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 #9835)
680 South Fourth Street
Louisville, Kentucky 40202

Authorized Representative: Bud Wurdock
(502) 596-7718

2. Service District

District 7

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 7. However, letters of support were submitted as follows:

Kindred Hospitals East, L.L.C. (CON #9835) submitted 44 letters of support for the project, the majority of which were form letters.

Letters from Emil Miller, President and CEO of Wuesthoff Health System and 10 Brevard County physicians provide general form letters of support that indicate that many patients would benefit from a local long-term care hospital. These letters do not provide the specific number of patients that would benefit. Ms. Doreen Woods, Vice President of Quality Resource Management at Wuesthoff Health System, indicates her support for the project and states that the closest long-term care facility located in Orlando is unable to meet Wuesthoff's referral needs due to no capacity. It is noted that the 35-bed Select Specialty Hospital Orlando averaged 71.28 percent occupancy during calendar year 2004, so there was an average daily census of 25 beds, leaving 10 available on any given

day. In addition, Select Specialty Hospital – Orange has a 40-bed long-term care facility that is CON approved and yet to be licensed in District 7 (proposed to be located in Orange County). Select Specialty Hospital – Orange indicated that it has purchased land at 5579 S. Orange Avenue in Edgewood, Florida for the location of the proposed facility and have already begun developing the site to allow the immediate commencement of site preparation.[1] This location is less than 61 miles driving distance and an estimated 56-minute drive from the Wuesthoff Medical Center – Melbourne facility and an approximate 46-mile drive distance and an estimated 44 minutes from Wuesthoff Medical Center - Rockledge.[2] Therefore, the proposed facility location should greatly decrease the travel time for Brevard County patients.

There were two Melbourne area physician letters that indicate that they are personally aware of more than 250 patients (over 150 and 100 respectively) that could benefit from a long-term care hospital in Brevard County. However, these letters did not provide the time frame to support the number of patients they felt would have been appropriate for long-term care hospital services, and did not state how and where these patients were treated. AHCA hospital discharge data indicates that during calendar year 2004, there were 40 Brevard County area patients discharged from long-term care facilities. While 17 of these patients were treated at Kindred Hospital – North Florida (the applicant's District 4 facility) and seven at Kindred Hospital – Fort Lauderdale (one of the applicant's District 10 facilities), seven of these were discharged from Select Specialty Orlando, however; this facility was licensed June 12, 2003 and is presently building its census. As stated earlier, District 7 has 40 long-term care beds that are CON approved but not yet licensed.

There were no other letters from physicians or facility representatives located in Brevard County or District 7. The remaining letters of support were from facility representatives and physicians located in District 9.

There were three form letters from physicians affiliated with Indian River Medical Center (District 9) and letters from nine case managers at Indian River Memorial Hospital. There were two letters from physicians affiliated with Sebastian River Medical Center (also located in Indian River County) and letters from four case managers at Sebastian River Memorial Hospital. Thomas R. Pentz, the CEO of Lawnwood Regional Medical Center & Heart Institute, located in St. Lucie County (District 9), also provided a general letter support. Ms. Dianne Pederson, Director of Case Management at Lawnwood Regional Medical Center & Heart Institute submitted a letter as did four Port St. Lucie physicians. There

[1] Source: AHCA stipulation agreement for the modification of CON #9654 dated 4/15/05.
[2] Source: www.exepediamap.com obtained 6/10/05.

were 17 Indian River County patients discharged from long-term care facilities during CY 2004 and 14 of these were discharged from Kindred Hospital Fort Lauderdale. There were 41 St. Lucie River County patients discharged from long-term care facilities during CY 2004 and 38 of these were discharged from Kindred Hospital Fort Lauderdale. On June 9, 2005, the applicant was issued CON #9662 to construct a 70-bed long-term care facility to be located in the north central portion of Palm Beach County (District 9) and Select Specialty Hospital - Palm Beach was issued CON #9661 has been approved to construct a 60-bed long-term care located close to JFK Medical Center in Palm Beach County (District 9). Therefore, these facilities locations should greatly decrease the travel time for District 9, Indian River and St. Lucie County patients.

C. PROJECT SUMMARY

Kindred Hospitals East, L.L.C. (CON #9835) proposes to construct a freestanding 60-bed LTCH to be located in Brevard County, District 7. 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 construct a 31-bed LTCH in District 3. The applicant has concurrently submitted an application to establish a LTCH in District 4, Volusia 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 costs is estimated to be $13,071,773 with total project costs of $20,853,762.

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 architecturals 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, and 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 provided 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 probably 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 increasing 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 LTCHs 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 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 Brevard County to more effectively meet the needs of the residents in District 7. However as discussed below, the applicant did not demonstrate that patients needing LTCH services were unable to obtain them.

There were two Melbourne area physician letters that indicate that they are personally aware of more than 250 patients (over 150 and 100 respectively) that could benefit from a long-term care hospital in Brevard County. However, these letters did not provide the time frame to support the number of patients they felt would have been appropriate for long-term care hospital services, and did not state how and where these patients were treated. AHCA hospital discharge data indicates that during calendar year 2004, there were 40 Brevard County area patients discharged from long-term care facilities. Seven of these were discharged from Select Specialty Orlando, however; this facility was licensed June 12, 2003 and is presently building its census. As stated earlier, District 7 has a 40-bed long-term care facility that is CON approved and proposed to be located within 46 miles and approximately 44-minute drive and 61 miles and approximately 56-minute drive of the Wuesthoff facilities.

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-North Florida	4	60	21,960	19,817	90.24%
Specialty Hospital Jacksonville	4	107	39,162	21,786	55.63%
Kindred-Bay Area-St. Petersburg	5	82	30,012	21,104	70.32%
Kindred-Central Tampa	6	102	37,332	25,306	67.79%
Kindred-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-South Florida-Hollywood	10	124	45,384	29,111	64.14%
Kindred-South Florida-Ft. Lauderdale**	10	70	23,880	16,840	70.52%
Kindred-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-Ft. Lauderdale was initially licensed for 64 beds and on 4/16/04 was licensed for 6 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 7 and the occupancy rates for the 12-month period ending June 2004.

Acute Care and Postacute Care Providers District 7 and Utilization July 2003-June 2004		
Facility Type	**Total Beds**	**Average Occupancy**
Long-Term Hospital Care	35	56.45%
Acute Care	4,665	67.98%
Comprehensive Medical Rehabilitation	192	71.70%
Hospital Based Skilled Nursing	38	70.26%
Community Nursing Homes	9,147	91.17%

Sources: *Florida Hospital Bed Need Projections by District*, Volume II, published 01/28/05 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 and Subdistrict July 2004-June 2004, published 10/08/04.

The following table illustrates the population estimates for the next five years for District 7 and the state.

Population Estimates for District 7 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**
Brevard	527,680	570,098	8.04%	9.74%	8.33%
Orange	1,043,846	1,173,409	12.41%	20.22%	14.16%
Osceola	231,417	277,271	19.81%	34.20%	28.17%
Seminole	415,004	457,917	10.34%	19.74%	10.69%
Total District 7	2,217,947	2,478,695	11.76%	17.69%	12.80%
Total State of Florida	17,844,137	19,478,414	9.16%	14.21%	8.73%

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

As shown above, the overall population in District 7 is expected to increase by 11.76 percent during the next five years, with the 65 and over and 75 and over age cohort increasing by 17.69 percent and 12.80 percent, respectively. Orange County is the most populous county in the district and by the year 2010 is projected to have 47 percent of the total population, 38 percent of the 65 and over population and 38 percent of the 75 and over population in the district. Brevard County is the second most populous county in the district and by 2010 is projected to have 22.9 percent of the total population, 34.27 percent of the 65 and over population and 36 percent of the 75 and older population. The applicant contends that as a result of the increase in the senior population in Brevard 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 Brevard County did not have access to LTCH services. The applicant also contends that the travel distance for the residents of Brevard 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 Brevard County (Melbourne) to the existing LTCH facilities in the state.

Mileage Chart-Florida LTCH Facilities													
	SemperCare Hospital of Panama City	Kindred Hospital-North Forida	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 Emanual Hosp. for Cont. Care	Proposed Kindred Brevard/Melbourne
SemperCare Hospital of Panama City		301	286	417	392	405	378	584	577	605	601	603	459
Kindred Hospital-North Florida	301		32.3	234	213	216	124	316	309	337	332	335	162
Specialty Hospital Jacksonville	286	32.3		243	222	225	133	325	318	346	341	344	171
Kindred Hospital-Bay Area-St. Petersburg	417	234	243		26.7	19	111	250	249	262	264	266	171
Kindred Hospital-Central Tampa	392	213	222	26.7		9.1	89.8	258	251	284	274	276	150
Kindred Hospital-Bay Area-Tampa	405	216	225	18.7	9.1		93	256	249	263	285	288	153
Select Specialty-Orlando	378	124	133	111	89.8	93		223	216	244	239	241	74.4
Kindred Hospital-South Florida-Hollywood	584	316	325	250	258	256	223		12	24.3	19.5	21.8	158
Kindred Hospital-South Florida-Ft. Lauderdale	577	309	318	249	251	249	216	12		33	28.2	30.5	151
Kindred Hospital-Coral Gables	605	337	346	262	284	263	244	24.3	33		5	5.7	179
Select Specialty-Miami	601	332	341	264	274	285	239	19.5	28.2	5		3.3	174
Sister Emanuel Hosp. for Cont. Care	603	335	344	266	276	288	241	21.8	30.5	5.7	3.3		179
Proposed Kindred Brevard/Melbourne	459	162	171	171	150	153	74.4	158	151	179	174	179	

Source: www.expediamap.com. The Brevard County Health Department in zip code 32901 for Melbourne was used as the estimated location of the applicant's proposed site.

As shown in the table above, it is approximately 74.4 miles from the proposed site in Brevard County (Melbourne) to the currently licensed LTCH in District 7, Select Specialty Hospital-Orlando, Inc. The applicant contends that this LTCH has designated Orlando as its primary service area as stated in its application (CON #9654). The applicant further states that SemperCare-Orlando (now called Select Specialty Hospital-Orange due to purchase of the company) stated in its application that it recognized that the LTCH need in the area was greater than the number of beds they proposed (35 beds). However, the applicant did not demonstrate that this existing 35-bed LTCH or the approved 40-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 District 7, including Brevard County. The 35-bed LTCH is attached to Florida Hospital's main campus. The 40-bed CON approved, but not yet established District 7 LTCH by Select Specialty Hospital – Orange is proposed to be located at 5579 S. Orange Avenue in Edgewood, Florida. This location is less than 61 miles driving distance and an estimated 56-minute drive from the Wuesthoff Medical Center – Melbourne facility and an approximate 46-mile drive distance and an estimated 44 minutes from Wuesthoff Medical Center - Rockledge. Therefore, the proposed facility location should greatly decrease the travel time for Brevard County patients.

With changes in Medicare reimbursement, it is reasonable to assume that both LTCHs, particularly the CON approved not yet licensed freestanding LTCH, will serve larger areas than the one discussed in CON applications.

The applicant expects that this proposed facility would experience utilization rates similar to those of Select Specialty Hospital of Orlando. Select Specialty of Orlando's utilization rates increased from 34.73 percent during its first quarter of utilization to 74 percent in April- June 2004, its 3rd quarter of utilization. However, utilization data is not yet available regarding Select Specialty Hospital-Orange, so it remains to be seen if its rates will match Select Specialty Hospital-Orlando, Inc. With recent changes to CON law, existing LTCHs can add beds without CON review. It is noted that this may be somewhat difficult for the LTCH located on Florida Hospital's campus.

The applicant states that physicians are often not willing to travel a great distance to see patients transferred from short-term hospitals to long-term care facilities resulting in families objecting to the transfer. The applicant sites letters of support that discuss physician's reluctance to travel. 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. The letters of support collectively identified approximately 250 Brevard County (District 7) patients who would have benefited from LTCH services. With the exception of two letters, the letters were not specific as to the time frame involved. The letters do not state that physicians are unwilling to see patients who are transferred to LTCHs. 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.

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 7. The applicant provided a chart comparing LTCHs, rehabilitation facilities and skilled nursing facilities. According to the chart, the difference noted in treatment is that 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 7.

The applicant states the average case mix for the acute care hospitals in District 7 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 1.26 for acute care facilities in District 7 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 Melbourne facility. However, comparing the case mix index of acute care hospitals to LTCHs does not have much meaning as their admission criterion differs. In addition, at 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 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 Brevard 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 assumes that referrals to the proposed Melbourne 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 18,400 potential long-term hospital days from the six acute care hospitals in the area, for an average daily census of 50.4 (ADC=18,400/365=50.4). The applicant then removed the 41 patients who live in Brevard County but sought care in Clay County at Kindred Hospital-North Florida and Kindred Hospital-South Florida-Fort Lauderdale, accounting for 2,229 days for the 12 months ending March 2004 (ADC=2,229/365=6.1). The applicant added the resulting ADC of 6.1 to the ADC of 50.4 for a potential ADC result of 56.5.

The applicant applied the projected growth rate of 10.8 percent (using January 2005 to January 2005 data) for Brevard County for the next five years yielding a potential ADC of 61.7 by 2010 (56.5 + 5.2). The applicant's final step is to apply an 85 percent occupancy rate to the projected ADC of 61.7 yielding a projected need of 72.5 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 Indian River County because these patients live closer to the proposed Brevard County site than to Kindred Hospital-South Florida-Fort Lauderdale in Broward County. According to the applicant, Kindred Hospital-South Florida-Fort Lauderdale discharged 10 patients from Indian River County who received 625 days of LTCH care for the 12-month period ending March 2004 (1.7 ADC). AHCA data indicates this number to be 14 for calendar year 2004. However, the applicant did not provide the number of Brevard County patients discharged from LTCHs. AHCA hospital discharge data for calendar year 2004, indicates that 40 Brevard County residents were discharged from LTCHs, with 17 of those discharged from Kindred North Florida, three from Specialty Hospital in Jacksonville, seven from Select Specialty Orlando, six from the two Kindred Tampa facilities and seven from Kindred Hospital South Florida-Fort Lauderdale, no other LTCH facility had more than five Brevard County resident discharges. Calendar year 2004 AHCA data also indicates that 17 Indian River patients were discharged from three Florida LTCHs: two from Specialty Hospital in Jacksonville, one from Kindred's St. Petersburg facility and as noted above, 14 from Kindred's Fort Lauderdale facility.

The applicant failed to provide any evidence that LTCH appropriate patients were unable to access or were denied LTCH services in District 7. There is one relatively newly operational and one CON approved LTCH District 7. The operational 35-bed LTCHs average annual occupancy for the 12-month period ending June 30, 2004 was 56.45 percent. The 40-bed CON approved, but not yet established District 7 LTCH by Select

Specialty Hospital – Orange is proposed to be located at 5579 S. Orange Avenue in Edgewood, Florida. This location is less than 61 miles driving distance and an estimated 56-minute drive from the Wuesthoff Medical Center – Melbourne facility and an approximate 46-mile drive distance and an estimated 44 minutes from Wuesthoff Medical Center - Rockledge. Therefore, the proposed facility location should greatly decrease the travel time for Brevard County patients. With recent Medicare reimbursement changes, it is not likely that the patient population originally represented in the CON applications will entirely make up the patient populations of these LTCHs, particularly with the 40-bed not-yet-built project that was recently modified because of changes in Medicare reimbursement. As noted earlier, additional Medicare changes for LTCH reimbursement are planned for October. These planned changes along with changes in Florida CON law that allow existing LTCHs to add beds without CON review, make it reasonable to expect a broader service area for the existing and CON approved LTCHs in District 7 if they are to be financially viable hospitals. A third LTCH approved to serve this area is likely to impact both of the Select facilities with a negative impact on the not-yet-built LTCH.

The applicant did not demonstrate need in District 7 where there is currently one licensed and one approved LTCH. In addition, the applicant's need analysis does not address comments made by MedPAC. For example it 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 these comments and 2003 and 2004 MedPAC reports, CMS announced that it plans to revise the relative weights for DRGs to LTCHs this fall with other updates planned for October 1, 2005.

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 outside the Orlando area. The applicant cites the current travel distance from Brevard County to the nearest LTCH of over 70 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 74.4 miles from Melbourne to the existing Select Specialty Hospital-Orlando, Inc. in Orlando. However, the 40-bed CON approved, but not yet established District 7 LTCH by Select Specialty Hospital – Orange is proposed to be located at 5579 S. Orange Avenue in Edgewood, Florida. This location is less than 61 miles driving distance and an estimated 56-minute drive from the Wuesthoff Medical Center – Melbourne facility and an approximate 46-mile drive distance and an estimated 44 minutes from Wuesthoff Medical Center - Rockledge. Therefore, the proposed facility location should greatly decrease the travel time for Brevard County patients. 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 cost costly post-acute car 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.[3]

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.

[3] 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 reasonable 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 the application as Appendix 6.

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: nursing service (one), medicine/problems/errors/formulary (two), untrained/unqualified staff (one) patient care (four), 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 70.4 FTEs in the first year of operation, increasing to 121.7 FTEs in year two. The nursing staff will consist of 23.9 FTEs in year one and 55.2 FTE's 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 (LTCHs) 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.

Projected net revenue per adjusted patient day (NRAPD) of $1,314 in year two is between the control group median and lowest values of $1,443 and $1,245. 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 $1,237 in year two is between the control group median and lowest values of $1,362 and $1,081. (See Comparative Table). Compared to the control group these costs are considered cost-efficient.

The year two operating profit for the hospital of $907,539 computes to an operating margin per adjusted patient day of $77 which falls between the group lowest and median values of -$456 and $128. The computed operating margin ratio is 5.6 percent.

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

Comparative Table

CON # 9835 **Kindred Hospitals East, LLC** **2003 DATA Peer Group 12**	2009 YEAR 2 ACTIVITY	YEAR 2 ACTIVITY PER DAY	VALUES ADJUSTED FOR INFLATION Highest	 Median	 Lowest
ROUTINE SERVICES	10,223,931	873	1,269	1,042	746
INPATIENT AMBULATORY	-	0	16	0	0
INPATIENT ANCILLARY SERVICES	40,895,724	3,490	4,354	3,370	2,166
OUTPATIENT SERVICES	-	0	79	0	0
OTHER OPERATING REVENUE	-	0	5	2	0
TOTAL REVENUE	51,119,655	4,363	5,635	4,346	3,304
DEDUCTIONS FROM REVENUE	35,722,436	3,049	*	*	*
NET REVENUES	15,397,219	1,314	1,871	1,443	1,245
EXPENSES					
ROUTINE	3,837,336	328	499	354	236
ANCILLARY	3,995,156	341	577	381	246
AMBULATORY		0			
OVERHEAD	6,657,188	568	920	619	534
OTHER		0			
TOTAL EXPENSES	14,489,680	1,237	1,950	1,362	1,081
OPERATING INCOME	907,539	77	333	128	-456
		5.9%			
PATIENT DAYS	11,717		VALUES NOT ADJUSTED FOR INFLATION		
ADJUSTED PATIENT DAYS	11,717				
TOTAL BED DAYS AVAILABLE	21,900				
ADJ. FACTOR	1.0				
TOTAL NUMBER OF BEDS	60				
PERCENT OCCUPANCY	54%		90.7%	69.3%	30.4%
PAYER TYPE	PATIENT DAYS	% TOTAL			
MEDICARE	7,373	62.9%	97.0%	79.5%	65.0%
COMMERCIAL	2,244	19.2%			
MEDICAID	112	1.0%	11.5%	0.0%	0.0%
SELF-PAY	-	0.0%			
HMO/PPO	1,871	16.0%	27.2%	11.0%	0.0%
OTHER	117	1.0%			
TOTAL	11,717	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. However, the applicant is the licensee for the majority of the comparison 2003 peer group, operating seven of the10

facilities. The other facilities consist of Specialty Hospital of Jacksonville, a 107-bed LTHC operated by Memorial Healthcare Group, Inc. with 53.78 percent occupancy during calendar year 2003; Select Specialty Hospital Orlando licensed on June 12, 2003 and operated by SemperCare until purchased by Select on March 11, 2005 and Select Specialty Hospital Miami a 40-bed LTCH, licensed on December 23, 2002 and in start-up mode for calendar year 2003 with only 32.68 percent occupancy. Therefore, the comparison consists of essentially the applicant's performance in the state.

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 Brevard 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 third floor, which is a bit unusual, but certainly acceptable.

The site for the new facility is projected to be roughly 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-Fort Lauderdale, Kindred Hospital-Central Tampa, and Kindred Hospital-North Florida) to a high of 11.5 percent (Kindred-St. Petersburg).

Kindred Facilities Percent Medicaid Days & Percent Charity Care Days for 2003		
Hospital	**Medicaid**	**Charity Care**
Kindred-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-South Florida-Fort Lauderdale) to a high of 2.5 percent (Kindred Hospital-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 #9835) proposes to construct a freestanding 60-bed LTCH to be located in Brevard 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 $13,071,773 with total project costs of $20,853,762.

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 7. It maintains that Brevard County is an appropriate service area for this project because the currently licensed, and approved, facilities are located in Orlando, primarily serving Orange County residents, and travel distance to current LTCHs. However, modifications have already been made to the CON approved, not yet established 40-bed LTCH in District 7 because of Medicare changes in LTCH reimbursement. With other planned changes in Medicare reimbursement not considered in the applicant's need methodology, representations made in initial CON applications by existing or CON approved LTCHs in District 7 will likely also be amended and the patient population may not be limited to Orange County as the applicant assumes in its analysis. Although support letters state that many patients would have benefited from LTCH services, the disposition of these patients is not known. The applicant did not demonstrate that area residents are unable to access needed LTCH care or that care currently being provided is inappropriate. It also did not demonstrate that the currently licensed and approved LTCH for the district would not be able to meet the needs of its residents needing LTCH services.

The CON approved, not yet operational LTCH in District 7 will likely be negatively impacted should this proposal by Kindred be approved.

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 s 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 #9835.

CON Action Number: 9835

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: ______________________

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Karen Rivera
Health Services and Facilities Consultant Supervisor
Certificate of Need

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Jeffrey N. Gregg
Chief, Bureau of Health Facility Regulation