

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Leesburg Regional Medical Center, Inc./CON #9869

600 East Dixie Avenue
Leesburg, Florida 34748

Authorized Representative: Louis H. Bremer, Jr.
(352) 323-5762

Promise Healthcare of Florida III, Inc./CON #9870

1001 Yamato Road, Suite 300
Boca Raton, Florida 33431-4403

Authorized Representative: Peter R. Baronoff
(561) 869-3100

Select Specialty Hospital - Lake, Inc./CON #9871

2021 Church Street, Suite 202
Nashville, Tennessee 37203

Authorized Representative: Greg Sassman
(615) 284-6716

2. Service District

District 3

B. PUBLIC HEARING

A public hearing was not held or requested with regard to the establishment of the proposed long-term care hospitals in District 3. However, letters of support were submitted as follows:

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Leesburg Regional Medical Center, Inc. (LRMC) (CON #9869)

submitted 16 letters of support for the project, the majority of which were form letters.

Hugh H. Gibson, III State Representative District 42 mailed in a letter of support for the project which states his belief that the project would fill the gap in the health care spectrum between short-term acute care hospitals and skilled nursing facilities. Timothy P. Menton, CEO of The Villages Regional Hospital provides a letter of support, which states that his facility fully supports this application and that his facility would be willing to transfer appropriate patients to LRMC's LTCH per Federal and State guidelines and in accordance with the wishes of both patient and physician. Six physicians on the medical staff at LRMC provide general form letters of support that indicate that many patients would benefit from a local long-term care hospital. These letters indicate that patients who require hospitalization for approximately 18-35 days would be referred to the LTCH but do not provide the specific number of patients that would benefit. Eight community members also provide letters stating the above.

Promise Healthcare of Florida III, Inc. (CON #9870) submitted no letters of support for its project, nor were any received via the mail.

Select Specialty Hospital - Lake, Inc. (CON #9871) submitted no letters of support from the Lake or Sumter County area, or District 3 community. The applicant did include general letters of support from four Miami area physicians and one family member praising Select Specialty Hospital Miami's provision of care. Select also included three general letters praising care provided at their Tennessee, North Carolina and Ohio facilities. Letters of support from Nova Southeastern University for its District 10 Broward LTCH project, which is proposed to be affiliated with Nova in Broward County and Nova literature were also included in this District 3 application.

Letter of Opposition

Ms. Jane Jackson, Administrator of Kindred Hospital-Ocala, a CON approved 31-bed LCTH, scheduled to begin operation in November 2005, submitted a letter of opposition to all three projects.¹ Her letter indicates that Kindred Hospital-Ocala will serve Lake County, as indicated in its

¹ Kindred Hospital-Ocala was licensed effective 10/27/05 and as such much of the applicant's discussion addresses the facility as a CON approved facility.

CON application. She also states that she believes that a long-term care hospital in Lake County will have a significant adverse impact on the future of Kindred Hospital-Ocala.

C. PROJECT SUMMARY

Leesburg Regional Medical Center, Inc. (CON #9869) is a not-for-profit entity that is licensed to operate Leesburg Regional Medical Center, a 294-bed acute care hospital and Leesburg Regional Medical Center North, a 15-bed comprehensive medical rehabilitation (CMR) hospital. The applicant also operates LRMC Nursing Center, a 120-bed community skilled nursing facility, co-located within 15-bed CMR hospital. The applicant proposes to construct a freestanding 50-bed LTCH in the existing Leesburg Regional Medical Center North building at 700 N. Palmetto Street, Leesburg, Florida 34748. This project proposes to close the 15-bed comprehensive medical rehabilitation hospital with the applicant anticipating relocating the rehabilitation beds within the main hospital and to delicense 35 of the 120 skilled nursing beds also located within this facility to make room for the LTCH.

The proposed project involves at total of 67,400 gross square feet (GSF), which consists of 37,000 GSF of new construction and 63,700 GSF of renovation. The facility will be comprised of 50 private rooms. Total construction cost is estimated to be \$6,464,891, and total project cost \$8,861,380.

As a condition of approval, the applicant agrees to the provision of three percent of the project's total patient days to Medicaid and/or charity care patients upon obtaining exclusion from the Medicare Inpatient Prospective Payment System. Medicare requires a six-month demonstration period prior to approval for reimbursement under the LTCH PPS system. However, annual condition compliance reports are required beginning from initial licensure of the LTCH facility and the provision of Medicaid and charity care is not dependent on the facility's receiving Medicare reimbursement.

Promise Healthcare of Florida III, Inc. (CON #9870) a wholly owned subsidiary of Promise Healthcare, Inc. (Promise), proposes to construct a freestanding 40-bed LTCH to be located in Lake County, District 3. Four potential sites near the cities Tavares and Eustis were identified as possible locations for the LTCH. The parent corporation is the licensee and operator of 11 LTCHs and one acute care hospital located in six states. Promise does not own or operate a facility in Florida. Promise

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has submitted four proposals in the current review cycle to develop LTCHs within the State of Florida. These involve proposals in Districts 3, 9, 10 and 11.

The proposed hospital involves 47,951 gross square feet (GSF) of new construction at an as yet unsecured location. The applicant indicates the 40-bed facility will consist of all private rooms. Total construction cost is estimated to be \$9,686,100 and total project cost is \$20,901,826.

As a condition of approval, the applicant agrees to a combined provision of two percent of the facility's total annual patient days to Medicaid and charity care patients.

Select Specialty Hospital-Lake, Inc. (CON #9871), a wholly owned subsidiary of Select Medical Corporation, proposes to establish a 44-bed freestanding LTCH to be located in District 3, Lake County. The applicant indicates that the proposed facility will likely be located in Leesburg, proximate to both Leesburg Regional Medical Center and Florida Hospital – Waterman. According to the applicant, Select Medical Corporation currently has 98 long-term care hospitals nationwide, including LTCHs in Panama City, District 2, Orlando, District 7 and Miami, District 11. Select Specialty has approved CONs to open a 54-bed LTCH in District 1 to be located in Pensacola, a second LTCH in District 2 of 29 beds to be located in Tallahassee, a 31-bed LTCH in District 3 to be located in Gainesville, a second LTCH in District 7 of 40 beds to be located in Edgewood and a 60-bed LTCH in District 9 to be located in Palm Beach County. On November 19, 2004, Select Medical Corporation announced that it signed an agreement to acquire and merge with SemperCare, Inc., and as a result of this transaction obtained the Panama City and Orlando LTCHs, assuming operation of these around February 1, 2005 and changing the facilities names effective March 15, 2005. Select Medical Corporation has submitted four proposals in the current review cycle to develop LTCHs within the State of Florida. These involve proposals in Districts 3, 9, 10 and 11.

The proposed hospital will consist of 51,160 gross square feet of new construction with construction cost of \$9,976,200. The facility will be a comprised of 44 private rooms. The total project cost is estimated to be \$18,604,556.

The applicant proposes to condition award of the certificate of need on the provision of 2.8 percent of the facility's total annual patient days to Medicaid patients and charity care patients.

D. REVIEW PROCEDURE

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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, James McLemore, analyzed the application in its entirety with consultation from the Financial Analyst, Ryan Fitch, who evaluated the financial data, and the Architect, James Gregory, 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, 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.

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A long-term care hospital is defined as a hospital licensed under Chapter 395, Florida Statutes, which meets the requirements of Part 412, subpart B, paragraph 412.23(e), Code of Federal Regulations; seeks exclusion from the acute care Medicare prospective payment system for inpatient hospital services and is 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.

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

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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.

In this comparative batch review, the three co-batched applicants have described their respective patient populations as “medically complex” and indicated they were high acuity patients. All co-batched applicants also indicated that the LTCH was the appropriate placement for these patients and that patients should not or could not be seen in a hospital-based or freestanding skilled nursing facility or a CMR. As noted by MedPAC, some portion of LTCH patients can be described as the co-batched applicants have described their respective patient populations, while others are of a lesser acuity level and could be treated in another post-acute care setting. As discussed below, it is the burden of any CON applicant applying outside of a state published fixed need pool to define its patient population and base need projections on that defined patient population. If, as here, the applicant proposes to serve a medically complex, high acuity patient population, then need projections should clearly identify that population and the medically complex high acuity population should be the only target.

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.

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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.

Earlier this year CMS responded to MedPAC's comments regarding recommendations that its Secretary evaluate LTCHs by establishing facility and patient criteria and LTCH monitoring protocols by Quality Improvement Organizations. CMS awarded a contract to Research Triangle Institute (RTI), International entitled "Long Term Care Hospital (LTCH) Payment System Refinement/Evaluation," for a thorough examination of the feasibility of implementing MedPAC's recommendations. That report was originally due in October of 2005, but extensions have been granted and as of this writing, the report has not been published.

According to documents posted on CMS's LTCH website the purpose of the RTI report is to:

"...protect the integrity of the Medicare program by insuring that Medicare is a prudent purchaser of LTC services. This will be accomplished by obtaining professional and technical services for the purpose of:

- 1) Performing policy and analytic analysis of LTCH patients and LTCHs for purposes of evaluating the feasibility of both patient and facility-level criteria to assure appropriate and cost-effective utilization of LTCHs as a provider category as recommended in MedPac's June 2004 RTC;*
- 2) Designing specific patient and facility-level criteria; This shall include an implementation approach, timelines, and estimated costs.*
- 3) Developing a plan to implement improvements to the LTCH PPS. This shall include short-term and long-term actions/recommendations, defining monitoring and refinement techniques, and the like.*

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The Medpac recommendations focus on development and monitoring of patient and facility criteria. They also raise several long-term and short-term questions for consideration and provide suggested patient and facility criteria. Medicare costs for episode of care at LTCHs are the highest for any provider type and therefore, it is vital that we establish an appropriate measure of what patients can best be treated at these hospitals and what the hospitals be required to provide..”

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 14 long-term care hospitals (LTCHs) with 876 beds licensed to operate in the State of Florida². There are an additional 317 approved, but not yet licensed LTCH beds³.

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

² Includes HealthSouth Lakeridge Hospital, a 40 bed long term care facility in District 8 licensed effective 6/9/05 and Kindred Hospital – Ocala, a 31 bed long term care facility licensed effective 10/27/05.

³ CON #9800 - Select Specialty Hospital-Escambia, Inc. to construct a 54 bed long term care hospital in District 1 was received after publication of the Florida Hospital Bed Need Projections & Service by District for the July 2005 batching cycle.

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Florida Approved-Not Yet Licensed Long-Term Care Hospital Beds		
Hospital	District	Beds
Select Specialty Hospital - Escambia, Inc.*	1	54
SemperCare Hospital of Tallahassee	2	29
Select Specialty Hospital - Alachua, Inc.	3	44
Kindred Hospital - North Florida	4	20
Select Specialty Hospital - Orange	7	40
Kindred Hospitals East, LLC	9	70
Select Specialty Hospital - Palm Beach, Inc.	9	60
Total		317

Source: Florida Hospital Bed Need Projections & Service Utilization by District published 07/29/05.

Note: *Select Specialty Hospital - Escambia, Inc.'s (CON #9800) 54 bed facility approval added per footnote below.

As shown in the table above, there are 317 approved, but not yet licensed LTCH beds distributed throughout Florida in Districts 1, 2, 3, 4, 7, and 9.

The average occupancy of the operational programs reporting utilization was 67.14 percent for the January - December 2004 reporting period. LTCH programs in operation for the total 12-month reporting period, ranged in occupancy from a low occupancy rate of 55.60 percent for Specialty Hospital Jacksonville to a high of 89.53 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 January through December 2004 reporting period:

Florida Long-Term Care Hospital Bed Utilization Calendar Year 2004					
Hospital	District	# Beds	Bed Days	Patient Days	Occupancy
Select Specialty Hospital - Panama City*	2	30	10,860	3,314	30.52%
Kindred Hospital - North Florida	4	60	21,960	19,660	89.53%
Specialty Hospital Jacksonville	4	107	39,162	21,776	55.60%
Kindred Hospital - Bay Area - St. Petersburg	5	82	30,012	20,143	67.12%
Kindred Hospital - Central Tampa	6	102	37,332	25,953	69.52%
Kindred Hospital - Bay Area-Tampa	6	73	26,718	16,737	62.64%
Select Specialty Hospital-Orlando, Inc.	7	35	12,810	9,131	71.28%
Kindred Hospital - South Florida - Hollywood	10	124	45,384	27,114	59.74%
Kindred Hosp.-South Florida-Ft. Lauderdale**	10	70	24,984	16,591	66.41%
Kindred Hospital South Florida Coral Gables	11	53	19,398	15,921	82.08%
Select Specialty Hospital-Miami	11	40	14,640	12,208	83.39%
Sister Emanuel Hospital for Continuing Care	11	29	10,614	8,771	82.64%
State Total***		805	293,874	197,319	67.14%

Source: Florida Hospital Bed Need Projections & Service Utilization by District published 07/29/05.

Notes: *Select Specialty Hospital - Panama City was license effective 1/5/04.

****Kindred Hospital - South Florida - Ft. Lauderdale added six beds effective 4/16/04.**

*****State Total & District 11 facility occupancy adjusted as 3rd & 4th quarter Bed Days per facility were incorrect.**

******As footnoted earlier, since this reporting period two LTCHs have been licensed: HealthSouth Lakeridge Hospital, a 40-bed long-term care facility in District 8 licensed effective 6/9/05 and Kindred Hospital - Ocala, a 31-bed long-term care facility licensed effective 10/27/05.**

The applicants expect to serve the residents of Lake & Sumter Counties, District 3. Promise also states that Hernando and Citrus Counties will

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be part of its service area but does not provide detail specific to admissions from these counties. As noted above, two new LTCHs have been approved for District 3, one recently licensed to Kindred Hospital - Ocala and one CON approved for Select Specialty Hospital - Alachua totaling 75 new LTCH beds in the district. Kindred Hospital-Ocala licensed effective October 27, 2005, has provided a letter in opposition to all projects indicating approval would negatively impact its facility.

As noted above, there have been two recently licensed and several recently approved LTCHs. The number of LTCHs in Florida has almost tripled in the past 10 years. In 1995, there were seven LTCHs in the state. By 2004 that number had increased to 12 and as of this writing there are six CON approved, not yet licensed LTCHs, bringing the total number of licensed and approved LTCH from seven in 1995 to 20 in 2005. Following is an inventory of existing, recently licensed, and CON approved LTCH beds by district:

Florida Long-Term Care Hospital Bed Inventory by District As of 11/2005			
Hospital	District	# Beds	Status
Select Specialty Hospital - Escambia, Inc.	1	54	CON approved
SemperCare Hospital of Tallahassee	2	29	CON approved
Select Specialty Hospital - Panama City	2	30	Operational in 2004
Select Specialty Hospital - Alachua, Inc.	3	44	CON approved
Kindred Hospital - Ocala	3	31	Licensed 10/05
Kindred Hospital - North Florida	4	*60	Operational in 2004
Specialty Hospital Jacksonville	4	107	Operational in 2004
Kindred Hospital - Bay Area - St. Petersburg	5	82	Operational in 2004
Kindred Hospital - Central Tampa	6	102	Operational in 2004
Kindred Hospital - Bay Area-Tampa	6	73	Operational in 2004
Select Specialty Hospital-Orlando, Inc.	7	35	Operational in 2004
Select Specialty Hospital - Orange	7	40	CON Approved
HealthSouth Lakeridge	8	40	Licensed 6/05
Select Specialty Hospital - Palm Beach, Inc.	9	60	CON Approved
Kindred Hospitals East, LLC	9	70	CON Approved
Kindred Hospital - South Florida - Hollywood	10	124	Operational in 2004
Kindred Hosp.-South Florida-Ft. Lauderdale	10	70	Operational in 2004
Kindred Hospital South Florida Coral Gables	11	53	Operational in 2004
Select Specialty Hospital-Miami	11	40	Operational in 2004
Sister Emanuel Hospital for Continuing Care	11	29	Operational in 2004
State Total		*1,173	

Source: Florida Hospital Bed Need Projections & Service Utilization by District published 07/29/05 and licensure records

***Kindred North Florida has 20 CON approved, not yet licensed beds, for 1,193 State total.**

The current bed complement, patient days and average occupancy of other forms of care in District 3 is presented as follows:

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**Acute Care and Post-Acute Care Providers
District 3 Beds and Utilization
Calendar Year 2004**

Facility Type	Total Beds District 3	District 3 Average Occupancy
Acute Care	3,562	67.30%
Comprehensive Medical Rehabilitation	115	76.67%
Hospital-Based Skilled Nursing	40	60.20%
Skilled Care Community Nursing Homes	7,528	89.77%

Source: Florida Hospital Bed Need Projections & Service Utilization by District for acute care & CMR beds for January 1, 2004 through December 31, 2004. Florida Nursing Home Utilization by District & Subdistrict January 1, 2004 through December 31, 2004, Avante of Mt. Dora, a 116-bed community nursing home located in Lake County failed to report utilization for the 4th quarter 2004. HBSNU Utilization by District & Subdistrict for January 2004-December 2004.

As previously noted, LTCHs are designed to treat patients with medical conditions requiring extended hospital-level services, for a period of time of at least 25 days on average. The applicants state that their proposals will provide LTCH services to patients with complex and medically unstable conditions that cannot be adequately addressed in licensed acute care beds, comprehensive medical rehabilitation beds, hospital-based skilled nursing unit beds, and nursing home beds in the service planning area. However, despite claims that proposals are for medically complex high acuity patients, no co-batched applicant demonstrated that a large portion of these identified patients are not currently appropriately being served in other post-acute settings after acute care discharge settings or that a number of patients are kept in acute care beds where treatment resulted in inappropriate care or where outcomes would have improved had long-stay patients been treated in a LTCH.

The MedPAC analysis of LTCHs found that between seven and eight percent of patients with the highest probability of using LTCHs used rehabilitation hospital services in markets both with and without LTCHs. Rehabilitation utilization in District 3 was 76.67 percent during CY 2004. This percentage is below the 85 percent benchmark for that service.⁴ As MedPAC points out, the diagnostic related group (DRG) itself or the length of stay in any particular group is not necessarily an indicator of need. MedPAC's findings indicate that lower acuity patients within any DRG can appropriately be served in a skilled nursing facility (SNF) at a lower cost as LTCHs are usually the most costly post-acute care setting at about three to 12 times that of SNFs. As noted above, SNF utilization in District 3 averaged 89.77 percent for the most recent reporting period.

⁴ Section 59C-1.039 Florida Administrative Code sets the occupancy standard at 85 percent for fixed need pool calculations.

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This utilization rate is significantly below the benchmark for SNF care set in the Florida Statutes at 94 percent.⁵ It is noted that each co-batched applicant analyzed data for its bed need projections on patients being treated in an acute care bed. Therefore, the identified patient populations in all need analyses presented in this review are not currently being treated in a post-acute care bed. Comments above are not meant to suggest that extended lengths of stay in acute care beds are inappropriate or that the acute care facility should have transferred or discharged the patient sooner. As noted earlier, LTCH lengths of stay must average 25 days. Both Select and Promise based projected bed need on acute care stays that were shorter than 25 days. LRMC's need methodology is somewhat different, but is similarly based. Therefore, applicants have assumed that the patient will stay in the LTCH some overlapping portion of the time they were in an acute care bed and some portion of the time they were in a post-acute setting. The comments above regarding skilled nursing care and CMR care are meant to address the post-acute days beyond the acute care stay. MedPAC has identified that not all LTCH patients are medically complex/high acuity and some percentage could have appropriately been treated in a less costly manner. It is again noted that it is the responsibility of the CON applicant, when need is not published, to show that need exists and to demonstrate that the patient population it has identified as needing services is actually the targeted population in need projections.

Although the applicants contend that LTCHs serve a distinct population they do not show that the patient population they expect to serve cannot appropriately be served in other post-acute care settings or by existing or proposed LTCHs within a reasonable proximity of their proposed facilities. Presented below are general findings regarding expected population growth in the district within the next five years.

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

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Population Estimates for District 3 Counties and Percent Change by County

County	Total July 2005	Total July 2010	Percent Change	Age 65+ July 2005	Age 65+ July 2010	65+ Percent Change
Alachua	239,711	256,970	7.20%	22,966	26,101	13.65%
Bradford	27,887	29,166	4.59%	3,866	4,362	12.83%
Citrus	131,534	143,803	9.33%	42,980	48,706	13.32%
Columbia	63,293	68,354	8.00%	8,884	10,236	15.22%
Dixie	15,697	17,167	9.36%	3,014	3,628	20.37%
Gilchrist	16,616	18,812	13.22%	2,335	2,780	19.06%
Hamilton	14,116	14,623	3.59%	1,568	1,719	9.63%
Hernando	147,563	162,538	10.15%	44,001	49,681	12.91%
Lafayette	7,731	8,122	5.06%	984	1,077	9.45%
Lake	258,665	296,905	14.78%	71,047	86,204	21.33%
Levy	38,611	42,594	10.32%	7,952	9,820	23.49%
Marion	298,390	333,227	11.67%	75,810	88,779	17.11%
Putnam	73,134	75,735	3.56%	14,039	15,354	9.37%
Sumter	68,605	80,181	16.87%	21,045	25,629	21.78%
Suwannee	39,002	42,991	10.23%	7,224	8,516	17.88%
Union	14,893	15,637	5.00%	1,250	1,517	21.36%
District Total	1,455,448	1,606,825	10.40%	328,965	384,109	16.76%
State Total	17,844,137	19,478,414	9.16%	3,153,525	3,601,571	14.21%

Source: AHCA Population Projections, published April 2005.

As shown above, the overall population in District 3 is expected to increase by 10.40 percent during the next five years, with the 65 and over age cohort increasing by 16.76 percent. Lake County, the second most populous county in the district and the proposed site of all three co-batched LTCH proposals, is expected to have the second highest percent increase in total population and fourth highest 65 and over population increase for the five-year projection period. Sumter County is the county with the highest expected percentage rate of growth overall and second highest 65 and over growth rate.

Below is a table illustrating the travel distances from the proposed facilities locations to other existing and CON approved LTCHs in the area.

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**Mileage Chart to Certain Existing & Approved LTCH Facilities
From the Proposed Applicant Locations**

	Kindred Hospital - Ocala	Select Specialty Hospital Orlando	Select Specialty Hospital Orange	Select Specialty Hospital-Alachua	Kindred Hospital Central Tampa	Kindred Hospital Bay Area Tampa
CON #9869 Leesburg Regional Medical Center North	30.9	48.5	49.3	68.3	80.7	88.8
CON #9870 Promise Healthcare of Florida III, Inc.	42.7	30.2	36.6	85.3	92.8	101.0
CON #9871 Select Specialty Hospital - Lake, Inc.	36.0	36.4	42.8	78.4	85.6	93.7

Source: www.expdiameter.com

Notes : CON #9870 Promise Healthcare site utilized is C-19A & Dillard Road in zip code 32778.

CON #9871 Select Specialty Hospital site utilized is Leesburg Regional Airport, as this location is most approximate to Leesburg Regional Medical Center & Florida Hospital-Waterman. Select Specialty Hosp.-Orange location (CON #9654) is 5579 S. Orange Avenue, Edgewood, Florida.

Select Specialty Hospital - Alachua location is Shands Teaching Hospital at the University of Florida, as Select CON #9704 indicated location would be freestanding approximate to Shands.

As shown in table above, there are two existing and one proposed LTCH within 50 miles of all three applicants' proposed locations and all are within 100 miles of two proposed and four existing facilities (with the exception of Promise (CON #9870) at 101 miles from Kindred Hospital-Bay Area-Tampa. There is at least one licensed LTCH within 40 miles of each proposed location and three proposed or licensed LTCHs within 50 miles driving distance.

As the applicants contend that their LTCH facilities will primarily serve residents of Lake and Sumter Counties (CON #9869 LRMC and CON #9871 Select Specialty) and Lake, Sumter, Hernando and Citrus Counties (CON #9870 Promise), the following table shows the LTCH facility of choice for residents of these counties.

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**Citrus, Hernando, Lake & Sumter County Residents
LTCH Facility Discharges
Calendar Year 2004**

Facility	Citrus	Hernando	Lake	Sumter	Facility Total
Kindred Hospital - Bay Area – Tampa	2	1	1	4	8
Kindred Hospital - Bay Area - St. Petersburg		2			2
Kindred Hospital - Central Tampa	10	27	1	8	46
Kindred Hospital - North Florida			4		4
Kindred Hospital - South Florida - Ft. Lauderdale				1	1
Select Specialty – Orlando			8		8
Specialty Hospital Jacksonville	1		2	1	4
County Total	13	30	16	14	73

Source: State Center for Health Statistics.

As shown above, Citrus, Hernando, Lake and Sumter Counties accounted for 73 LTCH patient discharges during CY 2004. As shown earlier, Kindred Hospital - Central Tampa, the LTCH with the majority of patient discharges from Citrus, Hernando and Sumter Counties, averaged occupancy of 69.52 percent during CY 2004. Select Specialty - Orlando, the largest provider of LTCH services to Lake County residents, averaged 71.28 percent occupancy during 2004. The state average was 67.14 percent for LTCH services. It is reasonable to expect many residents will to continue to seek services at these facilities, but it is also very likely that a number of residents will seek services in Kindred’s District 3 facility. As noted, it is also as likely that patients who live in Citrus County, for example, are willing to travel to Hillsborough County, that they will be equally as willing to travel a lesser distance from Citrus County to Kindred Hospital – Ocala (Marion County).

The applicants intend to focus on a segment of the District 3 patient population and must therefore demonstrate that this segment needs this service and is unable to receive it. It does not follow that the services are not available to this segment of District 3’s population because there is not a hospital physically located within the area the applicants wish to serve. If that were true, then anyone wishing to establish a hospital or any other health care service to serve a portion of a zip code or city block could claim that services were needed because there was an absence of services in that portion of the zip code or city block. Depending on where the line was drawn, this could mean across the street from an existing underutilized hospital. As noted at the beginning of this section and pursuant to section 59C-1.008 (2) (e) 3, Florida Administrative Code, 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 area⁶.

⁶ Underline added for emphasis

Discussions of the applicants' need analysis follows.

Leesburg Regional Medical Center, Inc. (CON #9869) indicates that the typical patients who benefit from long-term care include cardiac recovery from heart attacks or cardiac surgical procedures⁷, wound management for burns, multiple Stage II and IV decubiti, or other wounds following vascular or other surgery, pulmonary management for tracheotomies, oncology recovery, including chemotherapy and radiation therapy, rehabilitation for cerebral vascular accidents or complications following orthopedic surgery or care for medically complex conditions combined with diabetes, digestive disorders or renal disorders/failure.⁸ LMRC contends that these categories support the projected utilization of the proposed LTCH and need is based on population statistics, Florida LTCH use rates and the historical number of patients from LRMCs acute care host hospital that are likely to require LTCH care services. However, it is noted that many of patient care categories in the above areas include patients whose treatment is appropriate in less costly settings than the LTCH. More detail will be provided concerning this and LTCH use rate in the need discussion below.

Leesburg Regional Medical Center, Inc. projects that its primary service area will be Lake and Sumter Counties. The applicant contends that there is a need for additional LTCH beds even with the two CON approved facilities because the approved LTCHs are outside LRMCs primary service area. However, as noted earlier, the two LTCHs in District 3 were not operational when this proposal was initially submitted. Kindred's facility in Ocala was recently licensed and Select's facility in Alachua County is, as of this writing, not licensed. Distance, as discussed above, does not appear to be a prohibiting factor. Planning service areas for LTCH projects in Florida are districts. LTCH services are the most expensive post-acute care service and are generally provided to patients with complex medical conditions and therefore are not

⁷ It is noted that in a 2005 report to the Centers for Medicare and Medicaid services from *Rand Health*, the study found "Most congestive heart failure patients do not use Medicare-covered PAC in the 30 days after discharge, but of those who did, the vast majority used home health care or SNF.", page 21

⁸ It is noted that 10 of the 14 Lake & Sumter County nursing homes provide tracheotomy care. While it is noted that the District's nursing homes do not provide ventilator patient care, the newly licensed Kindred Ocala LTCH and the approved Select Specialty Hospital-Alachua LTCH will. Select Specialty Hospital -Orlando and the CON approved Select Specialty Hospital-Orange also include ventilator patient care. Appropriate post acute services may also be available at area rehabilitation hospitals because, as noted earlier, it is not clear that the applicant anticipates serving high acuity/medically complex patients that may have difficulty tolerating the intensity of services provided at rehabilitation hospitals, including the applicant's own rehabilitation facility.

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generally needed in each acute care planning area or dedicated to each acute care hospital. They are similar to comprehensive medical rehabilitation hospitals in this way and a district planning area is more appropriate than a subdistrict planning area for LTCH services.

The applicant presented letters of support for the project from six physicians on the medical staff at LRMC who provide general form letters of support that indicate that many patients who required hospitalization for approximately 18-35 days would benefit from a local long-term care hospital. These letters indicate these patients would be referred to the LTCH but do not provide the specific number of patients that would benefit. While Leesburg Regional Medical Center representatives and Mr. Timothy P. Menton, CEO of The Villages Regional Hospital indicated that they have patients that may have benefited from long-term hospital care, no other supporting documentation was provided by Leesburg Regional with regard to the ultimate placement of these patients or actual diagnosis to support possible LTCH placement.

LRMC also contends that its project should be approved because it is a not-for-profit entity with a commitment to providing charity and government sponsored indigent care to the residents of District 3 since 1963. The applicant proposes to condition approval to three percent of the LTCH's annual patient days being provided to Medicaid and charity care patients. However, the applicant anticipates delicensing 35 of its 120 skilled nursing facility beds and has 15-bed comprehensive medical rehabilitation beds. The current 120-bed skilled nursing facility had an average daily census of 91 beds in CY 2004 (33,027 patient days/43,920 beds days or 75.20 percent). LRMC also contends that 71.60 percent of its acute care patient days during the 12 months ended June 30, 2005, were appropriate for LTCH care. This again raises questions about whether the patient population described as needing LTCH care is actually the patient population currently being served in the hospital's skilled nursing and rehabilitation beds and if approved, the facility will continue to serve the same patient population with increased reimbursement.

The applicant provided an analysis of Lake and Sumter Counties, and District 3 population growth. According to the applicant's projections, Lake County is expected to grow by 29.4 percent (from 258,665 to 334,811 or by 76,146 persons) from July 2005 to July 2015. For the same time period, the applicant states that the 65 and over population is expected to increase by 48.9 percent (from 71,047 to 105,816 or by 34,769 persons). Sumter County is expected to grow by 33.79 percent (from 68,605 to 90,617 or by 22,012 persons) from July 2005 to July 2015. However, AHCA Population Estimates show the July 2005 Sumter County population at 91,785 resulting in a 33.92 percent increase. For

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the same time period, the applicant states that the 65 and over population is expected to increase by 46.86 percent (from 21,045 to 30,907 or by 9,862 persons). It is again noted that the applicant indicates it will delicense 35 of the 120 skilled nursing beds resulting in a capacity of 85 beds when its ADC averages 91 beds and considers 71.60 percent of its acute care patient days during the 12 months ended June 30, 2005, appropriate for LTCH care. District 3 is expected to grow by 20.6 percent from July 2005 to July 2015. However, the applicant does not provide the percent increase from July 2005 to the second year of operation for the project, which would be more pertinent to the need for the project. Also, the applicant's table had District 3 population increasing from 1,455,448 in July 2005 to 1,606,285 persons in July 2015. AHCA Population Estimates show the population provided for July 2015 is the July 2010 population, which results in a 10.40 percent increase from July 2005 to July 2010. For the same time period, the applicant states that the 65 and over population is expected to increase by 40.0 percent. The reviewer checked the applicant's projections with the AHCA Population Estimates published April 2005 and with the exceptions noted above they are correct.

With regard to short-term acute care, the applicant states that the need for long-term care hospitals stems from the acute care hospital patients that are medically unstable but past the imminent life-threatening state. LTCHs typically care for a more geriatric patient population and have been able to tailor clinical protocols and programs to serve these patients. With regard to comprehensive medical rehabilitation (CMR) services, the applicant states that rehabilitation patients must be able to tolerate at least three hours of therapies per day and are obviously medically stable, while LTCH patients are not. The applicant indicates that it will relocate its 15 CMR beds to another facility. With regard to hospital-based or nursing home skilled care, the applicant contends that these patients are generally less medically complex and are provided a more limited length of stay. It is again noted that, although in this discussion the applicant appears to indicate that it will only serve medically complex patients, discussion in other sections makes this less clear and suggest that the applicant intends to serve a lesser acuity patient population than is suggested here. Additionally, this does not show that medically complex post-acute patients were inappropriately cared for in this setting. The currently licensed 40 hospital-based skilled nursing beds in District 3 were utilized at only 60.20 percent, and the

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District's 7,528 skilled nursing beds reported 89.77 percent utilization for the calendar year 2004 reporting period. District 3's 115 CMR beds averaged 76.67 percent for the calendar year 2004 reporting period. LRMC Nursing Center, the applicant's 120-bed skilled nursing facility, averaged 75.20 percent and LRMC North, the applicant's 15-bed CMR facility, averaged 77.74 percent occupancy during CY 2004.

In the absence of an approved methodological approach to need for LTCH beds, the applicant presents two different methods for estimating need. The firm of Murer Consultants, Inc., was contracted to provide its copywrote Discharged Based Long Term Care Bed Need Methodology to the selected appropriate DRGs for long-term care hospital to the identified discharges.

The applicant indicates that using the Murer Consultants need methodology, 153 DRGs were identified to be appropriate for long-term care hospital treatment. This resulted in 10,467 discharges of the 15,473 LRMC patients discharged (67.65 percent) during the 12 months ended June 30, 2005, being included in its need analysis.

The applicant indicates that the first step involves a discharge based bed need methodology based on projecting the number of long-term care patient days with groupings of DRGs, then dividing the total of all patient days by 365 days to reach a total bed need for four major categories of long-term care. The projected patient days within each DRG grouping is calculated by multiplying the total number of discharges in a year from LRMC. This rate, according to the applicant, predicts the number of patients among this total who would benefit from long-term care based on industry averages. The resultant number is then multiplied by industry average lengths of stay in long-term care for that DRG grouping in order to reach the total patient days.

The applicant divided DRGs into four major areas for LTCH care: medically complex, respiratory, cardiovascular care and rehabilitation. The following table shows the applicant's cardiovascular care as an example of the application of the methodology. It is again noted that in a 2005 report to the Centers for Medicare and Medicaid services from *Rand Health*, the study found "Most congestive heart failure patients do not use Medicare-covered PAC in the 30 days after discharge, but of those who did, the vast majority used home health care or SNF."

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**Discharge Analysis Long-Term Care Hospital Bed Need
Cardiovascular Care
Leesburg Regional Medical Center
July 2004-June 2005**

Patient Category/DRGs	Total # of Discharges	Rate	LOS	Patient Days
Post Cardiac Surgery DRGs 103-108, 110, 111, 115, 116, 120, 525, 535, 536	999	10%	41	4,096
Circulatory Disorders DRGs 121, 122, 124, 125, 130, 131, 141, 144, 515, 516, 517, 518, 526, 527	2,662	20%	27	14,375
General Cardiac Care DRGs 126, 127, 135, 138, 140	963	15%	22	3,178
Total Patient Days				21,649
Total LTCH Beds Needed (Pt days/365)				59

Source: CON #9869, page 43.

The following chart shows the applicant's projected need based on LRMC discharges alone.

**Discharge Analysis Long-Term Care Hospital Bed Need
Leesburg Regional Medical Center
July 2004-June 2005**

Patient Category	Patient Days	Beds
Medically Complex	14,478	40
Respiratory	6,206	17
Cardiovascular Care	21,649	59
Rehabilitation	4,505	12
Total	46,838	128
Total Beds Needed at 85% Occupancy		151

Source: CON #9869, page 40.

The applicant's total bed need for 100 percent occupancy was stated to be 128; however, 128 beds would result in 100.26 percent occupancy. AHCA preliminary hospital utilization data for the 12-month period ending June 30, 2005 indicates that LRMC had a total of 65,423 patient days. Using the applicant's analysis, 71.60 percent (46,838/65,423) of LRMC's total patient days were actually long-term care patient days. This does not appear to be a reasonable expectation.

The applicant indicates that its predictor rate is defined as that percentage of all patient discharges under a selected DRG that might benefit from a long-term care hospital stay. As previously discussed, the June 2004 MedPAC Report to Congress indicates concern over current LTCH practice of serving patient populations with lower acuity levels that could appropriately and more cost-efficiently be served in SNFs or other post-acute care settings. In addition to comments made earlier and for example, the applicant's need analysis included 711 discharges in DRG 209 (Major Joint & Limb Reattachment Procedures of Lower Extremity)⁹, which is often more appropriate for settings other than LTCH. The

⁹ DRG 209 has been converted to DRG 544 for FY 2006.

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applicant has not demonstrated that its patient population will consist only of high acuity, medically complex patients and therefore it is likely that other forms of post-acute care are the appropriate and less costly settings for a large portion of its projected patient population. Furthermore, the applicant's acute patient days that it deems appropriate for LTCH care accounting for 71.60 percent of its total patient days for the 12 months ending June 2005, is quite large and appears to indicate that the applicant's LTCH would be treating patients who would otherwise be receiving the appropriate care in a less expensive setting.

The applicant also provides an analysis of the Villages Regional Medical Center's discharges. The Villages consists of 60 acute care beds that averaged 98.53 percent occupancy (21,578 patient days during the 12 months ended June 30, 2005). According to the applicant's methodology, 16,304 patient days of Villages' patient days were LTCH appropriate, resulting in a need for 45 LTCH beds at 100 percent occupancy. This translates to 75.56 percent of the Villages' total patient days being LTCH appropriate. The comments in the above paragraph to LRMC's facility specific need also apply to the Villages analysis.

The applicant next provides a "Population Based LTCH Bed Need Methodology" based on LTCH usage relative to total population in non-certificate of need states. This includes a LTCH factor per 100,000 population based on the incidence of LTCH beds to a given patient category/DRG as is typically found throughout non-certificate of need states. This methodology is formulated on the basis of estimated bed need as determined by the population as a whole. While the applicant indicates the population statistics utilized in this methodology was taken from the Florida Association of Counties website, it also states that the methodology is not dependent on population statistics based upon existing facilities, whether or not they are actually Medicare-certified as LTCHs. That being perfectly clear (page 52) the applicant indicates this methodology also utilizes predictor rates for both long-term care hospital need as well as average lengths of stay. It also predicts the number of long-term care hospital beds by product line for the population as seen in other areas of the country. The following table shows the district's proposed cardiovascular care as an example of this methodology.

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**Population Based Bed Need Methodology
District 3- Cardiovascular Care
July 1 Population of 1,380,457
Total Beds for LTCH Cardiac =7.30 Beds per 100,000**

Patient Category/DRGs	LTCH Factor per 100,000	Total Population in 100,000s	LTCH Beds Needed
Post Cardiac Surgery	1.61	13.80	22.23
Circulatory Disorders	3.28	13.80	45.28
General Cardiac Care	2.41	13.80	33.27
Total LTCH Beds Needed			101

Source: CON #9869, page 56.

The following chart shows the applicant's total projected LTCH need based on its methodology for District 3 for its estimated 2005 population. The applicant cites the AHCA Population Estimates for July 1, 2005 in its narrative of 1,455,448 but the tables have 1,380,457 based on the Florida Association of Counties website.

**Population Based Bed Need Methodology
District 3
July 1 2005 Population of 1,380,457**

Product Line	Beds
Respiratory	102
Medically Complex	123
Cardiovascular Care	101
Rehabilitation	56
Total	383
Total Beds Needed at 85% Occupancy	450

Source: CON #9869, page 58.

The table actually adds to 382 beds but the applicant has 383 probably due to rounding. The above table is the applicant's projected need for CY 2005, which is used as a baseline for its projections. LRMC states that the LTCH bed need will be 487 at 100 percent occupancy and 572 at 85 percent occupancy by 2015. The applicant does not provide sufficient documentation to analyze the numbers utilized in its "population based" projections and its District 3 projection for 2015, and it is not explained as to why the applicant chose 2015 for its projections nor use rates based on non-certificate of need states' experience. The applicant's choice of 2015 is inconsistent with the proposed project's operation in that the facility is projected to be operation in May 2008 per Schedule 10 or June 2006 per Schedule 7A as year two is stated to end June 30, 2008. It is noted that the methods by which the applicant determined need included the application of a projection of 85 percent occupancy;

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long-term care hospitals statewide experienced 67.14 percent occupancy during CY 2004. Need methodologies based solely on population, which do not consider utilization of the service, are not generally considered accurate indicators of numeric need. The applicant's methodology results in a high ratio of acute care discharges to LTCH admissions and does not appear reasonable.

The applicant did not demonstrate need in District 3 where there is currently one recently licensed but not fully operational and one approved, not yet licensed, LTCH. In addition, the applicant's need analysis does not specifically consider patients that may be LTCH appropriate that could not be more appropriately treated in lower cost long-term care facilities such as nursing homes and rehabilitation hospitals. For example, the applicant's need analysis included discharges in DRG 209 (major joint and limb reattachment procedures of lower extremity) and many cardiac DRGs, that are often more appropriate for settings other than LTCH. The applicant's facility specific projections for LTCH need for CY 2005 would seem to confirm this as LRMC had 71.60 percent of its total patient days for the 12 months ending June 2005 and Villages at 75.56 percent acute care facilities patient days that could be LTCH days based on the proposed need methodology. The applicant failed to show that an access problem exists in the district. Despite claims that this proposal is for medically complex high acuity patients needing and not receiving the most appropriate level of care, the applicant failed to show that a large portion of these identified patients are not currently appropriately being served in other post-acute settings after acute care discharge or that a number of patients are kept in acute care beds where treatment resulted in inappropriate care or where outcomes would have improved had long-stay patients been treated in a LTCH.

Approval of the project could negatively impact Kindred Hospital Ocala's newly opened facility located approximately 30.9 miles from Leesburg's project location and the yet to be opened LTCH approved in Alachua County.

Promise Healthcare of Florida III, Inc. (CON #9870) provides a discussion of the LTCH hospital patient setting compared to other care settings. The LTCH patient is described as meeting the necessity for acute care, needing medically complex care with multiple co-morbidities (five or more diagnosis identified) and having access to critical, intense medical interventions and services such as acute ventilator management and weaning, cardiac monitoring, pharmacy, diagnostic services, etc.

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However, as previously discussed, the June 2004 MedPAC Report to Congress indicates concern over the current LTCH practice of serving patient populations with lower acuity levels that could appropriately and more cost-efficiently be served in SNFs or other post-acute care settings. In response to this the applicant provided an analysis of typical cases and indicated that the key factor in identifying the most appropriate setting should be a comprehensive assessment of the patient but acknowledges that from a clinical perspective the determination for LTCH admission is not clear. As previously stated, the current Medicare reimbursement system, which although it does account for case-mix differences between patients, does not account for differences within each case-mix category, there is an incentive to admit patients with the least need for resources among those in the same diagnostic group.

The applicant also provides a detailed description of the levels of care; short-term acute care, LTCH, inpatient rehabilitation care, skilled nursing and home health in a chart format. Essentially these contend that LTCH care is distinct from short-term care, rehabilitation care and skilled nursing care. With regard to hospital-based or nursing home skilled care, the applicant contends that these patients are generally less medically complex and are provided a more limited length of stay. However, this does not show that medically complex post-acute patients were inappropriately cared for in this setting. The currently licensed 40 hospital-based skilled nursing beds in District 3 were utilized at only 60.20 percent and the district's 7,528 skilled nursing beds reported 89.77 percent utilization for the calendar year 2004 reporting period.

The applicant indicates its facility will be located at one of four sites in Lake County and will serve Lake, Sumter, Hernando and Citrus counties. The applicant provides a discussion of the total District 3 population consistent with the AHCA Population Estimates cited above, indicating that the total district population will grow by 10.4 percent between 2005 and 2010 and the 65 and over population by 16.8 percent.

Promise also discusses the travel distance to existing LTCHs but indicates the approved LTCHs will not meet the need for the four southern District 3 counties. However, the newly opened Kindred Hospital Ocala LTCH is 30.2 miles from the applicant's proposed location (see Mileage Chart to Certain Existing & Approved LTCHs).

Promise Healthcare indicates that its need analysis contains the following assumptions: Acute care and IRFs are not appropriate substitutes for LTCHs, a SNF would require specialized programs to care for similar populations; and LTCH patients cost Medicare more than similar patients who use alternative settings if similar services are available; however, when LTCH care is targeted to patients of the highest

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severity, the cost is similar. The applicant evaluated the number of CY 2004 discharges in District 3 hospitals above age 18 whose length of stay exceeded the geometric mean length of stay of the DRG associated with the discharge plus 15 days and only included DRGs (listed in attachment L of the application) that were discharged from existing LTCHs in Florida. This resulted in 1,667 acute care District 3 hospital discharges and approximately 63,400 patient days, or an ALOS of 38 days according to the applicant. The applicant's chart on page 34 of the application indicated the total patient days were 63,429, which results in an ALOS of 38.05 days.

The applicant applies the 2.9 percent age-adjusted average growth rate which, it states is based on the age 18 and over population growth from 2005 to 2010 (actually its July 2004 – July 2010 as July 2005 – July 2010 results in 2.3 percent) to the district LTCH discharges and determines that there will be 1,978 LTCH discharges in District 3 in 2010. However, due to Medicare reimbursement changes the applicant indicates a decrease the LTCH potential discharges by 25 percent based on its perception that 25 percent of the population will be better served in skilled/long-term care facilities. This results in 1,484 discharges (1,978 – 494 (25 percent)) projected for CY 2010. The applicant next addresses the length of stay and contends that due to projected Medicare reimbursement changes creating more restrictive patient admission criteria, LTCH length of stay may increase slightly. However, to be conservative the applicant keeps the CY 2004 Florida LTCH length of stay of 34.5 days for its need calculation. This results in 51,192 projected LTCH patient days (1,484 x 34.5) in 2010.

The following chart shows the applicant's need projections.

**Promise Healthcare of Florida
LTCH Bed Need
District 3**

	CY 2004	CY 2009	CY 2010
Acute Care Discharges	1,667	1,923	1,978
Potential Reduction in Discharges	0	481	495
Adjusted Discharges	1,667	1,442	1,484
Projected Days at 34.5 ALOS	57,512	49,752	51,192
Average Daily Census	158	136	140
Bed Need at 80 Percent	197	170	175
Existing Operational/Approved LTCH Beds	75	75	75
Total LTCH Beds Needed	122	95	100

Source: CON #9670 page 36.

The applicant indicates that its proposed hospital size of 40 beds for Lake County is based on its proposed service to residents of Lake, Sumter, Hernando and Citrus Counties. While the methods by which the applicant determined need included the application of a projection of 80 percent occupancy; long-term care hospitals statewide experienced 67.14

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percent occupancy during CY 2004. The applicant presented no letters of support from Lake, Sumter, Hernando and Citrus Counties or District 3 for the project. Much of its discussion centers on the travel distance from the acute care hospitals in these counties to existing LTCH hospitals based on District 3 residents most used LTCH facilities. However, this does not take into account changes in Florida law that allow newly licensed Kindred Hospital Ocala and the CON approved Select Hospital-Alachua to add beds at any time without CON approval. Although the applicant has recognized and accounted for the 75 new beds in the area, this need methodology assumes that the recently licensed and the CON approved, not yet licensed, facility will not add beds if the market shows need for additional beds once the new hospitals are fully operational and additional bed need can be determined. Unlike co-batched applicant LRMC, Promise has not selected a site and provided four possible sites for the project, and travel distance estimates were made and discussed earlier. The Lake County project is within 40 miles of three LTCHs, two in adjacent Orange County and Kindred's Ocala facility. There is no indication that needed services are not available within reasonable travel times.

The applicant failed to provide any evidence of an access problem in the district. Despite claims that this proposal is for medically complex high acuity patients needing and not receiving the most appropriate level of care, the applicant failed to show that a large portion of these identified patients are not currently appropriately being served in other post-acute settings after acute care discharge or that a number of patients are kept in acute care beds where treatment resulted in inappropriate care or where outcomes would have improved had long-stay patients been treated in a LTCH.

Approval of the project could negatively impact Kindred Hospital Ocala's newly opened facility located approximately 40.2 miles from the applicant's proposed project location (based on a selected site from the four proposed sites) and the yet to be opened LTCH approved in Alachua County. It is also noted that the CON approved yet to be operational Select Specialty Hospital-Orange is within approximately 36 miles of the proposed location and Select Specialty Hospital-Orlando is within 31 miles.

Select Specialty Hospital-Lake, Inc. (CON #9871) indicates that the typical patients who benefit from long-term care include post-surgical and trauma patients, wound care patients, head injury and spinal cord injury patients, patients with diseases such as muscular dystrophy, Gillain Barre syndrome and Myasthenia Gravis, respiratory/ventilator dependent patients and other medically complex patients who require extensive physiological monitoring, intravenous therapies, dialysis or

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post-operative care. Select's services include medically complex care for a range of underlying conditions and symptoms requiring intensive therapies and nursing care to maintain normal breathing without mechanical support, specialized care for patients with acute or chronic respiratory disorders who may have tracheotomies, ventilators or require extensive respiratory treatments to maintain normal breathing without mechanical support, wound/skin care, and care for patients who are unable to withstand three hours of intensive therapy a day or who require too high a degree of nursing or respiratory care to be acceptable for most acute rehabilitation programs.

Select Specialty Hospital-Lake, Inc. projects that its primary service area will be Lake County and Sumter County will be the secondary service area. The applicant presented no letters of support from Lake or Sumter County or District 3 for the project. With regard to short-term acute care, the applicant states that the need for long-term care hospitals stems from the patients that are surviving complicated surgical interventions or traumatic injuries only to need long-term life support and various other therapies. With regard to comprehensive medical rehabilitation (CMR) services, the applicant states that some rehabilitation will be offered at the LTCH but contends that LTCH care exceeds CMR care in terms of nurse hours per patient (up to 12 LTCH vs. three-five CMR) with one of the comparisons being stated that 22 percent of LTCH admissions expire compared to less than one percent of CMR patients. With regard to hospital-based or nursing home skilled care, the applicant contends that these patients are generally less medically complex and are provided a more limited length of stay. However, this does not show that medically complex post-acute patients were inappropriately cared for in this setting. As discussed earlier, criteria needed for LTCH admissions is being looked at by CMS. Lesser acuity medically complex patients are more appropriately treated in post-acute settling other than LTCH, which is the most expensive. The currently licensed 40 hospital-based skilled nursing beds in District 3 were utilized at only 60.20 percent and the district's 7,528 skilled nursing beds reported 89.77 percent utilization for the calendar year 2004 reporting period.

The applicant provided an analysis of the Lake County, Sumter County and District 3 population growth. According to the applicant's projections, Lake County population is expected to grow by 15.2 percent (from 251,091 to 289,339 or by 38,245 persons) from July 2004 to July 2009 (the second year of operation of the proposed project). For the same time period, the applicant states that the 65 and over population is expected to increase by 21.7 percent (from 68,128 to 82,909 or by 14,781 persons). Sumter County is expected to grow by 18.1 percent (from 65,941 to 77,900 or by 11,959 persons) from July 2004 to July

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2009 (the second year of operation of the proposed project). For the same time period, the applicant states that the 65 and over population is expected to increase by 26.1 percent (from 19,619 to 24,747 or by 5,128 persons). District 3 is expected to grow by 10.8 percent (154,182 persons) from July 2004 to July 2009. For the same time period, the applicant states that the 65 and over population is expected to increase by 8.0 percent. The reviewer checked the applicant's projections with the AHCA Population Estimates published April 2005 and they are correct.

In the absence of an approved methodological approach to need for LTCH beds, the applicant presents four different methods for estimating need. The first involves an extended length of stay analysis specific to Lake County based on the county's three acute care hospitals (Leesburg Regional, Florida Hospital Waterman and South Lake Hospital) discharges. The second and third methods address the geometric mean length of stay plus 15 days and 10 days, for Lake and Sumter Counties, respectively. The fourth method is a patient length of stay exceeding 24 days discharge analysis comparing Lake and Sumter and Counties without LTCHs to counties with LTCHs. The applicant's various methodologies fail to show acuity levels of identified patients or that a large portion of identified patients are not currently appropriately being served in other post-acute settings after acute care discharge or that a number of patients are kept in acute care beds where treatment resulted in inappropriate care or where outcomes would have improved had long-stay patients been treated in a LTCH.

With regard to the extended length of stay analysis, the applicant selected what it determined to be the top DRGs from Lake and Sumter Counties it considered appropriate for LTCH stay. The evaluation of the hospital discharges excluded lengths of stay of less than 24 days, patients under the age of 14, psychiatric diagnosis, substance abuse diagnosis, obstetric diagnosis, newborn diagnosis and rehabilitation diagnosis. The net number of discharges were then identified in an attempt to show potential need for LTCH beds. The applicant arrived at a total of 218 hospital discharges with a length of stay 24 days and greater. The applicant multiplied the potential number of patients by the average length of stay for LTCHs in Florida (35.0 days) to arrive at total patient days and then divided this number by 365 to arrive at the average daily census of 21 patients. Based on an 80 percent occupancy rate, the applicant arrived at a need for 26 beds in support of its 44-bed request. The expected length of stay of 35.0 days may be overstated. The ALOS for LTCH patients in the state is based largely on Kindred facilities focus on ventilator/pulmonary services and a corresponding longer length of stay. Kindred operated seven of the 12 operational LTCHs in the state that reported utilization in 2004. Unlike Kindred, Select does not indicate a focus on ventilator dependent patients. A

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more realistic method using a 28 to 30 day length of stay supports an average daily census of 17 to 18 patients or a potential hospital specific need, absence other factors, for 21 to 22 beds based on an 80 percent occupancy rate. Further, as noted earlier, no evidence has been presented by the applicant indicating that area residents needed LTCH services but were unable to obtain them from one of the several venues of post-acute services currently available within a reasonable distance, in District 3. There is one newly licensed LTCH and one CON approved LTCH in District 3, one within 36 miles and the other within 79 miles of the project's proposed location that have yet to begin operation. Orlando has one licensed and one approved LTCH that are within 43 miles of the applicant's proposed location.

The second method examines the geometric mean length of stay plus 15 days to arrive at 283 potential LTCH discharges and a bed need for 34 beds. This method results in a count similar to the extended length of stay method previously discussed and is also based on an average length of stay of 35.0 days. The third method examines the geometric mean length of stay plus 10 days to arrive at 773 potential LTCH discharges and a rather liberal need for 74 beds (93 at 80 percent occupancy). Additionally, as noted above, there is no evidence that the patients the applicant projects it can serve cannot be served in existing and CON approved health care settings in District 3.

The fourth method provides a more detailed, patient specific extended stay analysis comparison of Lake and Sumter County hospital discharges with average length of stays greater than 24 days to LTCH facilities compared to counties with LTCHs. For CY 2004, the applicant identified 432 discharges with 24 days or greater length of stay. According to the applicant, this analysis resulted in 4.5 percent of Lake County discharges and 17.5 percent of Sumter County discharges resulting in admissions to LTCHs. This compares to the 23.3 percent LTCH discharges as percentage of the county total for counties that have LTCHs. However, Sumter County LTCH penetration rate exceeded the rate of two of the eight counties (Orange and Pinellas) with LTCHs. The applicant contends that this demonstrates that counties without an LTCH with sufficient long-stay patients have an access and bed availability problem throughout the state. However, this does not take into account CON approved LTCHs within close proximity to Lake County. This analysis does not provide a potential bed need but rather presents length of stay discharge data in support of the applicant's perceived need for LTCH services and to show that these patients are not candidates for other post-acute settings. There was no documentation provided that patients are being inappropriately cared for. The fact that a patient stays in an acute care bed for 24 days or longer does not, in and of itself, demonstrate that the patient needed LTCH services for some

portion of that stay rather than the acute care services the patient received.

As with any LOS methodology, certain variations in patient characteristics can alter assumptions of need. These include the patient's functional ability, availability of caregivers at home, ethnicity, age, socio-demographics, and dependence on technology. Documentation from area hospital planners or area physicians with regard to discharges of potential LTCH patients is the best evidence of unmet need. The applicant did not provide this evidence.

In summary, the applicant failed to provide strong supporting documentation from area physicians or hospital discharge planners regarding potential referrals. The applicant's use rate approach is based on the experience of other LTCHs in other parts of the state and relies on assumptions that may or may not occur in the proposed service area. With regard to the LOS methodological approach, the applicant's projections are based on assumed capture rates with no supporting data or indication of potential referrals from area hospitals. It is noted that the methods the applicant determined need included the application of a projection of 80 percent occupancy; long-term care hospitals statewide experienced 67.14 percent occupancy during CY 2004. As noted above and like co-batched applicants despite claims that this proposal is for medically complex high acuity patients needing and not receiving the most appropriate level of care, the applicant failed to show that a large portion of these identified patients are not currently appropriately being served in other post-acute settings after acute care discharge or that a number of patients are kept in acute care beds where treatment resulted in inappropriate care or where outcomes would have improved had long-stay patients been treated in a LTCH. It was further not demonstrated that an access problem exists in the district.

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.**

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In charts below, utilization for area acute and post-acute care providers is again presented as is LTCH inventory and utilization statewide. Occupancy in existing LTCHs does not demonstrate excessive demand for this service and despite that fact, a number of additional LTCH facilities have been approved in recent years so that there is now an existing or approved LTCH(s) in every state district planning area. Additionally, as previously discussed, utilization in area acute and post-acute care beds is not high, indicating that there are acute and post-acute beds available for district residents to access.

CONs have been issued to establish two LTCHs within District 3 for a total of 75 LTCH beds. Kindred Hospital Ocala, a 31-bed LTCH was licensed effective October 27, 2005. The 44-bed Select Hospital – Alachua is not yet operational. Therefore, LTCH utilization in District 3 cannot be shown.

**Acute Care and Post-Acute Care Providers
District 3 Beds and Utilization
Calendar Year 2004**

Facility Type	Total Beds District 3	District 3 Average Occupancy
Acute Care	3,562	67.30%
Comprehensive Medical Rehabilitation	115	76.67%
Hospital-Based Skilled Nursing	40	60.20%
Skilled Care Community Nursing Homes	7,528	89.77%
Kindred Hospital – Ocala	31	Recently licensed
Select Hospital – Alachua	44	CON approved

Source: Florida Hospital Bed Need Projections & Service Utilization by District for acute care & CMR beds for January 1, 2004 through December 31, 2004. Florida Nursing Home Utilization by District & Subdistrict January 1, 2004 through December 31, 2004, Avante of Mt. Dora, a 116-bed community nursing home located in Lake County failed to report utilization for the 4th quarter 2004. HBSNU Utilization by District & Subdistrict for January 2004-December 2004

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Florida Long-Term Care Hospital Bed Inventory by District As of 11/2005			
Hospital	District	# Beds	Status
Select Specialty Hospital - Escambia, Inc.	1	54	CON approved
SemperCare Hospital of Tallahassee	2	29	CON approved
Select Specialty Hospital - Panama City	2	30	Operational in 2004
Select Specialty Hospital - Alachua, Inc.	3	44	CON approved
Kindred Hospital - Ocala	3	31	Licensed 10/05
Kindred Hospital - North Florida	4	*60	Operational in 2004
Specialty Hospital Jacksonville	4	107	Operational in 2004
Kindred Hospital - Bay Area - St. Petersburg	5	82	Operational in 2004
Kindred Hospital - Central Tampa	6	102	Operational in 2004
Kindred Hospital - Bay Area-Tampa	6	73	Operational in 2004
Select Specialty Hospital-Orlando, Inc.	7	35	Operational in 2004
Select Specialty Hospital - Orange	7	40	CON Approved
HealthSouth Lakeridge	8	40	Licensed 6/05
Select Specialty Hospital - Palm Beach, Inc.	9	60	CON Approved
Kindred Hospitals East, LLC	9	70	CON Approved
Kindred Hospital - South Florida - Hollywood	10	124	Operational in 2004
Kindred Hosp.-South Florida-Ft. Lauderdale	10	70	Operational in 2004
Kindred Hospital South Florida Coral Gables	11	53	Operational in 2004
Select Specialty Hospital-Miami	11	40	Operational in 2004
Sister Emanuel Hospital for Continuing Care	11	29	Operational in 2004
State Total		*1,173	

Source: Florida Hospital Bed Need Projections & Service Utilization by District published 07/29/05 and licensure records

***Kindred North Florida has 20 CON approved, not yet licensed beds, for 1,193 state total.**

Florida Long-Term Care Hospital Bed Utilization Calendar Year 2004					
Hospital	District	# Beds	Bed Days	Patient Days	Occupancy
Select Specialty Hospital - Panama City*	2	30	10,860	3,314	30.52%
Kindred Hospital - North Florida	4	60	21,960	19,660	89.53%
Specialty Hospital Jacksonville	4	107	39,162	21,776	55.60%
Kindred Hospital - Bay Area - St. Petersburg	5	82	30,012	20,143	67.12%
Kindred Hospital - Central Tampa	6	102	37,332	25,953	69.52%
Kindred Hospital - Bay Area-Tampa	6	73	26,718	16,737	62.64%
Select Specialty Hospital-Orlando, Inc.	7	35	12,810	9,131	71.28%
Kindred Hospital - South Florida - Hollywood	10	124	45,384	27,114	59.74%
Kindred Hosp.-South Florida-Ft. Lauderdale†	10	70	24,984	16,591	66.41%
Kindred Hospital South Florida Coral Gables	11	53	19,398	15,921	82.08%
Select Specialty Hospital-Miami	11	40	14,640	12,208	83.39%
Sister Emanuel Hospital for Continuing Care	11	29	10,614	8,771	82.64%
State Total‡		805	293,874	197,319	67.14%

Source: Florida Hospital Bed Need Projections & Service Utilization by District published 07/29/05.

Notes: *Select Specialty Hospital - Panama City was licensed effective 1/5/04.

†Kindred Hospital - South Florida - Ft. Lauderdale added six beds effective 4/16/04.

‡State Total & District 11 facility occupancy adjusted as 3rd & 4th quarter Bed Days per facility were incorrect.

§As footnoted earlier, since this reporting period, two LTCHs have been licensed: HealthSouth Lakeridge Hospital, a 40 bed long term care facility in District 8 licensed effective 6/9/05 and Kindred Hospital - Ocala, a 31 bed long term care facility in District 3 licensed effective 10/27/05.

Leesburg Regional Medical Center, Inc. (CON #9869) contends that with the approval of this project availability and accessibility to LTCH services will increase because there are currently no LTCHs in its proposed service area. However, Kindred Hospital Ocala licensed effective October 27, 2005, is within approximately 31 miles from the applicant's proposed location, Select Specialty Hospital Orlando is approximately 49 miles and the 40-bed CON approved, but not yet

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established District 7 LTCH by Select Specialty Hospital – Orange is less than 50 miles from Leesburg’s location. In addition, the CON approved District 3 Select Specialty Hospital – Alachua is approximately 69 miles from the project’s location. The applicant did not demonstrate that residents in the area who need LTCH services 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. However, as discussed earlier, there is some confusion regarding the level of care proposed by the applicant. 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 most costly post-acute care setting at about 12 times that of SNFs. The SNF utilization rate in District 3 averaged 89.77 percent for CY 2004. LRMC’s 120-bed nursing bed average 75.20 percent occupancy during CY 2004. The utilization rate is below the benchmark for SNF care in Florida Statutes at 94 percent.¹⁰

According to the applicant, the proposed facility will improve the efficiency of its services, as it will be able to provide a full-range of care. However, the applicant did not demonstrate what efficiencies would be achieved as a result of this proposed project.

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. Approval of the project could negatively impact Kindred Hospital Ocala’s newly opened facility located approximately 31 miles from LRMC’s project location and the yet to be opened LTCH approved in Alachua County.

Promise Healthcare of Florida III, Inc. (CON #9870) restates its contention that because there are no LTCHs within a short driving distance of Lake County, its facility will greatly reduce travel time and increase availability and accessibility of LTCH services. The applicant failed to provide any evidence that LTCH appropriate patients are not currently being placed or that an access problem exists in the district. As previously stated, approval of the project could negatively impact Kindred Hospital Ocala’s newly opened facility located approximately 40.2 miles from the applicant’s proposed project location and the yet to be opened LTCH approved in Alachua County. It is also noted that the CON approved yet to be operational Select Specialty Hospital-Orange is

¹⁰ Subsection 408.034 (5), Florida Statutes, as amended July 1, 2004, sets the skilled nursing occupancy standard at 94 percent.

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within approximately 36 miles of the proposed location and Select Specialty Hospital-Orlando is within 31 miles.

As previously discussed, the applicant did not provide letters from area hospitals and physicians regarding potential LTCH referrals. Specific documentation from area providers with regard to delays in care would have been supportive and beneficial in showing an access problem to long-term care in the area.

In response to quality of care, the applicant discussed its corporate experience in monitoring care, outcomes and patient satisfaction.

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.

Select Specialty Hospital-Lake, Inc. (CON #9871) contends that Lake County and Sumter County are underserved with regard to the accessibility and availability of LTCH services and that clinically-appropriate patients are remaining in inappropriate bed situations.

As previously discussed, the applicant did not provide letters from area hospitals and physicians regarding potential LTCH referrals. Specific documentation from area providers with regard to delays in care would have been supportive and beneficial in showing an access problem to long-term care in the area.

In response to quality of care, the applicant discussed its corporate experience in monitoring care, outcomes and patient satisfaction. Select currently has three existing operational LTCH in Florida.

The applicant did not demonstrate need for the project as evidenced by the availability, quality of care, accessibility, and extent of utilization of existing health care facilities and health services in the applicant's service area. Approval of the project could negatively impact Kindred Hospital Ocala's newly opened facility located approximately 36 miles from Select's project location and the yet to be opened LTCH approved in Alachua County.

- 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.**

Leesburg Regional Medical Center, Inc. (CON #9869) states that it has an operational history of providing innovation, quality care and community service since 1963. The applicant states that LRMC is

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accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). LRMC's cardiovascular program was awarded the Solucient 100 Top Hospitals: Cardiovascular Benchmarks for Success award in CY 2004. A copy of the award notification is contained in the application in Appendix 2.

The applicant does not provide a description of the admission, care planning and discharge process nor its quality management functions. However, its need analysis provides an insight into the patients it plans to admit and provide care to in the LTCH. The review of the applicant's complaint history as of October 6, 2005 indicates there were no confirmed complaints for the past three years.

Promise Healthcare of Florida III, Inc. (CON #9870) is a new, development stage corporation, and as such has no operating history. However, the applicant is a controlled entity of Promise Specialty Hospital, Inc., an existing provider of LTCH services in six states with 12 LTCH facilities. The applicant provides a reasonable description of Promise Specialty's quality of care. The Promise Healthcare Code of Conduct is provided in Attachment M. Attachment D contains Promise Specialty Hospital's pre-admission screening document and Attachment E contains its standards of performance.

Select Specialty Hospital - Lake, Inc. (CON #9871) is a new, development stage corporation, and as such has no operating history. However, the applicant is a controlled entity of Select Medical Corporation, an existing provider of LTCH services nationwide with 98 existing facilities, including one in Miami, Florida that was licensed on December 23, 2002. Six confirmed complaints have been received on the parent corporation's Miami facility as of October 6, 2005. These involve patient care (one), pressure sores (one), use of restraints (one), medicine problems/errors/formulary (one), patient abuse/neglect (one) and infection control (one). Select Specialty Hospital – Orlando, one of the two former SemperCare facilities, that Select is the licensee of as of March 11, 2005, has had three confirmed complaints from March 11, 2005 through October 6, 2005. These involve medicine problems/errors/formulary (two) and patient care (one). The Panama City facility licensed on January 5, 2004, does not have any confirmed complaints.

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The applicant provided a description of Select Medical Corporation's performance improvement plan that establishes specific methods and techniques for monitoring and improving care delivery. A copy of Select Specialty Hospital's plan for improving organizational performance, year 2003, is included in Attachment 11 in Volume 2 of the application. Attachment 8 (Volume 2) contained Select Medical's plan for the provision of patient care/services and Attachment 21 in Volume 3 contained Select's utilization review plan.

- 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.**

Leesburg Regional Medical Center, Inc. (CON #9869): The audited financial statements for the periods ending June 30, 2004 and 2003 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:

	6/30/2004	6/30/2003
Current Assets	\$ 71,038,032	\$ 78,682,122
Cash and Current Investment	\$ 20,897,803	\$ 24,402,709
Assets Restricted for Capital Projects	\$ -	\$ -
Total Assets	\$ 305,485,985	\$ 302,335,207
Current Liabilities	\$ 40,604,406	\$ 39,946,677
Total Liabilities	\$ 152,199,534	\$ 151,219,969
Net Assets	\$ 153,286,451	\$ 151,115,238
Total Revenues	\$ 244,945,132	\$ 220,040,108
Interest Expense	\$ 4,812,965	\$ 4,940,807
Operating Income	\$ 5,247,219	\$ 978,884
Cash Flow from Operations	\$ 28,314,828	\$ 18,241,464
Working Capital	\$ 30,433,626	\$ 38,735,445
Current Ratio (CA/CL)	1.7	2.0
Cash Flow to Current Liabilities (CFO/CL)	0.7	0.5
Long-Term Debt to Net Assets (TL-CL/NA)	0.7	0.7
Times Interest Earned (NPO+Int/Int)	2.1	1.2
Net Assets to Total Assets (TE/TA)	50.2%	50.0%
Operating Margin (ER/TR)	2.1%	0.4%
Return on Assets (ER/TA)	1.7%	0.3%
Operating Cash Flow to Assets (CFO/TA)	9.3%	6.0%

Short-Term Position:

The current ratio of 1.7 indicates current assets are slightly less than two times current liabilities, an adequate position. The ratio of cash flows to current liabilities of 0.7 is average and considered an adequate position. The working capital (current assets less current liabilities) of \$30.4 million is a measure of excess liquidity that could be used to fund capital projects. Overall, the parent company has an adequate short-term position.

Long-Term Position:

The ratio of long-term debt to net assets of 0.7 is above average and considered a moderately weak position. The ratio of cash flow to assets of 9.3 percent is average and an adequate position. The most recent year had \$5.2 million of income from operations, which resulted in an operating margin of 2.1 percent. Overall, the parent has a moderately weak but adequate long-term position.

Capital Requirements:

Schedule 2 indicates the applicant has capital projects and maturities of long-term debt through the start of this project totaling \$22 million. It should be noted that the applicant is projecting an operating loss of \$2.4 million during the first six months of this project. 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 projected loss in the first six months of operations is attributable to the difference in Medicare reimbursement rates for acute care hospitals and LTCHs. The applicant would have to fund this operating loss in addition to the capital projects and maturities of long-term debt listed on Schedule 2.

Available Capital:

The ratio analysis discussed above indicates that operating cash flows for the most recent year were \$30.7 million with \$30.5 million in working capital. In addition, the balance sheet indicates \$32.5 million of cash and investments designated for capital purposes.

Conclusion:

It appears that the applicant has sufficient working capital and operating cash flows to cover the capital budget and the six-month operating loss of the project. Based on the above, funding for this project and all capital projects should be available as needed.

Staffing:

Leesburg Regional indicates that it will be able to successfully recruit the clinical and administrative staff for the LTCH from its existing system staff and the surrounding community citing the alternative in terms of the pace of patient care and attractive alternative to the very rapid short-term acute care hospital patient turnover. The applicant included a Schedule 6 indicating a total of 73.5 FTEs with no period of operation noted so it's probably the first year of operation. Schedule 6 shows the project calls for 54.0 nursing FTEs. The applicant also includes a Schedule 6A for year ended June 30, 2007 showing 79.5 FTEs added with 51.0 nursing FTEs. As previously stated Schedule 7A shows the second year of the project ends June 30, 2008 and Schedule 10 shows the project will not be licensed until March 2008. The applicant's decrease in nursing staff from the undated Schedule 6 to the Schedule 6A is confusing and it is not clear as to the exact number of staff purposed for the project. The applicant does not provide details of its recruitment and retention policies.

However, based on the applicant's projections that approximately 71 percent of the Leesburg Regional's acute care patient days are appropriate for the LTCH, it is questionable as to the need to increase staff. The applicant should have more than sufficient staff at the existing acute care facility that can relocate to the new LTCH facility.

Promise Healthcare of Florida III, Inc. (CON #9870) is a development stage company incorporated on August 2, 2005. An audit of the development stage company revealed total assets of \$60,000 and no results from operations. Because this applicant is a development stage company and the applicant did not provide audited financial statements of its parent company (Promise Healthcare, Inc. – a privately held company), a review of the applicant's short and long-term position cannot be determined.

Capital Requirements:

Schedule 2 indicates that the only project planned is the construction of the 40-bed LTCH, which is the subject of this application. The total cost of this project is \$20,901,826. It should be noted that the applicant is projecting an operating loss of \$2.5 million during the first year of this project. 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 projected loss in the first six months of operations is attributable to the difference in Medicare reimbursement rates for acute care hospitals and LTCHs as well as low occupancy during the first year. The applicant would have to fund this operating loss in addition to

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the capital projects and maturities of long-term debt listed on Schedule 2.

Available Capital:

The notes to Schedule 3 indicate that the applicant intends to fund this project through debt financing. The applicant provided a letter of interest dated October 12, 2005, from Founding Partners Capital Management Company (Lender) expressing an interest in financing the project and working capital. A letter of interest is not considered a firm commitment to lend. In the absence of a firm commitment to lend, we would typically evaluate the financial strength of the company to determine the likelihood that the applicant would be able to obtain debt financing. The stronger the applicant's financial position, the more likely it would be able to obtain additional debt. The weaker the applicant's financial position, the less likely the applicant would be able to acquire and maintain additional debt. As discussed above, this is a development stage company with no reported operating results. Therefore, the applicant's short and long-term financial position could not be determined.

In this case, it is likely that the applicant would rely on the financial position of the parent company to secure debt financing. The applicant provided a narrative indicating that in August, the parent had cash of \$3.1 million, total assets of \$95.4 million and net patient revenue of \$182.6 million. These values were not presented with an auditor's report and no information regarding the parent's liabilities was included. Therefore, the financial position of the parent company cannot be determined nor can a conclusion be reached regarding the parent company's ability to secure debt financing for the applicant.

Conclusion:

As discussed above, funding for this project is dependent on the applicant's ability to obtain debt financing. Based on the information provided, the likelihood that the applicant will be able to obtain the financing necessary to fund this project and the associated working capital cannot be determined.

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Staffing:

The applicant states that its parent, Promise Healthcare currently employs over 1,500 staff nationwide. The applicant provides a detailed description of its staffing, orientation, medical recruiting and leadership team. This project calls for the recruitment of 44.2 FTEs in the first year of operation, increasing to 105.7 FTEs in year two ending March 31, 2010. The nursing staff will consist of 21.1 FTEs in year one and 52.4 FTEs in year two.

Select Specialty Hospital - Lake, Inc. (CON #9871): The audited financial statements of the applicant were reviewed to assess the financial position as of the balance sheet date and the financial strength of its operations for the period presented. The applicant is a development stage company with \$10 in assets as of August 24, 2005. The applicant is a wholly owned subsidiary of Select Medical Corporation (Parent). Select Medical Corporation will provide funding for this project. Therefore, the audited financial statements of the parent for the periods ending December 30, 2003 and 2004 were analyzed for the purpose of evaluating the parent'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:

SELECT MEDICAL CORPORATION

	12/31/2004	12/31/2003
Current Assets	\$ 549,335,000	\$ 485,066,000
Cash and Current Investment	\$ 247,476,000	\$ 165,507,000
Assets Restricted for Capital Projects	\$ -	\$ -
Total Assets	\$ 1,113,721,000	\$ 1,078,998,000
Current Liabilities	\$ 235,620,000	\$ 296,686,000
Total Liabilities	\$ 591,111,000	\$ 653,922,000
Net Assets	\$ 515,943,000	\$ 419,175,000
Total Revenues	\$ 1,660,791,000	\$ 1,392,366,000
Interest Expense	\$ 33,634,000	\$ 26,340,000
Operating Income	\$ 200,482,000	\$ 125,219,000
Cash Flow from Operations	\$ 174,276,000	\$ 246,248,000
Working Capital	\$ 313,715,000	\$ 188,380,000
Current Ratio (CA/CL)	2.3	1.6
Cash Flow to Current Liabilities (CFO/CL)	0.7	0.8
Long-Term Debt to Net Assets (TL-CL/NA)	0.7	0.9
Times Interest Earned (NPO+Int/Int)	7.0	5.8
Net Assets to Total Assets (TE/TA)	46.3%	38.8%
Operating Margin (ER/TR)	12.1%	9.0%
Return on Assets (ER/TA)	18.0%	11.6%
Operating Cash Flow to Assets (CFO/TA)	15.6%	22.8%

Short-Term Position:

The current ratio of 2.3 indicates current assets are slightly greater than two times current liabilities, an adequate position. The ratio of cash flows to current liabilities of 0.7 is average and considered an adequate position. The working capital (current assets less current liabilities) of \$313.7 million is a measure of excess liquidity that could be used to fund capital projects. Overall, the parent company has an adequate short-term position.

Long-Term Position:

The ratio of long-term debt to net assets of 0.7 is above average and considered a moderately weak position. The ratio of cash flow to assets of 15.6 percent is above average and a good position. The most recent year had \$200.5 million of income from operations, which resulted in an operating margin of 12.1 percent. Overall, the parent has a good long-term position.

Capital Requirements:

Schedule 2 indicates the applicant has capital projects and maturities of long-term debt through the start of this project totaling \$18.7 million. It should be noted that the applicant is projecting an operating loss of \$2.3 million during the first six months of this project. 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 projected loss in the first six months of operations is attributable to the difference in Medicare reimbursement rates for acute care hospitals and LTCHs as well as low occupancy during the first year. The applicant would have to fund this operating loss in addition to the capital projects and maturities of long-term debt listed on Schedule 2.

Available Capital:

As discussed above, the parent corporation will be providing funding for this project. The ratio analysis discussed above indicates that operating cash flows for the most recent audited year were \$174.3 million with \$313.7 million in working capital. Subsequent to the audit, the parent was acquired by and became a wholly owned subsidiary of EGL Holding Company. The parent incurred expenses associated with the merger of \$148.2 million. According to the June 30, 2005, 10-Q the balance of cash and cash equivalents at June 30, 2005, was reduced by \$226.4 million to \$21.1 million.

Conclusion:

The costs associated with the corporate merger discussed above had a material impact on the parent's financial position. However, the acquisition is a one-time event and the cost associated with merger has been recognized in the parent's 10-Q report. The parent's historic audited operating results indicate that sufficient cash should be generated on a going forward basis to fund this project. Based on the above, funding for this project and working capital should be available as needed.

Staffing:

The applicant indicates that its parent, Select currently employs over 21,100 medical and business professionals. The applicant provides a detailed description of its staffing, orientation, medical recruiting and leadership team. Salaries are stated to be based on Select's evaluation of the area and its experience in recruiting. This project calls for the recruitment of 63.5 FTEs in the first year of operation, increasing to 74.0 FTEs in year two ending January 2010 based on Schedule 10 as the Schedules 6-8 all had no operational periods provided. The nursing staff will consist of 25.0 FTEs in year one and 29.5 FTE's in year two.

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.

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Leesburg Regional Medical Center, Inc. (CON #9869) will be compared to the hospitals in Group 12 (LTCH Group). Per diem rates are projected to increase by an average of 4.1 percent per year. Inflation adjustments were based on the new CMS Market Basket, 3rd Quarter, 2005. Typically, gross revenues, net revenues, and costs would be obtained from Schedules 7 and 8 in the financial portion of the application. However, it appears that the information contained on Schedules 7 and 8 includes operations other than the freestanding LTCH proposed in this application. We were able to use supplemental data provided, which included projections of the 50-bed LTCH in order to complete our review.

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 provided two full years of projections following the demonstration period. Our analysis is based on the two years following the demonstration period.

Projected net revenue per patient day (NRPD) of \$1,207 in year one and \$1,268 in year two are between the control group median and lowest values of \$1,278 and \$1,180 in year one and \$1,324 and \$1,170 in year two. With net revenues falling between the median and lowest level, the facility is expected to consume health care resources in proportion to the services provided. (See Comparative Table). The applicant indicated that it would condition CON approval on maintaining a Medicaid/charity level of three percent. As discussed above, Schedules 7 and 8 appear to include operations other than the freestanding LTCH. Therefore, notes to the supplemental projection of the 50-bed LTCH were relied upon in order to determine the projected payer mix. According to the notes to the supplemental projection, 85 percent of the patient days are expected to be Medicare and 15 percent are expected to be commercial/managed care. There does not appear to be an allowance for a three percent Medicaid/charity level. Therefore, NRPD may be overstated.

Projected cost per adjusted patient day (CAPD) of \$1,101 in year one and \$1,098 in year two is between the group median and lowest values of \$1,219 and \$915 in year one and \$1,263 and \$947 in year two. This level of expense is considered efficient with projected cost falling between the control group median and lowest values. (See Comparative Table). It

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should be noted that the overhead expense per patient day is well below the lowest value in the group. This indicates that overhead expense may be understated. The applicant is projecting a decrease in CPD between year one and year two of approximately 14.3 percent. It should be noted that this application is for a new LTCH. The first year of operation has a below average occupancy rate. The low occupancy rate decreases economies of scale and as the occupancy rate increases, CPD would be expected to decrease.

Virtually all of the revenue projections and a majority of expense projections are dependant on the applicant's occupancy assumptions. An overstatement of the level of occupancy could have a materially negative affect on the projected financials.

The year two projected operating income is \$2.3 million, which computes to an operating margin per adjusted patient day of \$170. This is between the control group median and highest value of \$160 and \$334. The projected margin is likely to be reduced by the apparent overstatement of revenues and understatement of expenses discussed above.

As discussed above, it appears that revenues are overstated and expenses are understated. Therefore, the projected margin is likely to be reduced significantly. If the applicant were to meet the minimum overhead cost per patient day in the peer group, operating income would be reduced by approximately \$166 per patient day. This would result in the applicant operating at approximately break even in year two and cast doubt on the financial feasibility of this project.

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COMPARATIVE TABLE

LEESBURG REGIONAL MEDICAL CENTER, INC.

CON # 9869 2004 DATA Peer Group 12	Jun-08	YEAR 2	VALUES ADJUSTED		
	YEAR 2	ACTIVITY	FOR INFLATION		
	<u>ACTIVITY</u>	<u>PER DAY</u>	<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
ROUTINE SERVICES	9,351,636	683	2,045	1,080	723
INPATIENT AMBULATORY	0	0	17	0	0
INPATIENT SURGERY	0	0	0	0	0
INPATIENT ANCILLARY SERVICES	13,486,620	985	3,900	3,406	2,036
OUTPATIENT SERVICES	0	0	56	0	0
TOTAL PATIENT SERVICES REV.	<u>22,838,256</u>	<u>1,668</u>	<u>5,946</u>	<u>4,417</u>	<u>3,151</u>
OTHER OPERATING REVENUE	0	0	7	2	0
TOTAL REVENUE	<u>22,838,256</u>	<u>1,668</u>	<u>5,947</u>	<u>4,418</u>	<u>3,151</u>
DEDUCTIONS FROM REVENUE	5,481,183	400	0	0	0
NET REVENUES	<u>17,357,073</u>	<u>1,268</u>	<u>1,682</u>	<u>1,324</u>	<u>1,170</u>
EXPENSES					
ROUTINE	6,164,700	450	498	344	209
ANCILLARY	5,055,087	369	580	332	230
AMBULATORY	0	0	0	0	0
TOTAL PATIENT CARE COST	<u>11,219,787</u>	<u>819</u>	<u>0</u>	<u>0</u>	<u>0</u>
ADMIN. AND OVERHEAD	2,971,910	217	0	0	0
PROPERTY	838,332	61	0	0	0
TOTAL OVERHEAD EXPENSE	<u>3,810,242</u>	<u>278</u>	<u>673</u>	<u>534</u>	<u>444</u>
OTHER OPERATING EXPENSE	0	0	0	0	0
TOTAL EXPENSES	<u>15,030,029</u>	<u>1,098</u>	<u>1,669</u>	<u>1,263</u>	<u>947</u>
OPERATING INCOME	2,327,044	170 13.4%	334	160	-17
PATIENT DAYS	13,692				
ADJUSTED PATIENT DAYS	13,692				
TOTAL BED DAYS AVAILABLE	18,250		VALUES NOT ADJUSTED		
ADJ. FACTOR	1.0000		FOR INFLATION		
TOTAL NUMBER OF BEDS	50		<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
PERCENT OCCUPANCY	75.02%		89.5%	69.5%	55.7%
PAYER TYPE	<u>PATIENT</u>	<u>% TOTAL</u>			
SELF PAY	<u>DAYS</u>				
MEDICAID	0	0.0%	5.8%	0.3%	0.0%
MEDICAID HMO	0	0.0%			
MEDICARE	11,638	85.0%	98.7%	77.9%	55.0%
MEDICARE HMO	0	0.0%			
INSURANCE	0	0.0%			
HMO/PPO	2,054	15.0%	23.6%	16.0%	0.0%
OTHER	0	0.0%			
TOTAL	<u>13,692</u>	<u>100%</u>			

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Promise Healthcare of Florida III, Inc. (CON #9870) will be compared to the hospitals in Group 12 (LTCH Group). Per diem rates are projected to increase by an average of 4.1 percent per year. Inflation adjustments were based on the new CMS Market Basket, 3rd Quarter, 2005. Gross revenues, net revenues, and costs were obtained from Schedules 7 and 8 in the financial portion of the application and were compared to the control group as a calculated amount per patient day.

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. Only the second 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, thereby distorting net revenues when compared to the control group.

Projected net revenue per patient day (NRPD) of \$1,495 in year two is between the control group median and highest values of \$1,409 and \$1,790. With net revenues approximating the median, the facility is expected to consume health care resources in proportion to the services provided. (See Comparative Table). NRPD appears reasonable.

Projected cost per patient day (CPD) of \$1,402 in year two is between the group median and highest values of \$1,344 and \$1,776. With projected CPD approximating the median value in the group, costs appear reasonable. (See Comparative Table).

The year two projected operating income is \$1 million, which computes to an operating margin per adjusted patient day of \$93. This is between the control group median and lowest value of \$160 and a negative \$17.

Virtually all of the revenue projections and a majority of expense projections are dependant on the applicant's occupancy assumptions. An overstatement of the level of occupancy could have a materially negative affect on the projected financials.

Assuming the applicant will be able to achieve the projected patient days, the year two operations of this project appear to be feasible. However, staff were unable to determine the likelihood that the applicant will be able to finance the construction of the proposed long-term care hospital. Further, staff were unable to determine the likelihood that the applicant will be able to finance the working capital necessary to fund the projected \$2.5 million operating loss in year one. Although there is a projected profit in year two, the questions regarding the applicant's financial ability

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to construct and keep the facility viable through year one cannot be determined. Therefore, staff cannot find that this project is financial feasible based on the information provided.

COMPARATIVE TABLE

PROMISE HEALTHCARE OF FLORIDA III, INC.

CON # 9870 2004 DATA Peer Group 12	Mar-10	YEAR 2	VALUES ADJUSTED		
	YEAR 2	ACTIVITY	FOR INFLATION		
	<u>ACTIVITY</u>	<u>PER DAY</u>	<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
ROUTINE SERVICES	50,830,912	4,532	2,177	1,149	769
INPATIENT AMBULATORY	0	0	18	0	0
INPATIENT SURGERY	0	0	0	0	0
INPATIENT ANCILLARY SERVICES	0	0	4,152	3,625	2,167
OUTPATIENT SERVICES	0	0	60	0	0
TOTAL PATIENT SERVICES REV.	50,830,912	4,532	6,328	4,701	3,353
OTHER OPERATING REVENUE	247,873	22	7	2	0
TOTAL REVENUE	51,078,785	4,554	6,330	4,702	3,354
DEDUCTIONS FROM REVENUE	34,306,024	3,059	0	0	0
NET REVENUES	16,772,761	1,495	1,790	1,409	1,246
EXPENSES					
ROUTINE	4,186,714	373	530	366	222
ANCILLARY	4,568,965	407	617	353	244
AMBULATORY	0	0	0	0	0
TOTAL PATIENT CARE COST	8,755,679	781	0	0	0
ADMIN. AND OVERHEAD	2,997,319	267	0	0	0
PROPERTY	3,132,136	279	0	0	0
TOTAL OVERHEAD EXPENSE	6,129,455	546	717	568	473
OTHER OPERATING EXPENSE	839,391	75	0	0	0
TOTAL EXPENSES	15,724,525	1,402	1,776	1,344	1,008
OPERATING INCOME	1,048,236	93 6.2%	334	160	-17
PATIENT DAYS	11,216				
ADJUSTED PATIENT DAYS	11,216				
TOTAL BED DAYS AVAILABLE	14,600				
ADJ. FACTOR	0.9951				
TOTAL NUMBER OF BEDS	40				
PERCENT OCCUPANCY	76.82%				
PAYER TYPE	<u>PT. DAYS</u>	<u>% TOTAL</u>			
SELF PAY	112	1.0%			
MEDICAID	112	1.0%	5.8%	0.3%	0.0%
MEDICAID HMO	0	0.0%			
MEDICARE	6,936	61.8%	98.7%	77.9%	55.0%
MEDICARE HMO	2,924	26.1%			
INSURANCE	112	1.0%			
HMO/PPO	1,020	9.1%	23.6%	16.0%	0.0%
OTHER	0	0.0%			
TOTAL	11,216	100%			

VALUES NOT ADJUSTED
FOR INFLATION

Highest Median Lowest
89.5% 69.5% 55.7%

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Select Specialty Hospital – Lake, Inc. (CON #9871) will be compared to the hospitals in Group 12 (LTCH Group). Per diem rates are projected to increase by an average of 4.1 percent per year. Inflation adjustments were based on the new CMS Market Basket, 3rd Quarter, 2005. Gross revenues, net revenues, and costs were obtained from Schedules 7 and 8 in the financial portion of the application and were compared to the control group as a calculated amount per patient day.

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. Only the second 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, thereby distorting net revenues when compared to the control group.

Projected net revenue per patient day (NRPD) of \$1,235 in year two is between the control group median and lowest values of \$1,397 and \$1,234. With net revenues falling between the median and lowest values, the facility is expected to consume health care resources in proportion to the services provided. (See Comparative Table). NRPD appears reasonable.

Projected cost per patient day (CPD) of \$1,211 in year two is between the group median and lowest values of \$1,332 and \$999. Projected CPD is considered efficient when compared to the peer group with CPD falling between the median and lowest values. Costs appear reasonable. (See Comparative Table).

The year two projected operating income is \$212,646, which computes to an operating margin per adjusted patient day of \$24. This is between the control group median and lowest value of \$160 and a negative \$17.

Virtually all of the revenue projections and a majority of expense projections are dependant on the applicant's occupancy assumptions. An overstatement of the level of occupancy could have a materially negative affect on the projected financials.

Assuming need is supported financial feasibility of this project appears likely.

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COMPARATIVE TABLE

SELECT SPECIALTY HOSPITAL - LAKE, INC.

CON # 9871 2004 DATA Peer Group 12	Dec-09	YEAR 2	VALUES ADJUSTED		
	YEAR 2	ACTIVITY	FOR INFLATION		
	<u>ACTIVITY</u>	<u>PER DAY</u>	<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
ROUTINE SERVICES	8,322,000	950	2,157	1,139	762
INPATIENT AMBULATORY	18,547,787	2,118	18	0	0
INPATIENT SURGERY	315,182	36	0	0	0
INPATIENT ANCILLARY SERVICES	0	0	4,114	3,593	2,147
OUTPATIENT SERVICES	0	0	59	0	0
TOTAL PATIENT SERVICES REV.	<u>27,184,969</u>	<u>3,104</u>	<u>6,272</u>	<u>4,659</u>	<u>3,323</u>
OTHER OPERATING REVENUE	<u>0</u>	<u>0</u>	<u>7</u>	<u>2</u>	<u>0</u>
TOTAL REVENUE	<u><u>27,184,969</u></u>	<u><u>3,104</u></u>	<u><u>6,274</u></u>	<u><u>4,660</u></u>	<u><u>3,324</u></u>
DEDUCTIONS FROM REVENUE	<u>16,364,113</u>	<u>1,868</u>	<u>0</u>	<u>0</u>	<u>0</u>
NET REVENUES	<u><u>10,820,856</u></u>	<u><u>1,235</u></u>	<u><u>1,774</u></u>	<u><u>1,397</u></u>	<u><u>1,234</u></u>
EXPENSES					
ROUTINE	2,082,500	238	525	363	220
ANCILLARY	3,405,402	389	612	350	242
AMBULATORY	0	0	0	0	0
TOTAL PATIENT CARE COST	<u>5,487,902</u>	<u>627</u>	<u>0</u>	<u>0</u>	<u>0</u>
ADMIN. AND OVERHEAD	2,426,129	277	0	0	0
PROPERTY	2,694,179	308	0	0	0
TOTAL OVERHEAD EXPENSE	<u>5,120,308</u>	<u>585</u>	<u>710</u>	<u>563</u>	<u>469</u>
OTHER OPERATING EXPENSE	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL EXPENSES	<u><u>10,608,210</u></u>	<u><u>1,211</u></u>	<u><u>1,760</u></u>	<u><u>1,332</u></u>	<u><u>999</u></u>
OPERATING INCOME	212,646	24 2.0%	334	160	-17
PATIENT DAYS	8,759				
ADJUSTED PATIENT DAYS	8,759				
TOTAL BED DAYS AVAILABLE	16,060		VALUES NOT ADJUSTED		
ADJ. FACTOR	1.0000		FOR INFLATION		
TOTAL NUMBER OF BEDS	44		<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
PERCENT OCCUPANCY	54.54%		89.5%	69.5%	55.7%
PAYER TYPE	<u>PATIENT</u>	<u>% TOTAL</u>			
	<u>DAYS</u>				
SELF PAY	70	0.8%			
MEDICAID	175	2.0%	5.8%	0.3%	0.0%
MEDICAID HMO	0	0.0%			
MEDICARE	6,777	77.4%	98.7%	77.9%	55.0%
MEDICARE HMO	0	0.0%			
INSURANCE	1,303	14.9%			
HMO/PPO	434	5.0%	23.6%	16.0%	0.0%
OTHER	0	0.0%			
TOTAL	<u><u>8,759</u></u>	<u><u>100%</u></u>			

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

The following pertains to all co-batched applications. Competition to promote quality and cost-effectiveness is driven primarily by the best combination of high quality and fair price. Competition forces healthcare facilities to increase quality and reduce charges/cost in order to remain viable in the market.

Currently, there are no licensed LTCH beds in District 3. However, two LTCHs have been approved in the district with a total of 75 beds. The co-batch applicants and the other two approved LTCHs will compete directly for LTCH patients in District 3. However, competition is limited by the potential impact on competitors' overall operations.

Price-based competition will be limited by the amount of patient days that are represented by fixed government payers like Medicare. The applicants are projecting that a material portion of their patient days (LRMC with 85 percent Medicare, Promise with 88.9 percent Medicare, Medicare HMO and Medicaid and Select with 79.4 percent Medicare and Medicaid) are expected to come from government payers.

The applicants' projects are not likely to foster competition to promote quality and cost-effectiveness. Further, even if a material shift in market share that resulted in a material adverse financial impact on the competitors' operations were to occur, competition to promote cost-effectiveness would be minimized by the large share of fixed government payers.

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 noted that the applicant's LRMC Nursing Center is a 120-bed skilled nursing facility with an average daily census of 91 patients. However, the applicant's architectural data does not indicate that LRMC Nursing Center is a 120-bed skilled nursing facility.

Leesburg Regional Medical Center, Inc. (CON #9869) proposes to establish a new 50-bed freestanding long-term care hospital (LTCH) at the North campus of Leesburg Regional Medical Center. This new hospital will occupy an existing three story building currently being utilized as a 73-bed licensed nursing home, 15 hospital rehabilitation beds, an outpatient rehabilitation clinic, and a health and fitness facility.

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According to the application, the 15 hospital rehabilitation beds are intended to be relocated to another unspecified location, presumably to Leesburg Regional Medical Center, South Campus. The nursing home bed license is intended to be reduced by 35 beds, leaving a total of 38 nursing home beds inside of the existing facility. These beds are then to be relocated into two different areas of the new LTCH. One of these areas will be a single wing on the first floor and the other area will be the entire third floor of the new hospital. The outpatient rehabilitation clinic and the health and fitness facility are also intended to remain in the new hospital building in the same areas in which they are presently located. Although the term “new freestanding long-term acute care hospital” is used in the application, this new hospital will be sharing building utilities and building spaces with a nursing home, an outpatient clinic and a health and fitness center.

It is assumed the use of the hospital building by these other entities will be established through some unspecified sub-lease agreement(s). However, for review purposes, the entire building must meet the requirements for a new health care occupancy in regards to the National Fire Protection Association (NFPA) and institutional unrestrained occupancy in regards to the Florida Building Code (FBC).

Although the applicant asserts the entrances to the hospital, nursing home, outpatient rehabilitative services, and health and fitness center are “separate and distinct”, the submitted plans indicate the hospital and nursing home will share a common entrance and waiting lobby area on the first floor, and the outpatient rehabilitation service, the health and fitness center, and the emergency room of the LTCH will all share the only other public entrance to the building.

All of the 50 LTCH patient rooms are located on the second floor of the building in three wings of medical beds with a separate wing of six intensive care unit beds. All of the rooms are private and exceed the minimum size requirements for new hospitals. Each medical room has a private toilet room with a lavatory and shower. It appears that more than 10 percent of the new bedrooms have been made accessible. The nursing stations and support spaces appear to be meet the minimum requirements if the FBC. The ICU did not provide an isolation room but this can be added to the project with little impact.

All of the support spaces for a LTCH hospital appear to be provided on either the first or second floor of the facility. A pharmacy area was not indicated on the plans, but there appears to be ample space to provide one. There is an emergency room indicated along with an operating room suite. There is no isolation room provided as part of the operation room suite; however, this can be added to the project with little impact.

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It appears that some of the existing operating rooms are to be used as additional unspecified storage areas that will require fire ratings. The administrative areas, facility management areas, dining, kitchen, radiology, and a small laundry are all provided on the first floor of the building. There was no body hold room indicated on the plan.

The 38-bed nursing facility is to be split between the first and third floors with 18 nursing home beds on the first floor and the remaining 20 on the third floor. This arrangement is somewhat unusual in that the nursing home is separated by a LTCH. Some resident functions such as the beauty salon will only be available to the nursing home by accessing through the LTCH on the first floor. A clearer separation between the nursing home functions and the LTCH functions should be incorporated. There was no dedicated elevator for either the LTCH or the nursing home beds located on the third floor.

Although the application asserts “administrative space supporting the skilled nursing functions” is located on the third floor, only two small office areas are located there and do not appear to be large enough for the administrative functions of the nursing home. The FBC requires the following administrative areas be provided for a nursing home: General offices shall be provided for business transactions, admissions, social services, private interviews, medical and financial records, and administrative and professional staff. Clerical files and staff office space shall be provided as needed. This means that more space from the LTCH will need to be assigned to the nursing home functions in the facility.

Although the plans indicate some multipurpose activity areas for the nursing home residents, these areas do not meet the minimum requirements of the FBC. The FBC requires there to be a total of 35 square feet per nursing home bed for these areas or a total of 1,330 square feet for 38 beds. This space cannot be shared with the hospital. Additional space will need to be utilized by the nursing home that will take space away from the space for the LTCH.

The beauty salon for the nursing home is located outside of the nursing home areas with access through the hospital gift shop. This area will have to be relocated so it is clearly dedicated to the nursing home residents. It also appears that a minimum of 50 percent of the nursing home bed rooms are not designed to be accessible. The necessary redesign of these rooms may impact the hospital plan to provide the additional square footage of the larger nursing home bedrooms.

According to the plans and the application, it is intended to make the entire building comply with all new codes and standards including the hurricane provisions of the FBC, Chapter 4, Section 419.4. However,

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there is no indication in the application that there will be on site water storage for the patients and staff as required by the FBC.

Although there are some deficiencies in the plan and the nursing home function may require additional square footage from the LTCH, the existing building is large enough to accommodate the necessary revisions for both the nursing home and the LTCH. All space requirements must be more clearly separated and identified so each program will have its requirements met.

The cost estimated for renovating the areas of the LTCH appear to be reasonable although as an existing building there may be further unidentified deficiencies that will require correction. And although not specifically stated, it is assumed the cost to renovate the building for the dedicated nursing home areas, the outpatient clinic and the health and fitness areas were not included in the cost estimates for the hospital. If that is the case, there may be additional cost not included in this application for the renovations for these other programs.

The time period for the construction and renovation of the LTCH of 17 months is very generous. The application did not specify whether or not the building would be vacated during renovations but it would be very difficult to maintain an occupied building during such extensive renovations of building systems and spaces. The temporary relocation of the nursing home residents during the renovations to the facility was not addressed in the application.

The plans submitted with this application were very schematic in detail with the expectation that they will necessarily be revised and refined during the design development (preliminary) and contract document stages. The architectural review of the application shall not be construed as an in-depth effort to determine complete compliance with all applicable codes and standards. The final responsibility for facility compliance ultimately rests with the owner.

Promise Healthcare of Florida III, Inc. (CON #9870) proposes to establish a new 40-bed freestanding long-term care hospital (LTCH) located within Lake County, Florida. This new hospital will be designed as a single-story, protected, non-combustible, fully sprinklered building.

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All of the 40 LTCH medical patient rooms are private and exceed the minimum size requirements for new hospitals. Each medical bed room has a private toilet room with a lavatory and shower. It appears that more than 10 percent of the new bedrooms have been made accessible. The patient support spaces appear to meet all of the space requirements of the current edition of the Florida Building Code (FBC).

According to the application and the submitted plan, this new hospital will consist of three medical bed wings, and two four-bed critical care units (CCU). The medical beds are supported from a large centralized nursing station with several sub-nursing units located in each of the patient room wings of seven beds, 11 beds and 14 beds. The CCU rooms contain four beds each and are separated into two areas by two dedicated sub-nursing stations. There is one patient toilet and shower for each of these rooms which meet the FBC requirements. The centralized nurse station contains a multi-purpose room, nourishment station, medicine distribution cart, staff toilet, and a pharmacy. There is also a respiratory therapy area located in one of the patient wings.

The therapy suite includes hydrotherapy, occupational therapy, physical therapy and speech therapy. There is an emergency department that contains a triage room, treatment room, and an emergency holding area for several patients. This area also contains a small lab and a CT scan room.

The operating suite contains two operating rooms, a four-bed post-anesthesia care unit with an isolation room, two pre-op beds, and control and nursing stations. All other supporting service elements appear to be provided for this operating suite although the locker/change rooms will have to be redesigned to provide for one way entry into the operating room suite.

In addition all of the supporting service areas such as administration, medical records, dining, dietary, maintenance, storage, and other spaces and utilities as required by the FBC have all be provided for a fully functional facility.

According to the plans and the application, the entire building will comply with all new codes and standards including the hurricane provisions of the FBC, Chapter 4, and Section 419.4 including onsite water storage, and protection of all utilities. It is also intended that the complete building utilities including the HVAC will be connected to emergency generators.

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The cost estimated for the construction of the new LTCH appears to be reasonable. There is no indication of a specific site on which to build this facility so total cost of the project is not possible to determine.

The time schedule of a 14-month construction period from the time of building permit to final inspection seems ambitious but possible.

The plans submitted with this application were very schematic in detail with the expectation that they will necessarily be revised and refined during the design development (preliminary) and contract document stages. The architectural review of the application shall not be construed as an in-depth effort to determine complete compliance with all applicable codes and standards. The final responsibility for facility compliance ultimately rests with the owner.

Select Specialty Hospital - Lake, Inc. (CON #9871) proposes to establish a new 44-bed freestanding long-term care hospital (LTCH) located within Lake County, Florida. This new hospital will be designed as a single-story, protected, non-combustible, fully sprinklered building.

All of the 44 LTCH medical patient rooms are private and exceed the minimum size requirements for new hospitals. Each medical bed room has a private toilet room with a lavatory and shower. It appears that more than 10 percent of the new bedrooms have been made accessible. The patient support spaces appear to meet all of the space requirements of the current edition of the Florida Building Code (FBC).

According to the information from the submitted plan, this new hospital will consist of two medical bed wings or areas, and one wing or suite of intensive care units (ICU). The medical beds are supported from two centralized nursing stations that serve 19 beds each. The ICU suite contains a total of six beds and is served by a dedicated nurse station. There is one private toilet and shower for each of the medical rooms which meet the FBC requirements. The ICU rooms do not have a dedicated shower or toilet for each room but this design is permitted by the FBC. There is an isolation room provided for the ICU suite and one isolation room is provided for each of the two medical patient bed areas. The medical nursing stations contain a staff room, nourishment station, medicine room, staff toilet, equipment storage spaces.

The therapy suite includes physical therapy and respiratory therapy. There is an emergency entrance that leads to an emergency treatment room. This area also contains a radiology room.

There is a centrally located pharmacy and lab area. This centralized area also contains a patient assisted shower and a sitz bath room.

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The operating suite contains one operating room, a two-bed post-anesthesia care unit with an isolation room, one pre-op or holding bed, and control and nursing stations. All other supporting service elements appear to be provided for this operating suite including locker/change rooms.

In addition all of the supporting service areas such as administration, medical records, dining, dietary, maintenance, storage, and other spaces and utilities as required by the FBC have all be provided for a fully functional facility.

It is assumed the entire building will comply with all new codes and standards including the hurricane provisions of the FBC, Chapter 4, and Section 419.4., including onsite water storage, and protection of all utilities although this is never alluded to in the application.

The cost estimated for the construction of the new LTCH appears to be reasonable. There is no indication of a specific site on which to build this facility so total cost of the project is not possible to determine.

The time schedule of a 15-month construction period from the time of building permit to final inspection seems reasonable.

The plans submitted with this application were very schematic in detail with the expectation that they will necessarily be revised and refined during the design development (preliminary) and contract document stages. The architectural review of the application shall not be construed as an in-depth effort to determine complete compliance with all applicable codes and standards. The final responsibility for facility compliance ultimately rests with the owner.

- 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 2004 Hospital Financial Data Report, LTCHs in the state averaged 1.7 percent Medicaid patient days and 0.8 percent charity care patient days.

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Leesburg Regional Medical Center, Inc. (CON #9869) has a history of providing Medicaid and charity care in its acute care facility. During FY 2004, Leesburg Regional provided 6.7 percent of its patient days to Medicaid and 2.3 percent to charity care. This is below the District 3 acute care facilities average of 13.6 percent Medicaid and 3.0 percent. The applicant proposes to condition the award of the certificate of need on the combined provision of three percent of patient days to Medicaid and charity care patients. The applicant's financial data did not provide a break-out of the project's Medicaid and charity care days. The notes to the supplemental projection indicated the LTCH's patient days would consist of 85 percent Medicare and 15 percent commercial/managed care.

Promise Healthcare of Florida III, Inc. (CON #9870) is a new development stage company with no operating history. The applicant proposes to condition the award of the certificate of need on the combined provision of two percent of patient days to Medicaid and charity care patients. Schedule 7B indicates that one percent of the facility's annual patient days will be provided to Medicaid patients and one percent to self-pay patients which it indicates is charity care in the Schedule 7B's notes.

Select Specialty Hospital - Lake, Inc. (CON #9871) is a new development stage company with no operating history. The applicant indicates that nationwide Select, its parent corporation provided 2.4 percent of its calendar year 2004 patient days to Medicaid patients. However, AHCA Hospital Financial Budget Data indicates that Select Specialty Hospital - Miami, the only LTCH operated by Select throughout 2004 provided 0.7 percent (87 of 12,209 total patient days) to Medicaid patients. Select Specialty - Orlando provided 0.1 percent (12 of its 9,137) patient days to Medicaid and Select Specialty - Panama City provided no Medicaid patient days. As the calendar year and the Select Florida facilities fiscal years end December 31, 2004, Select's nationwide experience exceeds the performance of its Florida facilities, which were below the state average in Medicaid and charity care. The applicant indicates that LTCH charity care is minimal and in some cases non-existent in Florida; however, the state average for CY 2004 was 0.8 percent per AHCA Hospital Financial Budget Data. None of the Select facilities reported any charity care.

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Select proposes to condition the award of the certificate of need on the combined provision of 2.8 percent of patient days to Medicaid and charity care patients. Schedule 7B indicates that two percent of the facility's annual patient days will provided to Medicaid patients and 0.8 percent to charity care. This would exceed the parent corporation's experience in Florida for CY 2004.

F. SUMMARY

Leesburg Regional Medical Center, Inc. (CON #9869), a not-for-profit entity that is licensed to operate LRMC, a 294-bed acute care hospital and LRMC North, a 15-bed comprehensive medical rehabilitation facility, proposes to construct a freestanding 50-bed LTCH in the existing LRMC North building in Lake County, District 3.

The proposed project involves at total of 67,400 gross square feet (GSF), which consists of 37,000 GSF of new construction and 63,700 GSF of renovation. The facility will be comprised of 50 private rooms. Total construction cost is estimated to be \$6,464,891, and total project cost \$8,861,304.

The applicant agrees to condition project approval to the provision of three percent of the facility's total patient days to Medicaid and/or charity care patients.

Promise Healthcare of Florida III, Inc. (CON #9870), a wholly owned subsidiary of Promise Healthcare, Inc., proposes to construct a freestanding 40-bed LTCH to be located in Lake County, District 3. Four potential sites near the cities Tavares and Eustis were identified as possible locations for the LTCH.

The proposed hospital involves 47,951 gross square feet (GSF) of new construction at an as yet unsecured location. The applicant indicates the 40-bed facility will consist of all private rooms. Total construction cost is estimated to be \$9,686,100 and total project cost is \$20,901,826.

As a condition of approval, the applicant agrees to a combined provision of two percent of the facility's total annual patient days to Medicaid and charity care patients.

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Select Specialty Hospital-Lake, Inc. (CON #9871), a wholly owned subsidiary of Select Medical Corporation, proposes to establish a 44-bed freestanding LTCH to be located in District 3, Lake County. The applicant indicates that the proposed facility will likely be located in Leesburg, proximate to both Leesburg Regional Medical Center and Florida Hospital – Waterman.

The proposed hospital will consist of 51,160 gross square feet of new construction with construction cost of \$9,976,200. The facility will be comprised of 44 private rooms. The total project cost is estimated to be \$18,604,556.

The applicant proposes to condition award of the certificate of need on the provision of 2.8 percent of the facility's total annual patient days to Medicaid patients and charity care patients.

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.

Pertains to **all co-batched projects** - The newly licensed Kindred Hospital Ocala and the CON approved, not yet operational LTCH in District 3 will likely be negatively impacted should a new facility be approved. In addition there is one licensed and one CON approved LTCH hospital in Orlando, District 7 located within approximately 50 miles of all applicants proposed locations. Kindred Hospital Ocala sent a letter in opposition to all of the projects, stating approval of any one would adversely affect its facility.

Leesburg Regional Medical Center, Inc. (CON #9869) projects that its primary service area will be Lake and Sumter Counties. The applicant indicates that its LTCH patient volume can be obtained from Leesburg Regional Medical Center and The Villages Regional Hospital acute care patients based on long length of stay discharges. Patients to be served in the LTCH include many patient care categories whose treatment may be appropriate in less costly settings than the LTCH. The applicant's need analysis contends that during the 12 months ended June 30, 2005, LRMC had 46,838 of the facility's 65,423 total or 71.60 percent of the facility's acute care patients were LTCH appropriate and that 16,304 of the 21,578 total patient or 75.56 percent Villages' patient days were appropriate for LTCH care. The applicant's district analysis included the

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same type of LTCH patient potential volume and uses non-certificate of need state utilization rates, which it does not provide background data on to project need. 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 LTCHs in the district and those within close proximity of Leesburg would not be able to meet the needs of its residents needing LTCH services.

Promise Healthcare of Florida III, Inc. (CON #9870) provides a discussion of the LTCH hospital patient setting compared to other care settings. The LTCH patient is described as meeting the necessity for acute care, needing medically complex care with multiple co-morbidities (five or more diagnosis identified) and having access to critical, intense medical interventions and services such as acute ventilator management and weaning, cardiac monitoring, pharmacy, diagnostic services, etc. The applicant's need analysis contains the following assumptions: Acute care and IRFs are not appropriate substitutes for LTCHs, a SNF would require specialized programs to care for similar populations; and LTCH patients cost Medicare more than similar patients who use alternative settings if similar services are available; however, when LTCH care is targeted to patients of the highest severity, the cost is similar. The applicant's use rate approach is based on the experience of other LTCHs in other parts of the state and relies on assumptions that may or may not occur in the proposed service area. With regard to the LOS methodological approach, the applicant's projections are based on assumed capture rates with no supporting data or indication of potential referrals from area hospitals.

The applicant provided no letters of support and did not demonstrate that area residents are unable to access needed LTCH care or that care currently being provided is inappropriate. Promise also did not demonstrate that the currently licensed and approved LTCHs in the district and those within close proximity of Leesburg would not be able to meet the needs of residents needing LTCH services.

Select Specialty Hospital-Lake, Inc. (CON #9871) projects that its primary service area will be Lake County and Sumter County will be the secondary service area. However, the applicant presented no letters of support from Lake or Sumter Counties or District 3 for the project. The applicant failed to provide strong supporting documentation provided from area physicians regarding potential referrals. The applicant's use rate approach is based on the experience of other LTCHs in other parts of the state and relies on assumptions that may or may not occur in the

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proposed service area. With regard to the LOS methodological approach, the applicant's projections are based on assumed capture rates with no supporting data or indication of potential referrals from area hospitals. It was further not demonstrated by the applicant that patients that may meet the definition of a LTCH patient are not currently being placed or that an access problem exists in the district. It also did not demonstrate that the currently licensed and approved LTCHs in the district and those in close proximity to Leesburg would not be able to meet the needs of its residents needing LTCH services.

Quality of Care:

Leesburg Regional Medical Center, Inc. (CON #9869) has a history of providing quality of care and is JCAHO accredited. The review of the applicant's complaint history as of October 6, 2005 indicates there were no confirmed complaints for the past three years.

Promise Healthcare of Florida III, Inc. (CON #9870) is a new development stage corporation and as such has no operating history. However, the applicant is a controlled entity of Promise Specialty Hospital, Inc., an existing provider of LTCH services in six states with 12 LTCH facilities. The applicant provides a reasonable description of Promise Specialty's quality of care.

Select Specialty Hospital - Lake, Inc. (CON #9871) is a new development stage corporation and as such has no operating history. However, the applicant is a controlled entity of Select Medical Corporation. The applicant provided a description of Select Medical Corporation's plan for improving organizational performance, year 2003, plan for the provision of patient care/services and Select's utilization review plan.

Two of the three Select Florida facilities have nine confirmed complaints under Select's operation as of October 6, 2005. These involve patient care (two), pressure sores (one), use of restraints (one), medicine problems/errors/formulary (three), patient abuse/neglect (one) and infection control (one). Select's Panama City facility does not have any confirmed complaints.

Cost/Financial Analysis

Leesburg Regional Medical Center, Inc. (CON #9869) has sufficient working capital and operating cash flows to fund the project and the six month operating loss projected for the project. Funding for this and all capital projects should be available as needed.

The applicant's revenues appear to be overstated and expenses are understated. There is doubt as to the financial feasibility of the project.

Promise Healthcare of Florida III, Inc. (CON #9870) is a wholly owned subsidiary of Promise Healthcare, Inc. The applicant did not provide evidence sufficient to determine if financing and associated working capital can be obtained.

Financial feasibility cannot be determined based on the information provided.

Select Specialty Hospital-Lake, Inc. (CON #9871) is a wholly owned subsidiary of Select Medical Corporation. The funding and working capital for the proposed project should be available, with the support of the parent company.

Assuming need is supported the project is considered to be financially feasible, with the parent sustaining working capital during the first two years of operation.

Architectural Analysis:

Leesburg Regional Medical Center, Inc. (CON #9869): The cost estimated for renovating the areas of the LTCH appear to be reasonable although as an existing building there may be further unidentified deficiencies that will require correction. And although not specifically stated, it is assumed the cost to renovate the building for the dedicated nursing home areas, the outpatient clinic and the health and fitness areas were not included in the cost estimates for the hospital. If that is the case, there may be additional cost not included in this application for the renovations for these other programs.

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The time period for the construction and renovation of the LTCH of 17 months is very generous. The application did not specify whether or not the building would be vacated during renovations but it would be very difficult to maintain an occupied building during such extensive renovations of building systems and spaces. The temporary relocation of the nursing home residents during the renovations to the facility was not addressed in the application.

However, it is noted that the applicant's architectural data indicated the existing skilled nursing facility was licensed for 73 beds when it is licensed for 120 and had an ADC of 91 patients during CY 2004.

Promise Healthcare of Florida III, Inc. (CON #9870): The cost estimated for the construction of the new LTCH appears to be reasonable. There is no indication of a specific site on which to build this facility so total cost of the project is not possible to determine.

The time schedule of a 14-month construction period from the time of building permit to final inspection seems ambitious but possible.

Select Specialty Hospital-Lake, Inc. (CON #9871): The cost estimated for the construction of the new LTCH appears to be reasonable. There is no indication of a specific site on which to build this facility so total cost of the project is not possible to determine.

The time schedule of a 15-month construction period from the time of building permit to final inspection seems reasonable.

G. RECOMMENDATION

Deny CON #'s 9869, 9870 and 9871.

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