that those residents living in Volusia County did not have access to LTCH services. Additionally, as noted earlier, when another LTCH proposed to establish a hospital in this area for essentially the same reasons, the applicant stated opposition, indicating that its Clay County facility would be adversely impacted and that the establishment of a third LTCH in District 4 would be a duplication of services.

The applicant also contends that the travel distance for the residents of Volusia County to travel to any existing long-term care facility is a burden. Below is a table illustrating the travel distances from the proposed Kindred facility in Volusia County (Daytona Beach) and the CON approved Kindred Hospitals East, L.L.C. in Marion County (Ocala) to the existing LTCH facilities in the state.

Mileage Chart-Florida LTCH Facilities

	SemperCare Hospital of Panama City	Kindred Hospital-North Florida	Specialty Hospital Jacksonville	Kindred Hospital-BayArea-St. Petersburg	Kindred Hospital-Central Tampa	Kindred Hospital-Bay Area-Tampa	SemperCare Hospital of Orlando	Kindred Hospital-South Florida-Hollywood	Kindred Hospital South Florida-Ft. Lauderdale	Kindred Hospital-Coral Gables	Select Specialty-Miami	Sister Emanuel Hosp. for Cont. Care	CON Approved Kindred Marion/Ocala (MRMC)	Proposed Kindred Volusia/Daytona Beach
SemperCare Hospital of Panama City	301	286	417	392	405	378	584	577	605	601	603	302	373	
Kindred Hospital-North Florida	301	32.3	234	213	216	124	316	309	337	332	335	84.5	77.3	
Specialty Hospital Jacksonville	286	32.3	243	222	225	133	325	318	346	341	344	107	86.5	
Kindred Hospital-Bay Area-St. Petersburg	417	234	243	26.7	19	111	250	249	262	264	266	120	158	
Kindred Hospital-Central Tampa	392	213	222	26.7	9.1	93	258	251	284	274	276	94.9	137	
Kindred Hospital-Bay Area-Tampa	405	216	225	18.7	9.1	93	256	249	263	285	288	103	140	
Select Specialty-Orlando	378	124	133	111	89.8	93	223	216	244	239	241	81.3	48	
Kindred Hospital-South Florida-Hollywood	584	316	325	250	258	223	12	24.3	19.5	21.8	387.0	241		
Kindred Hospital-South Florida-Ft. Lauderdale	577	309	318	249	251	249	216	12	33	28.2	30.5	281.0	234	
Kindred Hospital-Coral Gables	605	337	346	262	284	263	244	24.3	33	5	5.7	309	262	
Select Specialty-Miami	601	332	341	264	274	285	239	19.5	28.2	5	3.3	304	257	
Sister Emanuel Hosp. for Cont. Care	603	335	344	266	276	288	241	21.8	30.5	5.7	3.3	306.0	260	
CON Approved Kindred Marion/Ocala (MRMC)	302	84.5	107	120	94.9	103	81.3	287	281.0	309	304	306	83.7	
Proposed Kindred Volusia/Daytona Beach	373	773	86.5	158	137	140	48	241	234	262	257	260	83.7	

Data Source: www.expediamap.com. The intersection of I-4 and I-95 were used as the estimated location of the applicant's proposed facility site in Daytona Beach.

As shown in the table above, it is approximately 77.3 miles from the proposed site in Volusia County (Daytona Beach) to the Kindred Hospital-North Florida facility in Clay County (Green Cove Springs) and 86.5 miles from Daytona Beach to Jacksonville (locations of the two LTCHs in District 4). However, it is approximately six and a half miles further from the proposed site in Volusia County to the CON approved Kindred facility in Marion County (Ocala) for a distance of 83.7 miles. The chart also shows that it is 48 miles from Select Specialty Hospital Orlando, a 35-bed LTCH that had the second highest total of Volusia residents at 21 of the 85 total per AHCA hospital discharge data for CY 2004. Also, it is approximately 55 miles to the CON approved Select Specialty Hospital – Orange facility¹ that is yet to be licensed. The applicant states that physicians are often not willing to travel a great distance to see patients transferred to a LTCH and that as a result families are reluctant to transferred to a LTCH under the care of another physician and cites letters of support that discuss these issues. Of the 15 letters submitted by physicians, two identified a specific number of patients that did not go to receive LTCH services due to their reluctance to travel because of the distance. However, none of the letters state that physicians are unwilling to see patients transferred to LTCHs. In addition, the letters do not indicate how many patients were actually appropriate for the services offered by Kindred or the subsequent disposition of these patients within or outside the district.

It is noted that on a site visit to a Kindred facility in North Florida, agency staff were advised that physicians often don't follow patients to this facility and that the Kindred North Florida facility has its own physician staff. If LTCH need were based on physician willingness to travel, there would be need for several LTCHs in large cities as physicians may not want to drive across town to make patient visits. Further, as indicated above, the applicant has previously opposed the establishment of a LTCH in this area because of what it characterized as adverse impact to its Clay County facility. The applicant did not demonstrate that the district's circumstances have changed since their opposition letters of April 12, 2004 and October 31, 2003 for proposed LTCHs.

¹ Source: AHCA stipulation agreement for the modification of CON #9654 dated 4/15/05. Distance from I-4 & I-95 to proposed location is based on www.exepediamap.com.

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The applicant contends that residents of Volusia County do not have access to LTCH services in District 4. It states that, as demonstrated by the occupancy rates of the facilities, long-term care patients are rapidly utilizing available long-term care services. Below is a table illustrating the rates for the LTCH facilities in District 4 and a table illustrating the population growth for Clay and Duval Counties for the last five years.

District 4 Florida Long Term Care Hospitals Utilization Experience July 1999-June 2004							
Hospital	Dist.	County	July 99- June 00	July 00- June 01	July 01- June 02	July 02- June 03	July 03- June 04
Kindred Hospital-N. Florida	4	Clay	86.07%	88.39%	89.15%	90.63%	90.24%
Specialty Hosp. Jacksonville	4	Duval	53.29%	53.23%	55.01%	53.02%	55.63%
District 4	4		65.07%	65.86%	67.28%	66.54%	68.07%
Florida Total	State		76.80%	74.84%	77.18%	73.50%	66.34%

Source: Florida Hospital Bed Need and Service Utilization by District, Volume II, published 01/28/05, 01/23/04, 01/24/03, 01/25/02, 01/26/01. Note that July 01 –June 02 and July 02 – June 03 are corrected numbers as the published books had bed days set for the 1st and 2^d quarters of those years at 92 days with in fact 1st quarter of 2002 and 2003 were of 90 days and 2^d quarters were 91 days.

As shown above, the occupancy rate for Specialty Hospital Jacksonville has remained between 53 and 56 percent, while the occupancy rate for Kindred Hospital-North Florida has increased at a rate of 4.17 percent over the past five years. However, the facility’s patient days peaked at 19,848 for the July 2002 – June 2003 reporting period, decreasing to 19,817 during the July 2003 – June 2004 reporting period. During the July 1999 – June 2000 reporting period, Kindred North Florida provided 18,901 inpatient days, which has risen to 19,817 or only by 947 patient days as of the last reporting period. This does not illustrate that there has been rapid growth or demand for services at the applicant’s Clay County facility. Given population increases in the district of 14.06 percent from July 2000 through July 2004, Kindred Hospital North Florida has experienced slight growth at 4.17 percent and that Specialty Hospital Jacksonville experienced little growth. As mentioned earlier, the applicant states that it intends to add 20 beds to its Kindred Hospital-North Florida facility. The applicant has been approved for this but the addition of beds to an existing LTCH hospital no longer requires CON review. The bed addition will increase availability of LTCH beds in the district.

Though the applicant maintains that many patients appropriate for a LTCH setting are being served in other settings such as ICU units at acute care hospitals and comprehensive medical rehabilitation settings, it did not demonstrate how many of those patients, if any, exist in District 4. The applicant provided a chart comparing LTCHs, rehabilitation facilities and skilled nursing facilities. According to the chart, only LTCHs will treat patients who need respiratory therapy and telemetry pressors and dialysis, skilled nursing facilities and rehabilitation hospitals do not. That is not always true in every facility.

Respiratory therapy, for example, can be and at times has been provided in both rehabilitation hospitals and skilled nursing facilities. The applicant did not provide evidence that these services were unavailable at rehabilitation and skilled nursing facilities in District 4.

The applicant states the average case mix for the acute care hospitals in District 4 is 1.51 as compared to Kindred's facilities in Florida, which reported a case mix of 2.42 for 2003. AHCA data reveals a case mix of 1.29 for acute care facilities in District 4 and 2.22 for Kindred Hospitals for CY 2003 in Florida. (Note: the case mix index is a measure developed in conjunction with Medicare's prospective payment system (PPS) as a means of adjusting payments to hospitals based on case complexity). According to the applicant, this demonstrates that the LTCHs operated by Kindred in Florida care for a significantly sicker patient (on average) than acute care hospitals. The applicant anticipates this will occur at the proposed Daytona Beach facility. It is noted that acute care hospital case mix index includes mothers who are giving birth, for example. A specific example in District 4: During calendar year (CY) 2003, Bert Fish Medical Center had a case mix index excluding newborns of 1.267. There were 27 patients admitted that were younger than age one. Bert Fish does not have a Level II neonatal intensive care unit, so it is reasonable to assume that approximately 27 mothers were admitted who gave birth. This is one example of the type of patient that will affect the case mix index of an acute care hospital. Although these 27 patients account for a small percentage of Bert Fish's admissions that year, it does help to illustrate why comparing the case mix index of acute care hospitals to LTCHs does not have much meaning. The admission criteria for post-acute care settings varies and, as discussed earlier, MedPAC findings suggest that when LTCH care is targeted to patients with medically complex problems of the highest severity, the costs are comparable.

The applicant offers a discharged-based determination of bed-need that involves six steps. The first step is to identify (and omit) diagnosis of patients who are not appropriate for admission to a LTCH including all Diagnosis Related Groups (DRGs) in the Major Diagnostic Categories (MDC) of: 13-female reproductive system, 14-pregnancy, 15-newborns and other neonates, 19-mental disease and disorders, 20-alcohol and substance abuse, 22-burns, 23-factors influencing health factors, DRGs specific to patients less than 18 years of age and DRGs for transplant patients. The applicant provides a list of the remaining 387 acute care DRGs that represent potential LTCH patients.

The applicant then identifies the discharged patients who are inappropriate to LTCH including those who: (1) are assigned to one of the 387 LTCH referral DRGs, (2) are age 18 or older; and (3) have a length of

stay exceeding a threshold number of days (as defined in terms of the national geometric mean length of stay (Geomean) calculated by CMS for each DRG). The applicant maintains that the discharged patients are appropriate for LTCH service if they are discharged from an acute care hospital in Volusia County, are 18 years of age or older, are assigned to one of the 387 referral DRGs and have a length of stay that exceeds the Geomean of 15 days. The applicant's proposed methodology based on length of stay, does not document these patients were not appropriate for acute care or other long-term care facilities. As cited earlier, the MedPac study indicates LTCHs accept patients who could appropriately have stayed in acute care or gone to another type of long-term care facility for the same care at a lower cost. The applicant's proposed methodology does not document these patients were not appropriate for acute care or other long-term care facilities.

The applicant assumes that referrals to the proposed Daytona Beach Kindred LTCH will occur five days after a patient has passed their DRG-specific geometric mean length of stay. The applicant estimates that there are approximately 14,900 potential long-term hospital days from the five acute care hospitals in the area, for an average daily census of 40.8 ($ADC=14,900/365=40.82$). The applicant then removed the 53 patients who live in Volusia County but sought care in Clay County at Kindred Hospital-North Florida, accounting for 2,362 days for the 12 months ending March 2004 ($ADC=2,362/365=6.47$). The applicant added the resulting ADC of 6.4 to the ADC of 40.8 for a potential ADC result of 47.2.

CY 2004 AHCA hospital discharge data shows that Kindred Hospital North Florida was the leading provider of LTCH care to Volusia County residents with 54 of the 85 Volusia County resident discharges. However, the applicant's projections do not account for Volusia County patients that sought care at other long-term care facilities or the proposed location of newly approved LTCHs. Select Specialty Hospital Orlando was the second highest provider of LTCH services to Volusia residents with 21 of the 85 total for CY 2004. In addition, the newly approved Select Specialty Hospital Orange proposed to be located at 5579 S. Orange Avenue in Edgewood Florida is within a reasonable proximity.

As stated above, the applicant indicates that there are five acute care hospitals that it expects to generate its referrals. Below is a table illustrating the travel distances from the five Volusia County acute care hospitals to the applicant's existing facility, Select Specialty Orlando (the second leading LTCH provider for Volusia), the approved location for Select Specialty Orange, and CON approved Kindred Hospitals East, L.L.C. in Marion County (Ocala).

Long Term Care Hospital Mileage from Volusia County Acute Care Hospitals				
	Select Specialty Orlando	Select Specialty Orange	Kindred Marion	Kindred North Florida
Florida Hospital Fish Memorial	26.7	33.7	71.0	99.0
Florida Hospital DeLand	38.2	45.3	60.5	85.5
Halifax Medical Center	51.8	58.7	73.9	75.6
Bert Fish Medical Center	53.3	60.4	90.4	92.1
Florida Hospital Ormond Beach	57.8	64.8	70.2	68.7

Source: www.expedia.com.

The applicant does not demonstrate that the existing 35-bed LTCH in Orlando has not or would not offer LTCH services/or has denied LTCH services to those patients needing them who live in Volusia County. The 35-bed LTCH is attached to Florida Hospital's main campus. Additionally, there is a 40-bed CON approved, but not yet established District 7 LTCH, Select Specialty Hospital – Orange. That facility is proposed to be located at 5579 S. Orange Avenue in Edgewood, Florida. Therefore, the existing Select Specialty Orlando and proposed facility location for Select Specialty Orange should greatly decrease the travel time for Volusia County patients, as does the applicant's approved Kindred Marion project, albeit to a lesser extent.

With changes in Medicare reimbursement, it is reasonable to assume that all of the above LTCHs, particularly the CON approved not yet licensed freestanding LTCH, will serve larger areas than the one discussed in CON applications. With recent changes to CON law, existing LTCHs can add beds without CON review and the freestanding facility should be able to do so if needed.

The applicant applied the projected growth rate of 8.2 percent for Volusia County for the next five years yielding a potential ADC of 51.1 by 2010 (47.2 + 3.9). The applicant's final step is to apply an 85 percent occupancy rate to the projected ADC of 51.1 yielding a projected need of 60.11 (or 62) beds. It is not clear why the applicant chose an 85 percent occupancy rate for this estimation.

The applicant states that it believes some referrals will come from Flagler County because these patients live closer to the proposed Volusia County site than to Kindred Hospital-North Florida in Clay County. According to the applicant, Kindred Hospital-North Florida (the closest LTCH to the proposed site at approximately 77.3 miles) discharged 19 patients to Flagler County who received 511 days of LTCH care for the 12-month period ending March 2004 (1.4 ADC). Kindred Hospital-North Florida had an occupancy rate of 90.34 percent for the 12-month period ending June 2004 and intends to add 20 increasing its capacity to 80 beds. Further, as indicated above, the applicant has previously opposed the establishment of a LTCH in this area because of what it characterized as

adverse impact to its Clay County facility. The applicant did not demonstrate that the district's circumstances have changed since its opposition letter of April 12, 2004 for the 40-bed proposed LTCH.

The applicant contends that its discharged-based need analysis supports the need for the proposed 60-bed LTCH. However, the applicant's need analysis did not specifically consider high acuity patients that are LTCH appropriate that could not be more appropriately treated in lower cost long-term care facilities such as nursing homes and rehabilitation hospitals. As stated earlier, in consideration of Glenn M. Hackbarth, MedPac chairman comments in a March 29, 2005, letter to the Centers for Medicare and Medicaid Services (CMS) encouraging reimbursement changes for LTCHs based on MedPac's 2003 and 2004 reports, CMS announced that it plans to make changes in its reimbursement to LTCHs this fall with other updates planned for October 1, 2005.

The applicant's need analysis does not demonstrate need and the applicant failed to provide any evidence that LTCH appropriate patients were unable to access LTCH services in District 4. The district's 167 LTCH beds averaged 68.07 percent occupancy during the 12-month reporting period ending June 2004, indicating there are more than sufficient beds available for District 4 residents. As noted earlier, when another LTCH proposed to establish a hospital in this area for essentially the same reasons, the applicant stated opposition, indicating that its Clay County facility would be adversely impacted and that the establishment of a third LTCH in District 4 would be a duplication of services. The applicant's need analysis removes the Volusia and Flagler patients it presently serves at its Kindred North Florida facility, further indicating that the project would be a duplication of existing services. Additionally, the applicant intends to increase bed capacity in the district with the addition of 20 beds to its Kindred Hospital-North Florida facility and there is one licensed two CON approved but not yet licensed facilities within a reasonable driving distance for Volusia residents.

2. Agency Rule Criteria

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

3. Statutory Review Criteria

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

The applicant contends that with the approval of this project availability and accessibility to LTCH services will increase because there are currently no LTCHs in Volusia County. The applicant cites the current travel distance from Daytona Beach to the nearest LTCH of over 60 miles as a burden for patients and families seeking LTCH services in the district, particularly the medically indigent and handicapped population. The mileage chart displayed earlier on this reports indicates that it is approximately 77 miles from Daytona Beach to the Kindred Hospital-North Florida facility in Green Cove Springs and approximately 86 miles from Daytona Beach to Specialty Hospital Jacksonville, both located in District 4. The applicant contends that this constitutes an unmet need in the area, but as stated earlier, the applicant did not demonstrate that residents in the area who need them are not receiving LTCH services.

The applicant acknowledges that there are skilled nursing facilities and other subacute providers in the area, but states that they do not have the ability to provide the same level of care as provided in the proposed LTCH. As mentioned earlier in this report, MedPAC's findings indicate that lower acuity patients within any DRG can appropriately be served in a SNF at a lower cost; LTCHs are usually the costly post-acute care setting at about 12 times that to SNFs. The SNF utilization rate in District 4 averaged 89.97 percent for CY 2004. The utilization rate is below the benchmark for SNF care in Florida Statutes at 94 percent.²

According to the applicant, the proposed facility will improve efficiency of LTCH services, as it will be able to share services with other area Kindred facilities and utilize centralized services such as purchasing, project management, clinical and quality management, medical records and other services. However, the applicant did not demonstrate what efficiencies would be achieved as a result of this proposed project.

² Subsection 408.034 (5), Florida Statutes, as amended July 1, 2004, sets the skilled nursing occupancy standard at 94 percent.

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 district.

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

The applicant states that all of its currently licensed LTCHs are accredited by the JCAHO and that the necessary components are in place to ensure delivery of care. The applicant provided a description of the admission, care planning and discharge process. The quality management functions are contained in the Kindred strategic quality plan, a copy of which is contained in Appendix 6 of the application.

The review of the applicant's complaint history for the seven licensed Kindred LTCHs in the state as of March 28, 2005 indicates a combined listing of 12 confirmed complaints for the past three years. The 12 confirmed allegations involve: untrained/unqualified staff (one), patient care (four), medicine/ problems/errors/formulary (two), nursing service (one), discharge planning (one), staffing (one), restraints (one), patient's rights (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.**

The audited financial statements for the periods ending December 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 the accounts and ratios used in the analysis:

Kindred Hospitals East, LLC		
	12/31/2003	12/31/2002
Current Assets	\$ 115,343,532	\$ 95,586,452
Cash and Current Investment	\$ 929,338	\$ 2,556,678
Assets Restricted for Capital Projects	\$ 0	\$ 0
Total Assets	\$ 154,903,329	\$ 144,057,782
Current Liabilities	\$ 50,489,276	\$ 47,475,625
Total Liabilities	\$ 50,541,294	\$ 47,488,505
Total Equity	\$ 104,362,035	\$ 96,569,277
Net Operating Revenues	\$ 452,417,039	\$ 430,600,841
Interest Expense	\$ 804,668	\$ 143
Net Profit - Operations	\$ 21,902,494	\$ 12,439,445
Net Income	\$ 21,732,005	\$ 11,293,364
Cash Flow from Operations	\$ 12,286,483	\$ 48,507,659
Working Capital	\$ 64,854,256	\$ 48,110,827
Current Ratio (CA/CL)	2.3	2.0
Cash Flow to Current Liabilities (CFO/CL)	0.24	1.02
Long-Term Debt to Equity (TL-CL/TE)	0.0	0.0
Equity to Total Assets (TE/TA)	67.4%	67.0%
Operating Margin (NPO/NOR)	4.8%	2.9%
Total Margin (NI/NOR)	4.8%	2.6%
Return on Assets (NI/TA)	14.1%	8.6%
Operating Cash Flow to Assets (CFO/TA)	7.9%	33.7%

The applicant is a wholly owned subsidiary of Kindred Healthcare, Inc. (formerly Vencor, Inc.).

Short-term position:

The applicant's current ratio of 2.3 is strong in relation to all Florida Hospitals. The ratio of cash flow to current liabilities of 0.24 is weak. Working capital (current assets less current liabilities) of \$64.9 million is substantial in relation to the entity's size. Overall the applicant has an acceptable short-term position.

Long-term position:

The ratio of long-term debt to equity of 0.0 is the result of carrying no long-term debt on the books of the applicant. Long-term debt is carried on the books of the parent corporation. The ratio of cash flows to assets of 7.9 percent is below average. The most recent period had an operating profit of \$21.9 million, resulting in a margin of 4.8 percent. Total equity is \$104.4 million; the ratio of equity to assets is 67.4 percent. Overall, the applicant has an acceptable long-term position.

Capital requirements:

Schedule 2 indicates capital projects of \$74.2 million.

Available capital:

Funding for these projects will come from \$9.9 million in operating cash flows and \$64.3 million in cash in hand. The audited financial statements of the applicant show \$929,338 in cash on hand, and \$12.3 million in cash flows.

The applicant provided the 10-K report for its parent, Kindred Healthcare, Inc., for the period ended December 31, 2004. The report shows \$69.1 million in cash on hand, \$1.6 billion in assets, total liabilities of \$873.5 million and net worth of \$719.8 million. There were \$3.3 billion in revenues, \$85.9 million profit from continuing operations and \$268.1 million in cash flows.

Conclusion:

Based on the audited financial statements of the applicant, and the parents 10-K report, cash on hand and cash flows, if they continue at reported levels, would be sufficient to fund this project as proposed. Funding for this project and all capital projects is likely to be available as needed.

Staffing:

This project calls for the recruitment of 70.8 FTEs in the first year of operation, increasing to 122.6 FTEs in year two. The nursing staff will consist of 24.2 FTEs in year one and 56.0 FTEs in year two. The applicant states that it allocates resources to attract and retain qualified staff, including competitive salary and benefit levels, and opportunities for recognition and promotion. Kindred uses a number of methods to attract employees, including media advertising, job fairs, direct marketing and Internet recruitment.

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

A comparison of the applicant's estimates to the control group values provides for an objective evaluation of financial feasibility, (the likelihood that the services can be provided under the parameters and conditions contained in Schedules 7 and 8), and efficiency, (the degree of economies achievable through the skill and management of the applicant). In

general, projections that approximate the median are the most desirable, and balance the opposing forces of feasibility and efficiency. In other words, as estimates approach the highest in the group, it is more likely that the project is feasible, because fewer economies must be realized to achieve the desired outcome. Conversely, as estimates approach the lowest in the group, it is less likely that the project is feasible, because a much higher level of economies must be realized to achieve the desired outcome. These relationships hold true for a constant intensity of service through the relevant range of outcomes. As these relationships go beyond the relevant range of outcomes, revenues and expenses may, either go beyond what the market will tolerate, or may decrease to levels where activities are no longer sustainable.

The Centers for Medicare and Medicaid Services (CMS) published a prospective payment system (PPS) rule for long-term care hospitals (LTCH) effective for cost reporting periods beginning or after October 1, 2002. Under the PPS for LTCH a payment for a Medicare patient will be made at a predetermined, per discharge amount for each LTC-DRG. The law requires that the LTCH PPS be budget neutral, which means that total payments must equal the amount that would have been paid if the PPS had not been implemented. Therefore, a comparison of the applicant's revenue estimates to the control group values, based on the reasonable cost-based reimbursement system, provide a rational basis for evaluating estimated revenues.

Medicare requires a six-month period (demonstration period) before a hospital is eligible for reimbursement under the LTCH PPS. This period is required to demonstrate a minimum 25-day average length of stay. During the demonstration period the hospital is reimbursed at the acute care rate. The applicant states that revenue projections for the first six months were developed using acute care reimbursement rates. The stated strategy was to keep the census low during this period.

Comparative data were derived from hospitals in peer groups that reported data in 2003; the applicant will be compared to the hospitals in peer group 12. Group 12 contains 10 hospitals, seven of which are Kindred facilities. Per diem rates are projected to increase by an average of 3.4 percent per year. Inflation adjustments were based on the new CMS Hospital Market Basket Index for the 4th Quarter of 2004 as published in the Health Care Cost Review.

Only the 2nd year of operation will be considered for comparison with the control group because the hospital will be operating at acute care reimbursement rates during the first six months of operations, resulting in distorting net revenues when compared to the control group.

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Projected net revenue per adjusted patient day (NRAPD) of \$1,279 in year two is between the control group median and lowest values of \$1,438 and \$1,240. The lowest value is generally viewed as the practical lower limit on economies of operation. With net revenues per adjusted patient day falling between the lowest and median the facility is expected to consume health care resources in proportion to the services provided. (See Comparative Table).

Projected cost per adjusted patient day of \$1,211 in year two is between the control group median and lowest values of \$1,357 and \$1,076. (See Comparative Table). Compared to the control group these costs are considered cost-efficient.

The year two operating profit for the hospital of \$822,118 computes to an operating margin per adjusted patient day of \$68 which falls between the group lowest and median values of -\$456 and \$128. The computed operating margin ratio is 5.3 percent.

With the support of the parent, Kindred Healthcare, Inc., this project is likely to be financially feasible.

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Comparative Table

CON # 9831 Kindred Hospitals East, LLC 2003 DATA Peer Group 12	2009	YEAR 2	VALUES ADJUSTED		
	YEAR 2	ACTIVITY	FOR INFLATION		
	ACTIVITY	PER DAY	Highest	Median	Lowest
ROUTINE SERVICES	10,263,991	849	1,264	1,038	744
INPATIENT AMBULATORY	-	0	15	0	0
INPATIENT ANCILLARY SERVICES	41,055,964	3,397	4,337	3,357	2,158
OUTPATIENT SERVICES	-	0	79	0	0
OTHER OPERATING REVENUE	-	0	5	2	0
TOTAL REVENUE	51,319,955	4,246	5,613	4,329	3,292
DEDUCTIONS FROM REVENUE	35,858,734	2,967	*	*	*
NET REVENUES	15,461,221	1,279	1,864	1,438	1,240
EXPENSES					
ROUTINE	3,877,813	321	497	353	235
ANCILLARY	4,059,235	336	575	380	245
AMBULATORY		0			
OVERHEAD	6,702,055	554	916	617	532
OTHER		0			
TOTAL EXPENSES	14,639,103	1,211	1,942	1,357	1,076
OPERATING INCOME	822,118	68	333	128	-456
		5.3%			
PATIENT DAYS	12,087		VALUES NOT ADJUSTED		
ADJUSTED PATIENT DAYS	12,087		FOR INFLATION		
TOTAL BED DAYS AVAILABLE	21,900				
ADJ. FACTOR	1.0				
TOTAL NUMBER OF BEDS	60				
PERCENT OCCUPANCY	55%		90.7%	69.3%	30.4%
PAYER TYPE	PATIENT DAYS	% TOTAL			
MEDICARE	7,606	62.9%	97.0%	79.5%	65.0%
COMMERCIAL	2,314	19.1%			
MEDICAID	116	1.0%	11.5%	0.0%	0.0%
SELF-PAY	-	0.0%			
HMO/PPO	1,930	16.0%	27.2%	11.0%	0.0%
OTHER	121	1.0%			
TOTAL	12,087	100.0%			

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

The applicant projects managed care to represent 16.0 percent of its patient days. This is between the control group median and highest level of activity of 11.0 percent and 27.2 percent. The projected levels, if realized, are likely to increase competition to promote quality assurance and cost-effectiveness.

It should be noted that the applicant will be competing against itself largely. As discussed in the need section above, there are two LTCHs in District 4: Kindred Hospital - North Florida and Specialty Hospital at Jacksonville. Over the past five years Specialty Hospital Jacksonville has experienced little growth, while Kindred North Florida appears to have had slight growth. Both facilities have been serving this area for a number of years.

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

The applicant proposes a new 60-bed, 74,326 square foot long-term care hospital in Volusia County. The new facility will have three floors. There will be 52 patient rooms, three of which are isolation rooms with vestibules and there is an eight-bed ICU. The ground floor has the typical functional areas that would be expected. The operating suite is on the 3rd floor, which is a bit unusual, but certainly acceptable.

The site for the new facility is projected to be about five acres. Although the narrative mentions emergency water storage, there is no direct reference to the Florida Building Code requirements for disaster preparedness in Section 419.4.56. This is not only a building issue, but also a site issue. The owner would be advised to become familiar with these requirements before final site selection.

The 2004 Florida Building Code has some limitations on building size relative to site size. There does not seem to be problem from the information presented, but it would be worthwhile for the design professionals to verify that the building is within acceptable limits.

The new facility will have a steel frame with concrete or masonry walls, which is good from a disaster preparedness standpoint.

The application included a site plan, floor plans of the three-story building and larger scaled plans of typical patient rooms. All patient

rooms will be private and some patient toilet rooms appear to be wheelchair-accessible though no turning circles are shown. The patient rooms shown meet the code requirements for area and the headwall width appears sufficient, but should be verified. There is a lavatory within the rooms as well as one in the toilet room, which is required for new construction.

On the plans, many of the rooms are not labeled, so it is not possible to tell if all the required ancillary spaces have been provided. For instance, there appears to be a two-bed recovery space in the operating suite, but it is not identified and might actually be a pre-op space or a combination of the two functions. There is a reference to a fluoroscopy procedure room, but none is labeled on the plans so it is not possible to tell whether it has the required adjacent toilet room. The plans were not exactly to scale, so the design professional will need to verify that the size of the operating rooms meets code requirements.

The layout of the patient rooms is a bit puzzling and the narrative mentions that this may be readdressed. Some of the rooms have the plumbing wall back-to-back with the next room and some do not. While minimizing plumbing does not have quite the higher cost that it once had, it seems strange that the patient room layouts are not consistent. Each room has its own temperature control, which is an advantage.

The overall project is straightforward and the layout is good. The ancillary spaces, which are labeled, seem to be adequately sized and conveniently arranged for the functions that they support.

There is a list of applicable codes on the drawing, but by the time this project could be submitted to the AHCA Office of Plans and Construction, most of the codes will have been updated or changed. Schedule 9 in the narrative is somewhat out of date. The information from Schedule 10 indicates that sufficient time has been allowed for construction and the proposed budget appears reasonable.

- 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. This average is primarily set by Kindred as it operated seven of the 10 licensed LTCHs in Florida in 2003.

The applicant has a history of providing Medicaid and/or charity care albeit low. As shown below, according to the 2003 Financial Data Report, the applicant's licensed Florida facilities provided a percent of Medicaid patient days to total patient days, ranging from a low of zero percent (Kindred Hospital-North Florida, Kindred Hospital-Central Tampa and Kindred Hospital-Coral Gables) to a high of 11.5 percent (Kindred Hospital-Bay Area-St. Petersburg).

Kindred Facilities		
Percent Medicaid Days & Percent Charity Care Days for CY 2003		
Hospital	Medicaid	Charity Care
Kindred Hospital-North Florida	0.0%	0.5%
Kindred Hospital-Bay Area-St. Petersburg	11.5%	1.8%
Kindred Hospital-Central Tampa	0.0%	1.0%
Kindred Hospital-Bay Area-Tampa	0.3%	1.8%
Kindred Hospital-South Florida-Hollywood	0.1%	0.8%
Kindred Hospital-South Florida-Ft. Lauderdale	0.4%	0.0%
Kindred Hospital-Coral Gables	0.0%	2.5%
State of Florida	1.24%	0.94%

Source: CY 2003 AHCA Financial Data

As shown in the table above, charity care patient days ranged from a low of zero percent (Kindred Hospital-Fort Lauderdale) to a high of 2.5 percent (Kindred-Coral Gables).

As a condition of approval, the applicant agrees to condition award of the certificate of need on the combined provision of 2.2 percent of patient days to Medicaid and charity care patients in the second year of operation. According to Financial Schedule 7A, the applicant intends to provide 1.2 percent of patient days to Medicaid and Medicaid HMO in year two. This is below the state average. The applicant did not specifically indicate any charity care on the schedule. Based on the information provided, it does not appear that the applicant's combined Medicaid and charity care provision will meet or exceed the state average for either payor grouping.

F. SUMMARY

Kindred Hospitals East, L.L.C. (CON #9831) proposes to construct a freestanding 60-bed LTCH to be located in Volusia County, Florida.

The proposed project involves 74,326 gross square feet (GSF) of new construction, comprised of an eight-bed intensive care unit and 52 private rooms. The total construction cost is estimated to be \$12,641,565 with total project costs of \$20,884,061.

As a condition of approval, the applicant agrees to a combined provision of 2.2 percent of its total patient days to Medicaid and charity care patients beginning with the second year of operation.

After weighing and balancing all applicable review criteria, the primary issues are summarized below:

Need:

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

The applicant intends to focus on the provision of complex LTCH services (many requiring ventilator/pulmonary services) and contends patients remain in less appropriate settings in District 4. It maintains that Volusia County is an appropriate service area for this project due to the travel distance to a current LTCH. Although support letters state that many patients would have benefited from LTCH services, the disposition of these patients is not known and access problems to LTCH services was not shown. The applicant did not demonstrate that area residents are unable to access needed care or that care currently being provided is inappropriate.

The applicant's need analysis did not solely consider high acuity patients that are LTCH appropriate that could not be more appropriately treated in lower cost long-term care facilities such as nursing homes and rehabilitation hospitals. As stated earlier, CMS announced that it plans to make changes in its reimbursement to LTCHs this fall with other updates planned for October 1, 2005.

The applicant stated opposition when another LTCH proposed to establish a hospital in this area indicating that its Clay County facility would be adversely impacted and that the establishment of a third LTCH in District 4 would be a duplication of services.

Quality of Care:

The applicant has a history of providing quality of care and its current LTCHs are JCAHO accredited. The applicant provided a description of quality management functions to be incorporated at the proposed facility as currently used at other Kindred hospitals.

Cost/Financial Analysis:

The applicant is a wholly owned subsidiary of Kindred Healthcare, Inc. The applicant has an acceptable short-term and long-term position. Based on the financial statements, cash on hand and cash flows, (assuming the current level continues), funding for the project and all capital projects is likely to be available as needed.

Net revenues per adjusted patient day fall below the control group and it is doubtful that such economies would be achieved in the first two years. However, the project is considered to be financially feasible, with the parent sustaining working capital during the first two years of operation.

Architectural Analysis:

The project involves new construction of a 60-bed freestanding LTCH in Volusia County. Though water storage is mentioned, there is no direct reference to Florida Building Code requirements for disaster preparedness. The patient rooms shown meet the code requirements for area and headwall width and appear sufficient, but should be verified. Many of the rooms are not labeled on the plans, so it is not possible to tell if the required ancillary spaces have been provided. Patient room layouts are not consistent in that some rooms have the plumbing wall back-to-back with the next room and some do not.

Applicable codes were listed, but by the time the project could be submitted to the AHCA Office of Plans and Construction, most of the codes will have been updated or changed. The estimated project budget and schedule appear to be adequate based on the scope of the project.

G. RECOMMENDATION

Deny CON #9831.

AUTHORIZATION FOR AGENCY ACTION

Authorized representatives of the Agency for Healthcare 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