

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Kindred Hospitals East, L.L.C./CON #9884

680 South Fourth Street
Louisville, Kentucky 40202

Authorized Representative: Mr. Bud Wurdock
(502) 596-7718

Promise Healthcare of Florida IX, Inc./CON #9885

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

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

Select Specialty Hospital – St. Lucie, Inc./CON #9886

2021 Church Street
Nashville, Tennessee 37203

Authorized Representative: Greg Sassman
(615) 284-6716

2. Service District

District 9 (Indian River, Okeechobee, Martin, St. Lucie, and Palm Beach Counties)

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 9. Letters of support were submitted as follows:

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Kindred Hospitals East, L.L.C. (CON #9884) submitted 27 letters of support for the project to establish a long-term care hospital (LTCH) in District 9, the majority of which were some type of form letter. All letters were similar in content and attributed need for the proposed project to traveling distance, the reluctance to change doctors, the limited number of facilities willing to accept medically complex patients and the unstable conditions of the patients. Three letters were received from Lawnwood Regional Medical Center, both of which were also submitted for each of the two applicants co-batched with Kindred. Nine of the submitted letters were written by case managers and the CEO of St. Lucie Medical Center. The CEO also submitted support letters for each co-batched applicant. Seven letters were submitted by case managers at Raulerson Hospital in Okeechobee County, each of which quantified the number of patients who could have benefited from long-term care hospital services but did not due to the above listed contentions. Only one of these letters indicated the duration of time within which the patients were identified, and that letter indicated 30-50 patients over a three-year span. Eight letters were submitted by physicians in District 9, indicating a quantified number of patients who could have benefited from long-term care hospital services but did not due to the above listed contentions. None of these physician letters indicated the duration of time within which these patients were identified. None of the letters submitted acknowledged the approval of two new LTCHs for this area.

Promise Healthcare of Florida IX, Inc. (CON #9885) submitted two letters of support for its project and one additional letter was received via the mail. The writers of these three letters also submitted letters of support for each of the co-batched applicants: two administrators at Lawnwood Regional Medical Center and the CEO of St. Lucie Medical Center. These letters are similar in content and attribute need for the proposed project to the lack of a long-term hospital in St. Lucie County, the growing and aging population, the need for more convenient access, the reluctance to change physicians and the unstable conditions of the patients. The letter from the chief administrator at Lawnwood indicates that in the past year¹ “our hospitals” had more than 170 long-stay admissions. The writer is referencing hospitals in St. Lucie County and it is therefore assumed that he is referring to St. Lucie Medical Center and Lawnwood Regional Medical Center. The writer did not state that these 170 long-stay patients needed but did not receive long-term care hospital services, but simply named the number of long-term stay admissions during the year at “our hospitals.” This same administrator provided a support letter for the co-batched applicant Select Specialty

¹ This letter is dated September 13, 2005, so it is assumed that the year referenced is the fiscal year 2004 for the referenced facility(ies).

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Hospital that indicated 194 patients were discharged from Lawnwood alone during CY 2004 who had stayed for 24 or more days, 168 such patients were discharged from Lawnwood during CY 2003 and 176 in CY 2002. As is discussed later in this report, it cannot be assumed that every patient in any acute care hospital bed staying for 24 days or longer needed but did not receive long-term care hospital services. Of the three letters submitted, only the letter written by the chief administrator at Lawnwood acknowledged the approval of two LTCHs for this district, and stated that their proposed locations in Palm Beach County were too far from the northern areas of District 9, making travel difficult for elderly patients and their families. Data reported to the Agency show that 77 Indian River, Martin and St. Lucie County residents traveled to receive LTCH services and 135 Palm Beach County residents traveled to receive LTCH services. These District 9 residents primarily chose to receive services in Broward County, further from the northern areas of District 9 than Palm Beach County.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886) submitted 61 letters of support, including 57 form letters in support of proposed projects outside of District 9. Included in the submitted support were letters from the three administrators indicated above, who provided each of the co-batched applicants with a letter of support. In the letter from the CEO of Lawnwood Regional Medical Center, 194 patients were stated to have been discharged from Lawnwood during CY 2004 who had stayed for 24 or more days, with 168 such patients discharged during CY 2003 and 176 in CY 2002. As noted above and discussed later in this report, it cannot be assumed that every patient in any acute care hospital bed staying for 24 days or longer needed but did not receive long-term care hospital services. This letter indicates knowledge of the approved 130 beds, stating that patients admitted to St. Lucie County rarely opt to travel to Palm Beach to be admitted for a long-term stay, and therefore these patients “will not generally utilize the Palm Beach County LTACHs.” This letter additionally indicates that 704 long-stay patients were identified in northern District 9 (all counties excluding Palm Beach) and that patients admitted in St. Lucie County rarely opt to travel to Palm Beach County for long-term stay. It is noted that the type of long-term stay currently available in Palm Beach County includes services also currently available in St. Lucie County such as home health, rehabilitation, and skilled nursing. It is not clear why a patient would opt to travel to Palm Beach County when services are available nearer home. There are two not yet opened, but CON approved LTCHs in District 9. The Agency understands that both CON holders plan to build in Palm Beach County. This option is not yet available to District 9 residents. Additionally, data reported to the Agency show that 77 Indian River, Martin and St. Lucie County residents traveled to receive LTCH services and 135 Palm Beach County residents traveled to receive LTCH

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services. These District 9 residents primarily chose to receive services in an adjacent district. The letter written by the director of case management at Lawnwood acknowledges a singular LTCH approval for Palm Beach County, but does not indicate an understanding that two facilities are approved that will have the ability to add beds at any time outside of CON review. This letter further stated that Palm Beach County is too far for Lawnwood patients to travel. One additional letter was submitted by an area physician who states that he provided care to approximately 15 patients last year who would have likely been candidates for admission into a long-term care hospital if one were available in St. Lucie County or surrounding areas. The author makes no mention of the two approved facilities for the surrounding areas, and therefore it cannot be determined if this physician believes these 15 patients would not be served once these two facilities become operational, outside the approval of the proposed project. An additional 57 form letters were submitted indicating support for long-term care hospitals in Brevard and Broward Counties, both outside of District 9. It is noted that 28 of these 57 form letters were submitted by faculty of Nova Southeastern University (Broward County) in support of a long-term care hospital in Broward County. The two approvals for LTCHs in Palm Beach County would likely serve residents of Broward County to a greater degree than would a long-term care hospital in the applicant's proposed location in St. Lucie County.

C. PROJECT SUMMARY

Kindred Hospitals East, L.L.C. (CON #9884) (Kindred) proposes to construct a 50-bed freestanding LTCH in St. Lucie County, District 9. The applicant gave no specific information relative to the proposed site.

The applicant Kindred indicates that it owns and operates 23 long-term care hospitals including seven freestanding hospitals in Florida and one hospital within a hospital. The applicant has received certificate of need approval to establish a 70-bed freestanding facility to be located in Palm Beach County, District 9 and has recently licensed its eighth facility in Florida, a 31-bed hospital within a hospital in Ocala, District 3. The applicant has submitted two additional proposals for the current review cycle to develop LTCHs. These proposals are for a 60-bed facility in District 7 and a second smaller facility of 50 beds in District 9.

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The proposed project involves 66,961 GSF of new construction, consisting of 40 private rooms and five semi-private rooms. The total construction costs are estimated to be \$15,401,030 with total project costs of \$25,394,112.

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

Promise Healthcare of Florida IX, Inc. (CON #9885), a wholly owned subsidiary of Promise Healthcare, Inc. (Promise), proposes to construct a freestanding 40-bed LTCH to be located in St. Lucie County, District 9. Three potential sites in or near Port St. Lucie were identified in aerial photographs provided in Attachment L as possible locations for the LTCH. According to the applicant, 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 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. The applicant indicates the facility would be comprised 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 patient days to Medicaid and charity patients.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886), a wholly owned subsidiary of Select Medical Corporation, proposes to establish a 44-bed freestanding LTCH to be located in District 9. The applicant indicates that the proposed facility would be located near Lawnwood Regional Medical Center, which is in Fort Pierce, St. Lucie County. 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

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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 44-bed facility would be comprised of 28 private rooms and eight semi-private rooms. The total project cost is estimated to be \$18,351,053.

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

D. REVIEW PROCEDURE

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

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

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

As part of the fact-finding, the consultant Karen Weaver analyzed the application in its entirety with consultation from the Financial Analyst, John Williamson 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, Florida Administrative Code.

1. Fixed Need Pool

a. Does the project proposed respond to need as published by a fixed need pool? Ch. 59C-1.008, Florida Administrative Code.

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

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

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- Quality improvement organizations should be required to review long-term care hospital admissions for medical necessity and monitor that these facilities comply with defining criteria.

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

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

In this comparative batch review, the three co-batched applicants have each described their respective patient populations as "medically complex" and indicated they were high acuity patients. As noted by MedPAC, some portion of LTCH patients nation-wide can be described in the way 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.

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

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

The report further suggests that if its recommendations are developed, a facility that typically serves 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:

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- 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.*

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.

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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.

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:

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

The applicants expect to serve the residents of St. Lucie County, District 9. As noted above, two new LTCHs have been approved for District 9: one to Kindred Hospitals East, LLC in Palm Beach County and one CON approved for Select Specialty Hospital in Palm Beach County totaling 130 new LTCH beds in the district.

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:

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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.**

The current bed complement, patient days and average occupancy of other forms of care in District 9 are presented as follows:

**Acute Care and Post-Acute Care Providers
District 9 Beds and Utilization
Calendar Year 2004**

Facility Type	Total Beds District 9	District 9 Average Occupancy
Acute Care	4,382	64.49%
Comprehensive Medical Rehabilitation	264	78.58%
Hospital-Based Skilled Nursing	20	86.76%
Skilled Care Community Nursing Homes	8,760	87.43%
Long-Term Care Hospital*	130	Not yet licensed

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. Florida Hospital Based Skilled Nursing Unit Utilization by District & Subdistrict for January 2004-December 2004.

***Select Specialty Hospital - Palm Beach, Inc. is approved for 60 beds while Kindred Hospitals East, LLC is approved for 70 beds. Neither facility is operational.**

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

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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 9 was 78.58 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 9 averaged 87.43 percent for the most recent reporting period. This utilization rate is below the benchmark for SNF care set in the Florida Statutes at 94 percent.⁵ 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. The applicants each based projected bed need on acute care stays including those that were shorter than 25 days; 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.

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

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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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 CON approved, not yet licensed 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:

Population Estimates for District 9 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
Indian River	127,154	139,724	9.89%	35,836	39,941	11.45%
Martin	140,898	154,254	9.48%	38,608	43,289	12.12%
Okeechobee	38,206	40,308	5.50%	6,919	7,973	15.23%
Palm Beach	1,274,615	1,408,947	10.54%	282,732	318,754	12.74%
St. Lucie	223,572	248,222	11.03%	49,460	56,018	13.26%
District Total	1,804,445	1,991,455	10.36%	413,555	465,975	12.68%
State Total	17,844,137	19,478,414	9.16%	3,153,525	3,601,571	14.21%

Source: AHCA Population Projections, published October 2005.

As shown above, the overall population in District 9 is expected to increase by 9.89 percent during the next five years, with the 65 and over age cohort increasing by 11.45 percent. St. Lucie 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 highest percent increase in total population and second highest 65 and over population increase for the five-year projection period. Palm Beach County, the county approved for two LTCHs, is the county with the second highest expected percentage rate of growth overall and third highest 65 and over growth rate. There are two CON approved, not yet established LTCHs in District 9. Both have indicated they plan to build in Palm Beach County.

Discussion of each applicant’s need analysis follows.

Kindred Hospitals East, L.L.C. (CON #9884) did not submit a site for the project, but states that its facility would serve the Port St. Lucie/Fort Pierce market. In the applicant’s discussion of bed need, it states that bed need for residents of Palm Beach County is excluded, with discussion focusing on Indian River, Okeechobee, St. Lucie and Martin Counties. The applicant presented a long-term care hospital bed need based on acute care discharges and utilization data from local hospitals.

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Kindred contends utilization (patient days/bed days) is affected by timing of referrals and length of time a patient stays at the LTCH. Kindred assumes patients will be referred five days after they have passed the DRG specific geometric mean length of stay (GMLOS). Kindred does not provide the basis for these assumptions. The projected average length of stay in a LTCH is important because Medicare requires an average length of stay of 25 days or more.

The process used by Kindred consists of five steps:

The first step is to exclude patients who are not appropriate because they require care not usually provided at a LTCH. These discharges contain all diagnosis related groups (DRGs) within the major diagnostic categories (MDC) of: 13-female reproductive system, 14-pregnancy, 15-newborns and other neonates, 19-mental disease and disorders, 20-alcohol and substance abuse, 22-burns, 23-factors influencing health factors. Kindred provided a list of the 390 acute care DRGs representing potential LTCH admissions⁶.

The second step is to identify discharges that are:

- Assigned to one of the 390 LTCH potential referral DRGs;
- Patients are 18 years or older; and
- Have a length of stay exceeding the GMLOS by 15 days.

The third step is to determine the potential long-term care hospital days produced by this group of discharges. For calendar year 2004, Kindred estimates 15,905 potential long-term hospital days were provided by the seven local acute care hospitals, which results in an average daily census of 43. The applicant contends this is in excess of patient days in Palm Beach County facilities. Because this 43 average daily census is described as the “potential” pool of patient days, it can be concluded that this would be the greatest possibility of patient days, and therefore the probable average daily census could be significantly less.

The fourth step according to the applicant is to identify the number of patient days that are leaving the area for long-term hospital care due to the absence of LTCH services in the market. The applicant’s market includes Indian River, Okeechobee, Martin and St. Lucie Counties. It has presumably excluded adjacent Palm Beach County from its proposed service area because it and co-batched applicant Select are planning to establish the LTCHs recently approved for the district in Palm Beach County; therefore, there is not an absence of LTCH services in this state planning area. The applicant wishes to focus a segment of the District 9

⁶ CON application #9894, Appendix 4

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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 9's population because there is not a hospital physically located within the area the applicant wishes 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 area⁷.

The applicant states that for calendar year (CY) 2004, 75 residents of Indian River, Okeechobee, Martin and St. Lucie Counties were discharged from Kindred Hospital Fort Lauderdale in Broward County, and that the 2,922 days of LTCH care provided to those patients equated to an average daily census of eight. The proposed location of this LTCH is in St. Lucie County, which is separated from Fort Lauderdale by Palm Beach County, which has two approved long-term care hospitals that will result in 130 long-term care beds established in the same designated planning area with this daily census of eight. It is noted that despite claims in letters of support that area residents opt not to travel to obtain needed services, it appears some do and are willing to travel much further distances than they will need to in the future when the two approved LTCHs for this area are established.

The chart below illustrates District 9 discharges from Kindred's two District 10 LTCHs by county:

⁷ Underline added for emphasis

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**District 9 LTCH Discharges to District 10 Facilities
Calendar Year (CY) 2004**

County	Kindred Hospital - Ft. Lauderdale	Kindred Hospital - Hollywood	Total
Indian River	14		14
Martin	11	2	13
Okeechobee	11		11
Palm Beach	120	15	135
Saint Lucie	38	1	39
Total	194	18	212

Source: State Center for Health Statistics

As shown above, 77 of the patients discharged were from the applicant's proposed service area with an additional 135 from Palm Beach County. As shown earlier, occupancy in District 10 facilities is the lowest in the state. Kindred's Fort Lauderdale facility averaged 66.41 percent occupancy during 2004 while its Hollywood facility averaged 59.74 percent. The state average was 67.14 percent for LTCH services. It is reasonable to expect some Palm Beach County residents to continue to seek services in Kindred's District 10 facilities, but it is also very likely that a number of residents will seek services in its District 9 facility if that facility is closer. As noted, it is also as likely that if patients who live in Indian River County, for example, are willing to travel to Broward County, that they will be equally as willing to travel a lesser distance from Indian River County to Palm Beach County.

The fifth step detailed by the applicant is to consider the population growth projections for both total population and over-65 populations. The applicant states that the over-65 population of the four counties it has included in its service area is projected to increase by 11.7 percent over the next five years, with the total population of these counties increasing 10 percent; therefore, the applicant concludes that the LTCH market will increase by at least 10 percent during this time, which would result in a potential average daily census at the proposed facility of 56 in the year 2010. It is not known if the applicant is again including the days of Medicare patients with an estimated LTCH stay of 10 days or more, which the applicant already stated would be minimized in the interest of maintaining at least a 25-day average for Medicare patients as is required for its Medicare certification.

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The final step is to apply an 85 percent occupancy rate to the ADC of 56 yielding a projected need of 65 beds. As discussed above, this estimate would likely be greatly minimized, as the typical patient is described as over-65 (and therefore likely Medicare), and Medicare patients with estimated long-term hospital lengths of stay falling between 10 days (as the applicant includes in its analysis) and 25 days (the minimum average for Medicare certification quoted by the applicant) have been stated to be “minimized” by admission criteria. If admission of a certain Medicare patient would be minimized at the proposed facility, it is not clear why that Medicare patient’s estimated days would be included in the need analysis for the proposed facility. The applicant does not adequately support its contention of need for these beds if all of its assumptions are correct. Additionally, there is no clear evidence that these assumptions can be made. The applicant has assumed that because a patient was in an acute care bed a certain number of days past the GMLOS, he or she likely needed LTCH services. No acuity level was established for any of these patients. It cannot be assumed that certain DRGs signify acuity levels or that the age of the patient is an automatic indicator of acuity. As discussed earlier, the DRG alone is not an indicator of acuity level. CMS has contracted with a group to make recommendations on appropriate acuity measures for LTCH admissions because the DRG system does not function in that capacity. The person’s age is also not a guarantee of a high acuity level. Many elderly patients receive post acute care in skilled nursing facilities, rehabilitation hospitals and through home health agencies. Additionally, MedPac determined that even when there is a LTCH with available beds in the area, patients continue to remain in an acute bed and are not immediately discharged to the LTCH.

Kindred claims traveling long distances for extended periods of time imposes a great burden on patients and their families, as well as being impractical. However, the application did not specify the proposed site for this facility so the burden on the families could not be determined by analyzing the driving distances. LTCH services are the most expensive post-acute care service and are generally provided to patients with complex medical conditions and therefore are not 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 planning area larger than a subdistrict planning area is more appropriate for LTCH services. The applicant has not met its burden to demonstrate that the patient population it has identified is not already receiving needed care. Additionally, given that two new LTCHs have been approved for this area and are to be located in a nearby county, there is no evidence that any future need for LTCH care will not be met by these two approved facilities.

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Promise Healthcare of Florida IX, Inc. (CON #9885) indicated three potential sites in or near Port St. Lucie as possible locations for the LTCH. The applicant 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. 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, within the current Medicare reimbursement system (which although it does account for case-mix differences between patients, it 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. It is generally accepted that LTCHs serve a higher acuity patient population than other forms of post-acute care and are subsequently reimbursed for this higher level of care at a substantially higher level. However, in discussing need for this service in District 9, it is the applicant's burden to show that this medically complex high acuity patient population that cannot be served in other post-acute venues does not have access to appropriate care and therefore a facility is needed in the area. The applicant indicates its facility will be located at one of three sites in St. Lucie County and will serve all the counties of District 9: Indian River, Okeechobee, St. Lucie, Martin and Palm Beach Counties. Two LTCHs are already approved for this district, for a total of 130 LTCH beds, to accommodate any need such as that which the applicant describes.

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The applicant provides a discussion of the total District 9 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 over-65 population by 12.7 percent. No evidence was presented to indicate that the two CON approved LTCHs will not meet future need for this service.

The applicant discusses the travel distance to existing LTCHs but indicates the two approved LTCHs will not meet the need for the four northern District 9 counties. Because no LTCH is currently operational in District 9, 87.7 percent of long-term care patients from District 9 are stated to have outmigrated to Kindred Hospital – Fort Lauderdale and 8.2 percent are stated to have outmigrated to Kindred Hospital – Hollywood. According to data reported to the Agency, 220 long-term care District 9 patients were discharged from Florida LTCHs during calendar year 2004. 212 of those 220 discharged were discharged from District 10 facilities. Following is a chart illustrating, by county, LTCH discharges to Kindred’s two District 10 facilities:

**District 9 LTCH Discharges to District 10 Facilities
Calendar Year (CY) 2004**

County	Kindred Hospital - Ft. Lauderdale	Kindred Hospital - Hollywood	Total
Indian River	14		14
Martin	11	2	13
Okeechobee	11		11
Palm Beach	120	15	135
Saint Lucie	38	1	39
Total	194	18	212

Source: State Center for Health Statistics

Considering the average length of stay (ALOS) for LTCH patients must be 25 days (although Kindred’s ALOS is generally longer than 25 days) the chart above illustrates that at a minimum 5,300 patients days were used by District 9 patients in CY 2004. If the ALOS was higher, perhaps 45 days, patient days would have been 9,540. Occupancy in 130 for 5,300 patient days would have been 11.2 percent [$5,300 / 47,450 = 11.2$ percent ($130 \times 365 = 47,450$)] and for 9,540 patient days would have been 20.1 percent. The 130 long-term care beds already approved for District 9, the ability to add beds at those two approved facilities, as well as the possibility of deliberate patient choice to outmigrate, suggest that need does not exist for additional long-term care beds in District 9.

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The applicant provides driving time estimates from area acute care hospitals to the Fort Lauderdale (existing LTCH) and to Port St. Lucie (proposed city of location) and concludes that District 9 long-term care patients would save an estimated 48-91 minutes traveling to the proposed facility. It is noted that with the two approved LTCHs in Palm Beach County, patients requiring LTCH services will already have a closer facility option than Fort Lauderdale. As discussed above, the number of patients specifically requiring LTCH services has not been demonstrated to be sufficient to support a third LTCH in District 9.

Promise Healthcare indicates that its need analysis contains the following assumptions: Acute care facilities and intensive rehabilitation facilities⁸ (IRFs) are not appropriate substitutes for LTCHs; a SNF would require specialized programs to care for similar populations; LTCH patients cost Medicare more than similar patients who use alternative settings if similar services are available, but when long-term care is targeted to patients of the highest severity, the cost is similar. The applicant evaluated the number of CY 2004 discharges from District 9 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. According to the applicant, this resulted in 2,300 acute care long-stay District 9 hospital discharges and approximately 74,422 patient days, or an ALOS of 32.4 days. As noted earlier regarding co-batched applicant Kindred's need analysis, there is no clear evidence that Promise can assume these patients required but did not receive LTCH services. The applicant has assumed that because a patient was in an acute care bed a certain number of days past the GMLOS, he or she likely needed LTCH services. No acuity level was established for any of these patients. It cannot be assumed that certain DRGs signify acuity levels or that the age of the patient is an automatic indicator of acuity. As discussed earlier, the DRG alone is not an indicator of acuity level. CMS has contracted with a group to make recommendations on appropriate acuity measures for LTCH admissions because the DRG system does not function in that capacity. The person's age is also not a guarantee of a high acuity level. Many elderly patients receive post acute care in skilled nursing facilities, rehabilitation hospitals and through home health agencies. Additionally, MedPAC determined that even when there is a LTCH with available beds in the area, patients continue to remain in an acute bed and are not immediately discharged to the LTCH.

⁸ This is term used by the federal government. In Florida, this type of facility is known as a comprehensive medical rehabilitation (CMR) facility, and CMR units are also located in a number of acute care hospitals.

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The applicant applies the 2.32 percent age-adjusted average annual growth rate it indicates for 2005-2010 to the district LTCH discharges and determines that there will be 2,640 LTCH discharges in District 9 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 1,980 discharges (2,640 – 660 (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, but the applicant keeps the CY 2004 Florida LTCH length of stay at 34.5 days for its need calculation. This results in 68,298 projected LTCH patient days (1,980 x 34.5) in 2010, which the applicant equates to a need of 234 long-term care beds. It is noted that the method by which the applicant determined this number included the application of a projection of 80 percent occupancy; long-term care hospitals statewide experienced 67.14 percent occupancy during CY 2004. Further, this need methodology assumes that the two recently CON approved, not yet licensed, facilities 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. Promise has not selected a site for the project, and so travel distance estimates cannot be verified. 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. Additionally, given that two new LTCHs have been approved for this area, there is no evidence that any future need for LTCH care will not be met by these two approved facilities.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886) 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, Guillain Barre syndrome and Myasthenia Gravis, respiratory/ventilator dependent patients and other medically complex patients who require extensive physiological monitoring, intravenous therapies, dialysis or post-operative care. Select's services are indicated to include medically complex care for a range of underlying conditions and symptoms

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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 - St. Lucie, Inc. projects that its primary service area will be St. Lucie County, southern Indian River County and northern Martin County. The total service area is defined to include all of District 9 excluding Palm Beach County. Like co-batched applicant, Kindred, it has presumably excluded adjacent Palm Beach County from its proposed service area because it and Kindred are planning to establish the LTCHs recently approved for the district in Palm Beach County. With regard to short-term acute care, the applicant states that the need for long-term care hospitals stems from the fact that patients that are surviving complicated surgical interventions or traumatic injuries only to need long-term life support and various other therapies. With regard to services, the applicant states that LTCH care exceeds comprehensive medical rehabilitation (CMR) care in terms of nurse hours per patient, with up to 12 hours provided at a LTCH versus 3-5½ hours at a CMR. With regard to hospital-based or nursing home skilled care, the applicant contends that sub-acute patients placed in a SNF must be medically stable and yet they require more intensive nursing care than is normally provided in a nursing home facility. 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. Two LTCH hospitals are approved to serve District 9 and have not yet begun operations.

The applicant provided an analysis of the District 9 population growth broken down by county. According to the applicant's projections, the District 9 total population is expected to grow by 10.7 percent from July 2004 to July 2009 (the second year of operation of the proposed project), and the District 9 total population excluding Palm Beach County is projected to grow 10.1 percent for the same time period. The applicant states that the over-65 population is expected to increase by 10.6 percent throughout District 9 and by 10.9 percent in the defined service area.

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 the four

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defined service area counties (all of District 9 excluding Palm Beach County) based on the discharges from the seven area acute care hospitals. The second method addresses the geometric mean length of stay plus 15 days for the same four counties. The third method examines the long-stay “Short Term” acute care hospital penetration with that of long-term care hospitals. The fourth method is a discharge analysis of patient lengths of stay exceeding 24 days.

With regard to the extended length of stay analysis, the applicant selected what it determined to be the top DRGs from St. Lucie, Indian River, Martin and Okeechobee County hospitals 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, patients with psychiatric diagnoses, substance abuse diagnoses, obstetric diagnoses, newborn diagnoses and rehabilitation diagnoses. 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 704 hospital discharges with a length of stay 24 days and greater for the total service area. 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 68 patients for all of District 9 excluding Palm Beach County. From this the applicant concludes that 84 long-term care beds are needed in District 9. 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 currently operates eight of the 14 operational LTCHs in the state that reported utilization in 2004. Unlike Kindred, Select does not indicate a focus on ventilator dependent patients. It may be more realistic method to use a 28 to 30 day length of stay. Had this been otherwise supported, an average daily census of 54 to 58 patients or a potential hospital specific need, absent other factors, for 68 to 73 beds would have been shown. However, no evidence has been presented by the applicant indicating that area residents will require proximate LTCH services in excess of those already approved for this district. As noted earlier, there are two CON approved LTCHs in District 9 that have yet to begin operation and the applicant has made similar assumptions as that of co-batched applicants Kindred and Promise, which it also does not support.

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The second method examines the geometric mean length of stay plus 15 days to arrive at 940 potential LTCH discharges from the total service area and a need for 90-113 beds, depending which length of stay presented by the applicant is used. Again, there are two CON approved LTCHs in District 9 that have yet to begin operation and the applicant has made similar assumptions as that of co-batched applicants Kindred and Promise, which it also does not support.

The third method examines the long-stay “Short Term” acute care hospital penetration with that of long-term care hospitals. The applicant concludes from its analysis that the four service area counties have less than half of the statewide weighted average for patients admitted to a LTCH, which it indicates is evidence of an accessibility problem. However, no other evidence was presented to support this. Additionally, this does not take into account CON approved LTCHs within close proximity to the service area. There is no evidence that the patients the applicant projects it can serve cannot be served by the LTCHs that are CON approved for this district.

The fourth method provides a more detailed, patient specific extended stay analysis of service area hospital discharges with average length of stays greater than 24 days. For CY 2004, the applicant identified 704 discharges with 24 days or greater length of stay. According to the applicant, this analysis concluded that 10 percent of service area discharges may have benefited from admission to LTCHs. 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 receiving inappropriate care. 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.

In summary, the applicant failed to provide clear 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. The applicant has assumed that because a patient was in an acute care bed a certain number of days past the GMLOS, he or she likely needed LTCH services. No acuity level was established for any of these patients. It cannot be assumed that certain DRGs signify acuity levels or that the age of the patient is an automatic indicator of acuity. As discussed earlier, the DRG alone is not an indicator of acuity level. CMS has contracted with a group to make recommendations on appropriate acuity measures for LTCH admissions because the DRG system does not function in that capacity. The person's age is also not a guarantee of a high acuity level. Many elderly patients receive post acute care in skilled nursing facilities, rehabilitation hospitals and through home health agencies. Additionally, MedPac determined that even when there is a LTCH with available beds in the area, patients continue to remain in an acute bed and are not immediately discharged to the LTCH. 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 noted that an access problem will exist in the district after the two approved LTCHs have begun operations.

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.**

In charts below, utilization for area acute and post-acute care providers is again presented as is LTCH inventory and utilization statewide.

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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 9 for a total of 130 LTCH beds. Neither facility is operational. Therefore, LTCH utilization in District 9 LTCH cannot be shown.

**Acute Care and Post-Acute Care Providers
District 9 Beds and Utilization
Calendar Year 2004**

Facility Type	Total Beds District 9	District 9 Average Occupancy
Acute Care	4,382	64.49%
Comprehensive Medical Rehabilitation	264	78.58%
Hospital-Based Skilled Nursing	20	86.76%
Skilled Care Community Nursing Homes	8,760	87.43%
Long-Term Care Hospital*	130	Not yet licensed

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. Florida Hospital Based Skilled Nursing Unit Utilization by District & Subdistrict for January 2004-December 2004.

***Select Specialty Hospital – Palm Beach, Inc. is approved for 60 beds while Kindred Hospitals East, LLC is approved for 70 beds. Neither facility is operational.**

**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.**

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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 licensed effective 10/27/05.

Kindred Hospitals East, L.L.C. (CON #9884) contends the two approved LTCHs for this district will be up to 80 miles away from the most northern reaches of the district, and therefore would not be accessible for the populations outside of Palm Beach County in District 9. However, as previously indicated, with District 9 patients who live in Indian River, Martin and St. Lucie counties currently accessing LTCH care in facilities more than 80 miles away there is clearer evidence that services are currently accessible and the establishment of two new LTCHs in closer proximity to these residents makes the services even more accessible. As noted previously, the bed need analysis presented by the applicant makes a series of assumptions without backup documentation and where compelling evidence in the literature indicates that these assumptions are false so that need for this project has not been shown. Additionally, the analysis includes an unknown degree of patient days that the proposed facility would likely not admit due the requirements of its Medicare certification; therefore, the LTCH bed need projections presented are not reflective of likely utilization of the proposed beds. While no long-term hospitals exist in District 9 from which current utilization figures could be assessed, both the applicant and the co-batched applicant Select Specialty have received prior approvals to establish long-term hospitals in this district. Need for beds in addition to the approved 130 would be better established if the two approved facilities were to open, operating at or near capacity, and were unable to establish additional beds.

Availability and accessibility would increase with this project, according to the applicant, as skilled nursing facilities (SNFs) and other sub-acute

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providers are stated to lack the staff, equipment, facilities or capabilities to provide the services proposed, and acute care hospital facilities would not be subject to financial burdens resulting from low bed turnover. As discussed above, it is not clear that the number of patients fitting the applicant's admission criteria is sufficient to warrant long-term care beds in addition to the 130 already approved. It is further noted that recent changes in CON legislation would allow the two approved LTCHs in District 9 to add beds outside of CON review.

The applicant states the proposed facility would improve efficiency of LTCH services by integrating the continuum of care to ensure patients are placed in the most independent setting for their condition. Administrative services would reportedly be shared between the proposed facility and other Kindred facilities.

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.

Promise Healthcare of Florida IX, Inc. (CON #9885) restates its contention that because there are no LTCHs in District 9, 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 will exist in the district after the two approved facilities become operational.

The applicant's claims of evidence of access problems are not clearly supported. Specific documentation from area providers with regard to delays in care that will not be addressed by the two CON approved LTCHs would have been supportive and beneficial in showing an access problem to long-term care in the area.

It is noted that the applicant states twice in its application that Martin Memorial Hospital demonstrates its support for an approval of an additional LTCH for District 9 by virtue of its CON application #9837 for a LTCH. CON application #9837 was submitted by Martin Memorial to establish an acute care hospital, not a long-term care hospital.

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 - St. Lucie, Inc. (CON #9886) states that there are no like and existing LTCH facilities in the northern District 9 area and that clinically-appropriate patients are remaining in inappropriate bed situations. It is noted that the planning area for a LTCH proposal is the district, and District 9 has two currently approved but not yet licensed LTCHs. It is also noted that the applicant did not support its contention that clinically-appropriate patients are remaining in inappropriate bed situations. With LTCH patients in Indian River, Martin and St. Lucie Counties currently obtaining LTCH services in District 10, there is clear evidence to the contrary. The establishing of two new LTCHs closer to these counties will only serve to enhance access to this service.

As previously discussed, the applicant did not provide letters from area physicians regarding potential LTCH referrals in light of the two facility approvals. Specific documentation from area providers with regard to delays in care expected after initiation of operations at the two facilities would have been supportive and beneficial in showing a projected 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.

- 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.**

Kindred Hospitals East, L.L.C. (CON #9884) states all of its currently licensed LTCHs are accredited by the JCAHO and the necessary components are in place to ensure delivery of care. The applicant provided descriptions of case management plan, admission and assessment process, care planning, discharge process and quality initiatives.

Agency records indicate 12 confirmed complaints for the seven Kindred licensed LTCHs in the state for the three-year period ending October 5, 2005: patient care (five); medicine problems/errors/formulary (three); patient rights (one); untrained/unqualified staff (one); discharge planning (one); and nursing service (one).

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Promise Healthcare of Florida IX, Inc. (CON #9885) 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 O. Attachment G contains Promise Specialty Hospital's pre-admission screening document and Attachment H contains its standards of performance.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886) 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. 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 3 of the application. Attachment 8 (Volume 2) contains Select Medical's plan for the provision of patient care/services and Attachment 22 in Volume 3 contained Select's utilization review plan.

Agency records indicate six confirmed complaints have been received on the parent corporation's Miami facility for the three-year period ending October 5, 2005: 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, became the current licensee of as of March 11, 2005. From March 11, 2005 through October 5, 2005, agency records indicate the facility had three confirmed complaints: medicine problems/errors/formulary (two) and patient care (one). The Panama City facility licensed on January 5, 2004 had no confirmed complaints as of the writing of this report.

- 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.**

Kindred Hospitals East, L.L.C. (CON #9884): This review is for Kindred Hospitals East, L.L.C., Inc. that is applying to establish a freestanding 50-bed long-term care hospital in District 9, St. Lucie County, Florida. The financial impact of the project will include the project cost of \$25,394,112 and year two operating costs of \$15,564,807.

The audited financial statements of the applicant for the periods ending December 31, 2004 and 2003 were analyzed for evaluating the applicant's ability to provide the capital and operational funding necessary to implement the project. The following is a list of the accounts and ratios used in the analysis:

Kindred Hospitals East, LLC		
	12/31/2004	12/31/2003
Current Assets	\$ 104,609,085	115,343,532
Cash and Current Investment	\$ 1,170,425	929,338
Assets Restricted for Capital Projects	\$ 0	0
Total Assets	\$ 143,654,847	154,903,329
Current Liabilities	\$ 38,565,440	50,489,276
Total Liabilities	\$ 40,211,844	50,541,294
Total Equity	\$ 103,446,003	104,362,035
Net Operating Revenues	\$ 489,103,572	452,417,039
Interest Expense	\$	
Net Profit - Operations	\$ 20,680,700	21,902,494
Net Income	\$ 21,241,435	21,732,005
Cash Flow from Operations	\$ 31,083,886	12,286,483
Working Capital	\$ 66,043,645	64,854,256
Current Ratio (CA/CL)	2.7	2.3
Cash Flow to Current Liabilities (CFO/CL)	0.81	0.24
Long-Term Debt to Equity (TL-CL/TE)	0.0	0.0
Equity to Total Assets (TE/TA)	72.0%	67.4%
Operating Margin (NPO/NOR)	4.2%	4.8%
Total Margin (NI/NOR)	4.3%	4.8%
Return on Assets (NI/TA)	14.4%	14.1%
Operating Cash Flow to Assets (CFO/TA)	21.6%	7.9%

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

Short-term position:

The applicant's current ratio of 2.7 is above average in relation to all Florida Hospitals and a good position. The ratio of cash flow to current liabilities of 0.81 is above average and a good position. Working capital (current assets less current liabilities) of \$66.0 million is substantial in relation to the entity's size. Overall, the applicant has a good short-term position.

Long-term position:

The ratio of long-term debt to equity of 0.0 is the result of carrying no long-term debt on the books of the applicant. Long-term debt is carried on the books of the parent corporation. The ratio of cash flows to assets of 21.6 percent is above average and a strong position. The most recent period had an operating profit of \$20.7 million, resulting in a margin of 4.3 percent. Total equity is \$103.5 million; the ratio of equity to assets is 72.0 percent. Overall, the applicant has a good long-term position.

Capital requirements:

Schedule 2 indicates capital projects of \$146.5 million.

Available capital:

Funding for these projects will come from \$133.6 million in operating cash flows and \$12.9 million in cash in hand. The audited financial statements of the applicant show \$1.2 million cash on hand, and \$31.0 million in cash flows.

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

Staffing:

The applicant states that its commitment to successful employee recruitment and retention programs is evidenced by its allocation of substantial resources to attract highly qualified staff and provide them with incentives to stay, incentives that are named to include competitive salary and benefits, as well as opportunities for recognition and promotion. Recruitment methods indicated are media advertising, job fairs, direct marketing and internet recruitment. The need for additional staff is stated to be regularly assessed, and the applicant states that each

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Kindred facility has an adequate pool of candidates from which it can be selective in its hiring decisions. Schedule 6 indicates 120.5 total FTEs for the second year of operations at the proposed facility, with 12.1 allotted for registered nurses (RNs), 16.9 for licensed practical nurses (LPNs) and 15.9 for nurses' aides.

Conclusion:

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

Promise Healthcare of Florida IX, Inc. (CON #9885): This review is for Promise Healthcare of Florida IX, Inc. applying to establish a freestanding 40-bed long-term care hospital (LTCH) in District 9, St. Lucie County, Florida. The financial impact of the project will include the project cost of \$20,901,826 and year two operating costs of \$15,894,039.

The applicant 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), the applicant's financial position cannot be determined.

Capital Requirements:

Schedule 2 indicates that the only project planned is the construct 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 months of operation 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 cost of the facility listed on Schedule 2.

Available Capital:

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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 likelihood to be able to secure financing could not be determined.

In this situation, the applicant would have to 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, we cannot determine the financial position of the parent company and can not reach a conclusion about the parent company's ability to secure debt financing for the applicant.

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. Schedule 6 indicates 105.7 total FTEs for the second year of operations at the proposed facility, with 19.6 allotted for registered nurses (RNs), 14.4 for licensed practical nurses (LPNs) and 14.4 for nurses' aides.

Conclusion:

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

Select Specialty Hospital - St. Lucie, Inc. (CON #9886): This review is for Select Specialty Hospital – St. Lucie, Inc. applying to establish a freestanding a 44-bed long-term care hospital (LTCH) in District 9, St. Lucie County, Florida. The financial impact of the project will include

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the project cost of \$18,851,053 and year two operating costs of \$13,543,968.

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 9, 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 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		
	<u>12/31/2004</u>	<u>12/31/2003</u>
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

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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 \$18.5 million. It should be noted that the applicant is projecting an operating loss of \$2.3 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 is attributable to the difference in Medicare reimbursement rates for acute care hospitals and LTCHs as well as low occupancy during the first year.

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.

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. Schedule 6 indicates 100.0 total FTEs for the second year of operations at the proposed facility, with 20.0 allotted for registered nurses (RNs), 10.0 for licensed practical nurses (LPNs) and 17.0 for nurses' aides. An additional 2.0 FTEs are indicated for nurse liaisons.

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.

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.

Kindred Hospitals East, L.L.C. (CON #9884) 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. It should be noted that seven of the 11 facilities in Group 12 are Kindred facilities.

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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.

There was an error on Schedule 6; it shows 60 beds when the application is only for 50. The schedules appear to be prepared for a 50-bed facility. The only result of the error is to lower the year two occupancy rate from 61 percent for 50 beds to 51 percent for 60.

Projected net revenue per patient day (NRPD) of \$1,410 in year two is between the control group median and lowest values of \$1,486 and \$1,313. With net revenues between the control groups 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 \$1,393 in year two is between the group median and lowest values of \$1,417 and \$1,063. With projected CPD between the median and lowest values of the group, costs appear reasonable. (See Comparative Table).

The year two projected operating income is \$197,686, which computes to an operating margin per adjusted patient day of \$18. This is between the control group median and lowest values of \$160 and -\$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.

The applicant's estimated payer mix from Schedule 6 differs from statements in the application. While the applicant offered to provide 2.2 percent Medicaid days, only 1.2 percent of days on Schedule 6 are Medicaid/Medicaid HMO.

Based on the above analysis, financial feasibility of this project appears likely if the market is sufficient to enable the applicant to achieve its projected number of patient days.

Comparative Table

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CON # 9884 Kindred Hospitals East, LLC	2009	YEAR 2	VALUES ADJUSTED		
	ACTIVITY	PER DAY	FOR INFLATION		
			Highest	Median	Lowest
ROUTINE SERVICES	10,234,345	916	2,295	1,212	811
INPATIENT AMBULATORY	-	0	19	0	0
INPATIENT ANCILLARY SERVICES	40,937,380	3,663	4,377	3,821	2,284
OUTPATIENT SERVICES	-	0	63	0	0
OTHER OPERATING REVENUE	-	0	8	2	0
TOTAL REVENUE	51,171,725	4,579	6,673	4,957	3,535
DEDUCTIONS FROM REVENUE	35,409,232	3,168	*	*	*
NET REVENUES	15,762,493	1,410	1,887	1,486	1,313
EXPENSES					
ROUTINE	4,867,923	436	559	386	234
ANCILLARY	3,968,883	355	651	372	258
AMBULATORY		0			
OVERHEAD	6,728,001	602	755	599	499
OTHER		0			
TOTAL EXPENSES	15,564,807	1,393	1,872	1,417	1,063
OPERATING INCOME	197,686	18	334	160	-17
		1.3%			
PATIENT DAYS	11,176		VALUES NOT ADJUSTED		
ADJUSTED PATIENT DAYS	11,176		FOR INFLATION		
TOTAL BED DAYS AVAILABLE	21,900				
ADJ. FACTOR	1.0				
TOTAL NUMBER OF BEDS	60				
PERCENT OCCUPANCY	51%		89.5%	69.5%	55.7%
PAYER TYPE	PATIENT DAYS	% TOTAL			
MEDICARE	6,386	57.1%	98.7%	77.9%	55.0%
COMMERCIAL	2,948	26.4%			
MEDICAID	107	1.0%	5.8%	0.3%	0.0%
SELF-PAY	-	0.0%			
HMO/PPO	1,623	14.5%	23.6%	16.0%	0.0%
OTHER	112	1.0%			
TOTAL	11,176	100.0%			

Promise Healthcare of Florida IX, Inc. (CON #9885) 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

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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 \$1,526 in year two is between the control group median and highest values of \$1,495 and \$1,899. With net revenues falling between the control groups median and highest 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 \$1,417 in year two is between the control group median and lowest values of \$1,426 and \$1,070. With cost per patient day falling between the median and lowest level, these estimates appear to be reasonable and costs appear to be efficient. (See Comparative Table).

The year two projected operating income is \$1.2 million, which computes to an operating margin per adjusted patient day of \$109. This is between the control group median and lowest value of \$160 and a negative \$17.

Financial feasibility of this project appears likely if the applicant is able to secure financing and the market is sufficient to enable the applicant to achieve its projected number of patient days.

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Comparative Table

CON # 9885 Promise Healthcare of Florida IX, Inc.	2010	YEAR 2	VALUES ADJUSTED		
	YEAR 2	ACTIVITY	FOR INFLATION		
	ACTIVITY	PER DAY	Highest	Median	Lowest
ROUTINE SERVICES	50,830,912	4,532	2,310	1,220	816
INPATIENT AMBULATORY	-	0	19	0	0
INPATIENT ANCILLARY SERVICES	-	0	4,405	3,846	2,299
OUTPATIENT SERVICES	-	0	63	0	0
OTHER OPERATING REVENUE	253,006	23	8	2	0
TOTAL REVENUE	51,083,918	4,555	6,717	4,989	3,558
DEDUCTIONS FROM REVENUE	33,963,876	3,028	*	*	*
NET REVENUES	17,120,042	1,526	1,899	1,495	1,322
EXPENSES					
ROUTINE	4,278,594	381	562	389	236
ANCILLARY	4,617,511	412	655	374	259
AMBULATORY		0			
OVERHEAD	6,158,543	549	760	603	502
OTHER		75			
TOTAL EXPENSES	15,894,039	1,417	1,884	1,426	1,070
OPERATING INCOME	1,226,003	109	334	160	-17
		7.2%			
PATIENT DAYS	11,216		VALUES NOT ADJUSTED		
ADJUSTED PATIENT DAYS	11,216		FOR INFLATION		
TOTAL BED DAYS AVAILABLE	14,600				
ADJ. FACTOR	1.0				
TOTAL NUMBER OF BEDS	40				
PERCENT OCCUPANCY	77%		89.5%	69.5%	55.7%
PAYER TYPE	PATIENT DAYS	% TOTAL			
MEDICARE	6,936	61.8%	98.7%	77.9%	55.0%
COMMERCIAL	112	1.0%			
MEDICAID	112	1.0%	5.8%	0.3%	0.0%
SELF-PAY	112	1.0%			
HMO/PPO	3,944	35.2%	23.6%	16.0%	0.0%
OTHER	-	0.0%			
TOTAL	11,216	100.0%			

Select Specialty Hospital - St. Lucie, Inc. (CON #9886) 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.

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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 \$1,224 in year two is below the control group lowest value of \$1,313. On average, the hospital is consuming fewer health care dollars in proportion to services being provided than all of the hospitals in the control group. It is unlikely that such economies of operation would be achieved in the first two years. NRAPD is most likely understated. (See Comparative Table).

Projected cost per patient day (CPD) of \$1,116 in year two is between the group median and lowest value of \$1,417 and \$1,063. With cost per patient day falling between the median and lowest level, these estimates appear to be reasonable and costs appear to be efficient. (See Comparative Table).

The year two projected operating income is \$1.3 million. However, with net revenues likely understated, the projected operating margin cannot be relied on.

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.

Serious flaws were found in the financial projections. However, as the applicant has successfully operated similar hospitals, it cannot be said that the project is not feasible.

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COMPARATIVE TABLE

CON # 9886 Select Specialty - St. Lucie	2009	YEAR 2	VALUES ADJUSTED		
	YEAR 2	ACTIVITY	FOR INFLATION		
	ACTIVITY	PER DAY	Highest	Median	Lowest
ROUTINE SERVICES	11,530,150	950	2,295	1,212	811
INPATIENT AMBULATORY	25,912,258	0	19	0	0
INPATIENT ANCILLARY SERVICES	499,111	41	4,377	3,821	2,284
OUTPATIENT SERVICES	-	0	63	0	0
OTHER OPERATING REVENUE	-	0	8	2	0
TOTAL REVENUE	37,941,519	3,126	6,673	4,957	3,535
DEDUCTIONS FROM REVENUE	23,086,915	1,902	*	*	*
NET REVENUES	14,854,604	1,224	1,887	1,486	1,313
EXPENSES					
ROUTINE	3,342,925	275	559	386	234
ANCILLARY	4,686,542	386	651	372	258
AMBULATORY		0			
OVERHEAD	5,514,501	454	755	599	499
OTHER		0			
TOTAL EXPENSES	13,543,968	1,116	1,872	1,417	1,063
OPERATING INCOME	1,310,636	108	334	160	-17
		8.8%			
PATIENT DAYS	12,138		VALUES NOT ADJUSTED		
ADJUSTED PATIENT DAYS	12,138		FOR INFLATION		
TOTAL BED DAYS AVAILABLE	16,060				
ADJ. FACTOR	1.0				
TOTAL NUMBER OF BEDS	44				
PERCENT OCCUPANCY	76%		89.5%	69.5%	55.7%
PAYER TYPE	PATIENT DAYS	% TOTAL			
MEDICARE	9,414	77.6%	98.7%	77.9%	55.0%
COMMERCIAL	1,788	14.7%			
MEDICAID	243	2.0%	5.8%	0.3%	0.0%
SELF-PAY	97	0.8%			
HMO/PPO	596	4.9%	23.6%	16.0%	0.0%
OTHER	-	0.0%			
TOTAL	12,138	100.0%			

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

Competition to promote quality and cost-effectiveness is driven primarily by the best combination of high quality and fair price. Competition forces health care facilities to increase quality and reduce charges/cost in order to remain viable in the market.

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Kindred Hospitals East, L.L.C. (CON #9884): This application is for a 50-bed LTCH in District 9, St. Lucie County. Currently, there are two CON approved LTCHs in District 9. The applicant is one of the two and plans to establish a facility in Palm Beach County, the county adjacent to the proposed service area in this application.

The applicant will not offer a new choice of provider. Additionally, the applicant estimates 72.6 percent of patient days will come from Medicare/Medicare HMO and Medicaid/Medicaid HMO.

With itself and a co-batched applicant Select as approved providers in the service area and a high level of fixed price government payers, this project is not likely to promote quality and cost-effectiveness.

Promise Healthcare of Florida IX, Inc. (CON #9885): This application is for a 40-bed LTCH in District 9, Saint Lucie County. Currently there are two CON approved LTCHs in District 9.

The applicant will offer a new choice of provider, and this may increase competition. However, the applicant estimates 88.9 percent of patient days to come from fixed-priced government payers, which minimizes price competition.

With two providers approved for the area and a high level of fixed-priced government payers, any impact this project might have on competition to promote quality and cost-effectiveness would most likely be minimal.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886): This application is for a 44-bed LTCH in District 9, St. Lucie County. Currently, there are two CON approved LTCHs in District 9. The applicant is one of the two and plans to establish a facility in Palm Beach County, the county adjacent to the proposed service area.

The applicant will not offer a new choice of provider. Additionally, the applicant is projecting 79.6 percent of their total patient days to come from Medicare and Medicaid.

With itself and co-batched applicant Kindred as approved providers in the service area and a high level of fixed-price government payers this project is not likely to promote quality and cost-effectiveness.

- f. Are the proposed costs and methods of construction reasonable? Do they comply with statutory and rule requirements? ss. 408.035(10), Florida Statutes; Ch. 59A-3 or 59A-4, Florida Administrative Code.**

Kindred Hospitals East, L.L.C. (CON #9884) proposes to establish a new 50-bed freestanding long-term care hospital (LTCH) located in St. Lucie County, Florida. This new hospital will be designed as a two-story, protected, non-combustible building. Although not specified by the submission, it is assumed the building will be fully sprinklered to meet the minimum codes and standards.

Thirty of the 50-bed LTCH medical patient rooms are private and appear to exceed the minimum size requirements for new hospitals. Two of these rooms are designated to be isolation rooms. Five of the medical patient rooms are semi-private and there are 10 ICU rooms. Each medical bedroom has a private toilet room with a lavatory and shower. It appears that more than 10 percent of the new bed rooms are meant to be made accessible. Because of the insufficient information provided on the plan, it is impossible to tell if the patient support spaces will 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 two medical bed wings, and a 10-bed intensive care unit (ICU). The medical beds are supported from large centralized nursing stations.

The ICU wing, (it is too large to be considered as suite) contains 10 beds. At least four of the ICU rooms do not appear to be large enough to meet the minimum codes and standards. The ICU unit appears to have some space blocked out for the support functions required, such as soiled utility, clean utility, nourishment room, and medication room. However, because the plan is insufficient in the amount of detail that it provides, it is impossible to verify whether or not these functions can fit into that allotted space.

There is space on the first floor blocked out for an operating suite but there is no detailed information provided regarding number or size of the operating rooms, or support spaces so it is impossible to verify whether or not these functions can fit into that allotted space.

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There are supporting service areas such as administration, dietary, maintenance, storage, emergency treatment, class rooms, pharmacy, therapy, radiology and other spaces blocked out on the first floor but it is impossible to determine whether or not these functions can fit into the allotted space without additional plan details.

The plans indicate compliance with out of date codes, such as the Florida Building Code and Life Safety Code. There is no indication the building is intended to be in compliance with the hurricane provisions of the FBC, Chapter 4, and Section 419.4 including onsite water storage, and protection of all utilities. There is no information regarding building utilities.

There is insufficient information presented on this plan to determine whether or not the cost estimated for the construction of the new LTCH is reasonable.

There is insufficient information presented on this plan to determine whether or not the time schedule for construction from the time of building permit to final inspection is reasonable.

The plans submitted with this application did not give enough detail to determine whether or not this facility will be meeting all codes and standards or whether the design is feasible. Further plan development will be necessary before such determinations can be made.

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 IX, Inc. (CON #9885) 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.

All of the 40 LTCH medical patient rooms are private and exceed the minimum size requirements for new hospitals. Each medical bedroom has a private toilet room with a lavatory and shower. It appears that more than 10 percent of the new bed rooms 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).

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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 that 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 triage room, a treatment room, 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.

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.

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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 - St. Lucie, Inc. (CON #9886) proposes to establish a new 44-bed freestanding long-term care hospital (LTCH) located within St. Lucie County, Florida. This new hospital will be designed as a single-story, protected, non-combustible fully sprinklered building.

Although the application indicates a facility that will accommodate up to 60 beds, the facility submitted with this application will not support more than 44 beds. To add 60 beds to this facility would require additional square footage being added to the building because all of the rooms will not accommodate more than one bed.

All of the 44 LTCH medical patient rooms are private and exceed the minimum size requirements for new hospitals. Each medical bedroom 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 patient toilet and shower for each of the medical rooms that 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 beds 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.

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

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 construction 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 patient days.

Kindred Hospitals East, L.L.C. (CON #9884) states it has a history of providing Medicaid and charity care at its facilities, and states that its

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dedication to such care is demonstrated by its request for a condition on the provision of 2.2 percent of patient days for combined Medicaid and charity care patients. Schedule 7A indicates a 1.2 percent provision to Medicaid and Medicaid HMO patients in the second year of operations, with 1.0 percent listed under “Other Payers” on the charity care row. The applicant states that it does not discriminate or deny any individual access to care or services regardless of his or her ability to pay.

Promise Healthcare of Florida IX, Inc. (CON #9885) 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 provided to Medicaid patients and one percent to self-pay patients, which it indicates is charity care in the notes to Schedule 7B.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886) 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.

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 7A indicates that two percent of the facility's annual patient days will be 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

Kindred Hospitals East, L.L.C. (CON #9884) proposes to construct a 50-bed freestanding LTCH in St. Lucie County, District 9. The applicant indicated its proposed location would serve the Port St. Lucie and Fort Pierce market, but gave no specific information relative to the proposed site.

The proposed project involves 66,961 GSF of new construction, consisting of 40 private rooms and five semi-private rooms. The total construction costs are estimated to be \$15,401,030 with total project costs of \$25,394,112.

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

Promise Healthcare of Florida IX, Inc. (CON #9885) proposes to construct a freestanding 40-bed LTCH to be located in St. Lucie County, District 9. Three potential sites in or near Port St. Lucie were identified in aerial photographs provided in Attachment L as possible locations for the LTCH.

The proposed hospital involves 47,951 gross square feet (GSF) of new construction. The applicant indicates the facility would be comprised 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 patient days to Medicaid and charity patients.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886) proposes to establish a 44-bed freestanding LTCH to be located in District 9, St. Lucie County. The applicant indicates that the proposed facility would be located near Lawnwood Regional Medical Center, which is in Fort Pierce, St. Lucie County.

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The proposed hospital will consist of 51,160 gross square feet of new construction with construction cost of \$9,976,200. The 44-bed facility would be comprised of 28 private rooms and eight semi-private rooms. The total project cost is estimated to be \$18,351,053.

The applicant proposes to condition award of the certificate of need on the provision of a combined 2.8 percent of the facility's patient days to Medicaid and charity 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.

Two LTCH hospitals are CON approved but not yet licensed for Palm Beach County, District 9.

Kindred Hospitals East, L.L.C. (CON #9884) projects that its primary service area will be District 9 excluding Palm Beach County. The applicant states that the two LTCHs approved for District 9 will be too distant from the northern-most areas of the district, which would present lengthy traveling times for patient transfers. Need and access arguments were not supported. Although support letters state that many patients would have benefited from LTCH services, the disposition of these patients is not known and the approval of two new hospitals to serve this area appear to have not been considered. Need projections relied upon unsupported assumptions, which are just as likely to be false as true. 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 two currently approved LTCHs in the district would not be able to meet the needs of its residents needing LTCH services.

Promise Healthcare of Florida IX, Inc. (CON #9885) indicated three potential sites in or near Port St. Lucie as possible locations for the LTCH and indicates that it intends to serve District 9.

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Need projections relied upon unsupported assumptions, which are just as likely to be false as true. The applicant did not demonstrate that area residents are unable to access needed LTCH care or that care currently being provided is inappropriate. The applicant did further not demonstrate that further need will not be addressed with the initiation of services by the two approved facilities.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886) projects that its primary service area will be St. Lucie County, southern Indian River County and northern Martin County. The total service area is defined to include all of District 9 excluding Palm Beach County. Need projections relied upon unsupported assumptions, which are just as likely to be false as true. It was not demonstrated by the applicant that patients that may meet the definition of a LTCH patient are not currently being placed or that the two approved LTCHs for this district will be insufficient to accommodate demand.

Quality of Care:

Kindred Hospitals East, L.L.C. (CON #9884) states all of its currently licensed LTCHs are accredited by the JCAHO and the necessary components are in place to ensure delivery of care. Agency records indicate 12 confirmed complaints for the seven Kindred licensed LTCHs in the state for the three-year period ending October 5, 2005: patient care (five); medicine problems/errors/formulary (three); patient rights (one); untrained/unqualified staff (one); discharge planning (one); and nursing service (one).

Promise Healthcare of Florida IX, Inc. (CON #9885) 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 - St. Lucie, Inc. (CON #9886) 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.

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Two of the three Select Florida facilities have nine confirmed complaints under Select's operation as of October 5, 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 had no confirmed complaints as of the writing of this report.

Cost/Financial Analysis

Kindred Hospitals East, L.L.C. (CON #9884) has good short-term and long-term positions. Cash on hand and cash flows, if they continue at reported levels, would be sufficient to fund this project as proposed. Funding for this project and all capital projects is likely to be available as needed. Financial feasibility of this project appears likely if the market is sufficient to enable the applicant to achieve their projected number of patient days.

Promise Healthcare of Florida IX, Inc. (CON #9885) is a wholly owned subsidiary of Promise Healthcare, Inc. Because this applicant is a development stage company and did not provide audited financial statements of its parent company (Promise Healthcare, Inc. – a privately held company), the applicant's financial position cannot be determined. Funding for this project is dependent on the applicant's ability to obtain debt financing. Based on the information provided, the likelihood cannot be determined that the applicant will be able to obtain the financing necessary to fund this project and the associated working capital. Financial feasibility of this project appears likely if the applicant is able to secure financing and the market is sufficient to enable the applicant to achieve their projected number of patient days.

Select Specialty Hospital - St. Lucie, Inc. (CON #9886) is a wholly owned subsidiary of Select Medical Corporation. The parent company has adequate short-term and long-term positions. Funding for this project and working capital should be available as needed. Financial feasibility of this project appears likely if the market is sufficient to enable the applicant to achieve their projected number of patient days.

Architectural Analysis:

Kindred Hospitals East, L.L.C. (CON #9884): The plans indicate compliance with out of date codes, such as the Florida Building Code and Life Safety Code. There is no indication the building is intended to be in compliance with the hurricane provisions of the FBC, Chapter 4, and Section 419.4 including onsite water storage, and protection of all utilities. There is no information regarding building utilities. There is insufficient information presented on this plan to determine whether or

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not the cost estimated for the construction of the new LTCH is reasonable. There is insufficient information presented on this plan to determine whether or not the time schedule for construction from the time of building permit to final inspection is reasonable. The plans submitted with this application did not give enough detail to determine whether or not this facility will be meeting all codes and standards or whether the design is feasible. Further plan development will be necessary before such determinations can be made.

Promise Healthcare of Florida IX, Inc. (CON #9885): 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 - St. Lucie, Inc. (CON #9886): 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 construction from the time of building permit to final inspection seems reasonable.

G. RECOMMENDATION

Deny CON #'s 9884, 9885 and 9886.

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