STATE AGENCY ACTION REPORT

ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Landmark Hospital of Southwest Florida, LLC/CON #10137
240 South Mount Auburn Road
Cape Girardeau, Missouri 63701

Authorized Representative: Dr. William Kapp
(573) 331-8040

Kindred Hospitals East, LLC/CON #10138
680 South Fourth Street
Louisville, Kentucky 40202

Authorized Representative: Bud Wurdock
(502) 596-7718

2. Service District

District 8

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

Landmark Hospital of Southwest Florida, LLC (CON #10137) submitted one letter of support for the project. The letter was dated March 9, 2012 from Dr. Allen Weiss, President and CEO of the NCH Healthcare System. Dr. Weiss states that he can, "confidently state [that] patients, their families, physicians and the entire community would be better served by having an excellent local long-term acute care (LTAC) facility such as Landmark." He indicates that some of the 35,000 yearly discharges from the NCH Healthcare System would benefit by long-term acute care. Dr. Weiss adds that "Currently, patients too ill for

skilled nursing care are either kept as inpatients which is a misuse of valuable resources or shipped to facilities outside our area." He notes that this change of venue can be risky for patients and inconvenient to their families.

Dr. Weiss states that the proposed facility will help "keep our objective quality moving in the correct direction [and] assist the local economy on our journey to be a medical tourist attraction". He cites that one in eight inpatients at NCH come from outside southwest Florida, "the lower east coast, the original colonies and the 1-75 corridors along with other areas". Dr. Weiss maintains that, "having additional excellent capabilities along the continuum of health care such as Landmark will accelerate our progress".

He states that the proposed facility and NCH plan to share and collaborate whenever, "it makes sense in caring for patients". Dr. Weiss indicates that a seamless local transfer from inpatient ICU to a nearby LTAC with the same physicians caring for the patient will surely improve care. He states that NCH and the proposed facility will explore services that can be shared to take advantage of economies of scale to best compete efficiently in a global economy.

Kindred Hospitals East, LLC (CON #10138) submitted 143 unduplicated letters of support for the project (CON application #10138, Tab 4). One hundred and thirty-six letters were dated between March 6, and March 30, 2012. Seven letters were not dated. One hundred and forty were form letters. Thirteen of these form letters were missing information in the blanks provided.

Letters from local physicians include Dr. Richard J. Juda, Director of Critical Care Medicine at Physicians Regional Medical Center, who writes that there is an urgent need for a long-term care facility for the residents of Collier County because the current options, "are leading to increased morbidity hence worsening outcomes." Dr. Juda states that, "Over the past four-and-a-half years I have been caring for the critically ill in Southwest Florida [and] I have referred over 150 long-stay patients for long-term acute care who refused the transfer…due to geography and transportation difficulties." Citing the lack of a facility in the Naples/Fort Myers area, Dr. Juda writes that there is an increased morbidity and mortality in the area. He emphasizes that he has had "patients walk out of Kindred who years ago would be committed to long-term institutional

care for the rest of their lives" and that the proposed facility, "with its high caliber of patient care also decreases health care costs for not only the patient but the community it services."

Dr. Imtiaz Ahmad from the Allergy Sleep & Lung Care PA states that as a pulmonary and critical care specialist, he "desperately needs" a facility to transfer ventilator dependent patients that is closer to Lee County. Dr. Ahmad elaborates by stating, "Over the past eight years of my practice in Lee County, I have transferred a large number of patients who require long-term ventilator care. However, not having a facility nearby, certainly delayed providing appropriate care to hasten early recovery."

Dr. Robert P. Casola of Wound and Limb Restoration Center of Southwest Florida states, "The extensive population at this point demands that there be a facility for long-term care of certain individuals that may need certain type of reconstruction, ventilator support and long-term rehabilitation. Currently, there is no facility in this area that offers the unique services that we find at Kindred Hospital." Dr. Casola cites that currently, "I have a large volume of patients who after initial treatment and stabilization require the extensive long-term services and the expertise that is provided for them in the St. Petersburg area with the Kindred Hospital Facility." The importance of proper follow-up and postoperative and interventional services for patients is noted by Dr. Casola. He states that, "Kindred Facilities offer a well-known means of ensuring proper follow-up as well as excellent patient care for these individuals."

The applicant's 140 form letters had three formats. One letter cites:

- The growing population of the area, in particular the senior population will benefit from the proposed services.
- Kindred Healthcare has a long-standing history of responding to the hospital and health care needs of the residents throughout Florida.
- The location of the proposed facility will enhance service, offer patients continuity of care and provide easy access.

This letter was signed by 16 members of the Hospitalist Group of Southwest Florida, four members of Pulmonary Consultants of Southwest Florida, 18 members of the Physicians Regional Healthcare System, 18 members of the Fort Myers Republican Women's Club and 17 members of the Fort Myers and North Fort Myers community. Jorge Aguilera, Deputy Chief of EMS with the North Naples Fire Control & Rescue District added that "Currently, our resident's only option is to travel a long distance in order to obtain Kindred's high caliber care".

The second form letter restates the above language and adds:

- In my practice, I have seen ___ long-stay patients who would have benefited from the care provided at a long term care hospital if one were available in the Naples/Ft. Myers area. However, these patients rarely go to other existing long-term care facilities in Florida because of distance, reluctance to change physicians or medical instability that made transport difficult.

This letter was signed by 10 members of Pulmonary Disease Associates, P.A., three physicians with the Gulf Coast Cardiothoracic and Vascular Surgeons group, eight members of the NCH Healthcare Group, Pulmonary & Critical Care Medicine, one physician with Gulf Coast Medical Center and one physician's assistant with Physicians Regional Healthcare System. The NCH Healthcare Group had added "@ 100-long stay patients per year" in the blank, eight left it blank and none of the others were specific adding "many", one adding "65", one ">50" and one "50". Todd Lupton, CEO of Physicians Regional Healthcare System, signed this letter changing from "In my practice, I have seen" to state "As a Health Care System CEO, I am all too familiar with scores of long stay patients…."

The third form letter indicates that the writer is a registered nurse or caseworker (one in the case worker count struck case worker and added social worker) who is "compelled to write and ask that you grant" approval to the project, stating that:

- The additional beds will directly affect the medical care received by patients at my hospital.
- A most challenging aspect of my job is to arrange for continued inpatient care for patients who need a wide range of health services. This process is difficult due to reimbursement issues and the dwindling number of facilities willing to accept medically complex patients.
- I can identify ___ long-stay patients who would have benefited from the care provided at a long term care hospital if one were available in the Naples/Ft. Myers area. However, these patients rarely go to other existing long-term care facilities in Florida because of distance, reluctance to change physicians or medical instability that made transport difficult.
- I am familiar with Kindred hospitals and their high level of care and service to their patients.

This letter was signed by eight case managers with Physicians Regional Healthcare who could identify "many" and "multi" long-stay patients who would have benefited from LTCH care. Twenty two were signed by registered nurses with Physicians Regional Healthcare, one who identified "43", two "4" and one "2" long-stay patients, 13 inserted "many or multi" and five left the insert blank. Eleven of these were submitted by registered nurses with Gulf Coast Medical Center, one who could identify "100's", three "15", one "10" and six indicated that "many/countless/numerous" patients who would benefit from LTCH services. One of the RNs with Physicians Regional also provided one of these indicating that she worked at NCH & NCHO and could identify ">25" at these facilities.

C. PROJECT SUMMARY

Landmark Hospital of Southwest Florida, LLC (CON #10137), affiliated with Landmark Hospitals and Landmark Holdings of Missouri, LLC that operates four long-term care hospitals (LTCHs) nationwide, proposes to establish a long-term care hospital of 50 beds in District 8, Collier County. The proposed facility will have all private patient rooms, including a 10-bed ICU. The applicant did not include potential sites for the proposed facility.

The proposed hospital involves 56,809 gross square feet (GSF) of new construction. Total project cost per bed is $442,496. Total construction cost is estimated to be $13,480,000 and total project cost is $22,124,800.

As a condition of approval, the applicant proposes to provide 2.54 percent of the facility's total annual patient days to charity. Landmark also stated its willingness to accept any and all conditions placed on the award of the certificate of need based on statements contained within CON application #10137.

Kindred Hospitals East, LLC (CON #10138), a subsidiary of Kindred Healthcare, Inc. and licensee/operator of 31 LTCHs, 10 in the state of Florida, proposes to establish a 40-bed LTCH to be located in Collier County, District 8. The proposed facility will have all private patient rooms, including a 10-bed ICU. The applicant did not include potential sites for the proposed facility.

Kindred Healthcare Inc. is the parent corporation of the applicant and is one of the largest providers of post-acute health services in the United States, including 121 LTCHs.

The proposed hospital involves 56,581 GSF of new construction. Total cost per bed is $873,033. Total construction cost is estimated to be $17,075,774 and total project cost is $34,921,329.

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

D. REVIEW PROCEDURE

The evaluation process is structured by the certificate of need review criteria found in Section 408.035, Florida Statutes; and applicable rules of the State of Florida, Chapters 59C-1 and 59C-2, Florida Administrative Code. 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 evaluating the responses and data 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, applications are comparatively reviewed to determine which applicant best meets the review criteria.

Chapter 59C-1.010 (3) (b), Florida Administrative Code, prohibits any amendments once an application has been 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, Marisol Novak analyzed the application with consultation from Financial Analysts, Derron Hillman and Everett "Butch" Broussard, who evaluated the financial data, and Said Baniahmad of the Office of Plans and Construction, who reviewed the application for conformance with the architectural criteria.

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? ss. 408.035(1)(a), Florida Statutes and Ch. 59C-1.008(2), Florida Administrative Code.

Need is not published by the Agency for LTCH beds. It is the applicant's responsibility to demonstrate need.

An LTCH is defined as a hospital licensed under Chapter 395, Florida Statutes, which meets the requirements of Title 42, subpart B, paragraph 412.23(e), Code of Federal Regulations; the provider must have an agreement under Part 489 and the facility must have an average Medicare inpatient length of stay of greater than 25 days.

In addition to meeting the condition of participation applicable to acute care hospitals, as of 2007[1], LTCHs are now required to:

- Have a patient review process that screens patients both before admission and regularly throughout their stay to ensure appropriateness of admission and continued stay, although the law does not specify the patient criteria to be used to determine appropriateness.
- Have active physician involvement with patients during their treatment, with physician on-site availability on a daily basis to review patient progress and consulting physicians on call and capable of being at the patient's side within a period of time determined by the Secretary.
- Have interdisciplinary treatment teams of health care professionals, including physicians, to prepare and carry out individualized treatment plans for each patient.

MedPAC is a commission that makes recommendations to Congress and the Secretary of the federal Department of Health and Human Services (DHHS) regarding reimbursement for long-term hospital services.

[1] As part of the Medicare, Medicaid and SCHIP Extension Act of 2007.

Medicare is the primary payer for LTCH services—in 2010, Medicare spent $5.2 billion on care furnished in an estimated 412 LTCHs nationwide.[2] Under the current reimbursement system, Medicare reimburses LTCHs prospective per discharge rates based primarily on the patient's diagnosis and the facility's wage index.

LTCHs furnish care to patients with clinically complex problems, such as multiple acute or chronic conditions, which need hospital-level care for relatively extended periods. The highest single LTCH diagnostic related group [DRG] was respiratory system diagnosis with ventilator support for 96 or more hours in fiscal year 2010. According to MedPAC, over the past decade, there has been marked growth in the number and the share of critically ill patients transferred from acute care hospitals to LTCHs. The commission states that patients who can be appropriately treated in settings of lower acuity should not be admitted to LTCHs—because the cost of care in LTCHs is so high. However, it was noted by MedPAC that LTCH care may have value for very sick patients. While research has shown that Medicare pays more for patients using LTCHs than for similar patients in other settings, payment differences were not statistically significant when LTCH care was targeted to the most severely ill patients.

The commission cites that not all cases in LTCHs are high severity. In 2010, about 13 percent of LTCH cases were of minor or moderate severity, as measured by all patient refined DRGs. MedPAC states that LTCHs with the smallest shares of high-severity cases are far more likely to be located in rural areas (20 percent vs. five percent of all LTCHs) and are somewhat more likely to be not-for-profit (28 percent vs. 19 percent for all LTCHs).

MedPAC determined in its 2012 review, that Medicare accounts for about two-thirds of LTCH discharges. The commission determined that between 2005 and 2008, growth in cost per case outpaced that for payments. After Congress provided temporary relief from some payment regulations that would have constrained payments, payments per case climbed 6.4 percent between 2008 and 2009. Payment growth slowed to two percent between 2009 and 2010. In 2010, the Medicare margin for LTCHs was 6.4 percent and estimates LTCHs' aggregate Medicare margin will be 4.8 percent in 2012. It was also noted in the 2012 report that Medicare payments increased faster than costs between 2009 and 2010, resulting in an aggregate 2010 Medicare margin of 6.4 percent. Medicare margins increase for all types of LTCHs in 2010 except nonprofits. After

[2] According to the MedPAC *Report to the Congress: Medicare Payment Policy*, March 2012.

its study, the commission concluded that LTCHs could accommodate the cost of caring for Medicare beneficiaries in 2013 without an update to the payment rate.

Unlike most other health care facilities, LTCHs do not submit quality data to the Centers for Medicare and Medicaid Services (CMS). In the absence of this data, MedPAC uses unadjusted aggregate trends in rates of in-facility mortality, mortality within 30 days of discharge and readmissions from LTCHs to acute care hospitals. It should be noted that the Patient Protection and Affordable Care Act of 2010 mandates that CMS implement a pay-for-reporting program for LTCHs by 2014. A panel assembled by the commission suggested that CMS begin with a starter set of 10 to 12 measures based on those the LTCHs already use for internal quality monitoring. These panelists did warn that careful attention is needed in the creation of these measures so as not to create incentives for providers to avoid admitting certain types of cases. The commission states that the quality measures developed for LTCHs must be comparable to those used in other post-acute settings. MedPAC considers a pay-for-reporting program to be a first step toward pay for performance.

The commission has recommended that CMS develop patient and facility criteria that could be used to define LTCHs and ensure that patients admitted to such facilities were medically complex and had a good chance of improvement. MedPAC states that the development of these criteria has proven difficult as research has been unable to clearly distinguish LTCH patients from the medically complex patients receiving care in acute care hospitals and some skilled nursing facilities. In its March 2011 report, MedPAC stated its long-standing concern about the nature of services furnished by LTCHs and the possibility that acute care hospitals discharging patients to LTCHs may be unbundling services paid for under the acute care hospital prospective payment system (PPS).

There have been several provisions related to long-term care hospitals passed from 2007-2010[3]. These include:

- A moratorium on new LTCHs and new beds in existing facilities until December 29, 2012.

[3] These provisions are part of the Medicare, Medicaid and SCHIP Extension Act of 2007 subsequently amended in the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act of 2010.

- Currently the Secretary of the Department of Health and Human Services is prohibited from applying the 25 percent rule to freestanding LTCHs before cost-reporting periods beginning on July 1, 2012.[4] The current rolled-back implementation of the 25 percent rule for hospitals within hospitals and satellites, limits the proportion of Medicare patients who can be admitted from a hospital within a hospital or a satellite's host hospital during a cost-reporting period to not more than 50 percent and holding it at this level until October 1, 2012.
- The Secretary is prohibited from further reducing payments for LTCH cases with the shortest lengths of stay until December 29, 2012.
- The Secretary is prohibited from applying any budget-neutrality adjustment to the current LTCH prospective payment system until December 29, 2012.
- The requirement that the Secretary conduct a study on the use of LTCH facilities and patient criteria to determine medical necessity and appropriateness of admission to and continued stay at LTCHs. This study was due to the Congress in July 2009, as of March 2011 it is still pending.
- CMS is required to implement a pay-for-reporting program for LTCHs by 2014. The program should require LTCHs to report a specified list of quality measures—to be determined by CMS—each year in order to receive a full update to Medicare payment rates in the ensuing year.
- An annual update to the LTCH standard rate shall be reduced by a quarter of a percentage point in 2010 and by half of a percentage point in 2011. For rate years 2012-2019, any update shall be reduced by the specified productivity adjustment.

Despite the moratorium imposed in July 2007 on new LTCHs and new beds in existing LTCHs, the number of LTCHs filing Medicare cost reports increased 6.1 percent between 2008 and 2010—with almost all the growth taking place in 2009. MedPAC found that beneficiaries' use of services suggests that access has not been a problem since the moratorium was imposed. Controlling for the number of fee-for-service beneficiaries, the commission found that the number of LTCH cases rose 3.5 percent between 2009 and 2010—suggesting that access to care increased during this period.

[4] CMS established a 25 percent rule in fiscal year 2005 that uses payment adjustments to limit the percentage of Medicare patients who are admitted from a hospital within a hospital or satellite's host hospital and paid for at full LTCH payment rates.

It is noted in the March 2012 MedPAC report that LTCHs are not distributed evenly across the nation. Some areas have many LTCHs and others have none. The commission concludes that the absence of LTCHs in many areas of the country suggests that medically complex patients can be treated appropriately in other settings—making it difficult to assess the need for LTCH care and, therefore, the adequacy of supply. In fact, MedPAC's analysis of LTCH claims from 2010 found that average case mix for LTCH admissions is lower in communities with the highest use of LTCHs compared with communities with the lowest use of LTCHs. The commission states that these findings suggest that an oversupply of LTCH beds in a market may result in admissions to LTCHs of less complex cases that could appropriately be treated in less costly settings.

Additionally, the commission questions the clustering of LTCHs in certain markets as LTCHs are supposed to be serving unusually sick patients, a relatively rare occurrence. MedPAC states that an oversupply of LTCH beds in a market may result in admission to LTCHs of less complex cases that could be appropriately treated in other, less costly settings. The commission also cites that there is little evidence that patient outcomes in LTCHs are superior to those achieved in other settings.

In a report prepared for CMS, Kennell and Associates stated that the most commonly used definition of medically complex patients was proposed by Nierman and Nelson.[5] This stated that the chronically critically ill patient exhibited metabolic, endocrine, physiologic and immunologic abnormalities that resulted in profound debilitation and often ongoing respiratory failure, abnormalities that slowed or precluded recovery from a wide range of acute forms of medical, surgical and neurologic critical illness. On this definition's basis, Kennell suggested the following as specific attributes of medically complex patients:

- Prolonged mechanical ventilation
- Multiple organ failure
- Multiple or chronic comorbidities (such as coronary artery disease, chronic obstructive pulmonary disease, stroke, diabetes and renal failure)
- Multiple community-acquired or hospital-acquired infections or ulcers

[5] Determining medical necessity and appropriateness of care for Medicare long-term care hospitals was prepared under contract to the Centers for Medicare and Medicaid Services in 2010 by Kennell and Associates, Inc.

The commission notes that it is important that potential patients that are identified as medically complex should also be likely to benefit from a LTCH program, as some of the most severely ill medically complex patients are too sick for LTCH care or because their prognosis for improvement is so poor. MedPAC states that other options may be better suited to these patient's needs and may cost Medicare less.

In this comparative batch review, the two 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 nationwide 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, largely medically unstable, high acuity patient population, then need projections should clearly identify that population and the medically complex and unstable high acuity population should be the only target.

Medicare is identified by each co-batched applicant as its primary payer. Unlike what is used by CMS for other post-acute care providers, CMS does not have an accepted assessment tool for LTCH services and government evaluators have found some portion of LTCH admissions do not meet the patient profile described by both the co-batched applicants as the population it intends to serve. Of interest in this review is MedPAC's note that two large LTCH chains own slightly more than half of all LTCHs. One of these large LTCH chains is identified in the report as--Kindred Healthcare. This is one of the co-batched applicants in this review cycle.

Given the above, it is important that the determination of specific clinical complexity and clinical instability along with severity of conditions and multi-morbidities 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 appropriate staff be identified and that sufficient patient volume based on need for services be demonstrated.

b. Determination of Need.

In the absence of agency policy regarding long-term care hospital beds and services, Chapter 59C-1.008 (2)(e), Florida Administrative Code, provides a needs assessment methodology which must include, at a minimum, consideration of the following topics, except where they are inconsistent with the applicable statutory or rule criteria:

a. Population demographics and dynamics;
b. Availability, utilization and quality of like services in the district, subdistrict or both;
c. Medical treatment trends; and
d. Market conditions.

The existence of unmet need will not be based solely on the absence of a health service, health care facility, or beds in the district, subdistrict, region or proposed service area.

At present, there are 24 LTCHs with 1,398 beds licensed to operate in the State of Florida. There are an additional 168 approved, but not yet licensed LTCH beds representing four facilities in two districts.

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 - Lee, Inc. (CON #9715)	8	60
MJHS LTAC, LLC (CON #10092)	11	24
Select Specialty Hospital - Miami (NF #0700002)	11	24
Select Specialty Hospital - Dade, Inc. (CON #9892)	11	60
Total		**168**

Source: *Florida Hospital Bed Need Projections & Service Utilization by District* published 01/20/2012.
Note: Promise Healthcare, Inc., acquired all outstanding shares of Select Specialty Hospital-Lee, Inc. and Select Specialty Hospital-Dade, Inc. and is the sole shareholder of these entities.

As shown in the table above, there are 168 approved, but not yet licensed LTCH beds. However, MJHS LTAC, LLC (CON #10092) was terminated effective March 14, 2012. The 60 beds approved in District 8 are to be located in a new Lee County LTCH that will be owned and operated by Promise of Lee.[6]

[6] On March 31, 2008, Promise Healthcare, Inc. acquired all of the outstanding shares of Select Specialty Hospital—Lee, Inc. becoming the sole shareholder of the Select entity.

The average occupancy of the operational programs reporting utilization was 62.47 percent for the July 2010-June 2011 reporting period. LTCH programs in operation for the total 12-month reporting period, ranged in occupancy from a low occupancy rate of 35.65 percent for Kindred Hospital Melbourne (District 7) to a high of 92.21 percent for Select Specialty Hospital-Miami (District 11). The following chart shows statewide occupancy by year for the past five years.

Statewide LTCH Occupancy
12 Month Reporting Periods Ended
June 30, 2007-2011

Time Period	Occupancy Rate	Total Patient Days
July 2006-June 2007	65.73%	211,802
July 2007-June 2008	62.73%	239,987
July 2008-June 2009	58.70%	265,528
July 2009-June 2010	62.64%	293,303
July 2010-June 2011	62.47%	309,658

Source: *Florida Hospital Bed Need Projections & Service Utilization by District* published in January 2008-2012.

The service area for LTCH services is the district, not the county or any one geographic section or part of a county, or even necessarily a cluster of counties. One facility currently serves this district and one is approved to serve this district. HealthSouth Ridgelake Hospital in Sarasota County has 40 licensed LTCH beds with a 71.29 percent occupancy for July 2010-June 2011.[7] CON #9715, Select Specialty Hospital of Lee, Inc. is approved to construct a 60-bed LTCH in Lee County that is not yet under construction.

The chart below illustrates the number of LTCH discharges of District 8 residents (age 18+) July 1, 2010 through June 30, 2011.

[7] This facility changed ownership as of August 1, 2011, and is now licensed as Complex Care Hospital At Ridgelake.

LTCH District 8 Resident Discharges Age 18+ July 1, 2010 through June 30, 2011									
Facility Name	**Charlotte**	**Collier**	**DeSoto**	**Glades**	**Hendry**	**Lee**	**Sarasota**	**Total District 8 Discharges**	**Percentage of facilities' total Discharges**
HealthSouth Ridgelake Hospital	40	9	9			39	140	237	57.66%
Kindred Hospital-Bay Area-St Petersburg	5	14	1			38	11	69	18.11%
Kindred Hospital-South Florida-Hollywood		6			2	2		10	1.31%
Select Specialty Hospital-Palm Beach		1		2	7			10	1.82%
Kindred Hospital The Palm Beaches		1			6			7	1.72%
Kindred Hospital-Bay Area-Tampa		1	2			2		5	1.36%
Kindred Hospital-Central Tampa	1	2	1			1		5	1.00%
Kindred Hospital Melbourne						3		3	1.15%
Kindred Hospital-South Florida-Coral Gables		1				2		3	0.53%
Florida Hospital at Connerton Long Term Acute Care Hospital						1	1	2	0.37%
Kindred Hospital-North Florida						1		1	0.17%
Select Specialty Hospital-Miami					1			1	0.16%
Select Specialty Hospital Jacksonville						1		1	0.13%
TOTAL	**46**	**35**	**13**	**2**	**16**	**90**	**152**	**354**	

Source: Florida Center for Health Information and Policy Analysis hospital discharge data.

The chart below illustrates the number of LTCH discharges at the single LTCH facility currently operating in District 8 for July 1, 2010 through June 1, 2011 by county of origin.

HealthSouth Ridgelake Hospital Discharges* Patients Age 18+ July 1, 2010 through June 30, 2011		
County of Residence	**Health Planning District**	**Number of Admissions**
Alachua	3	1
Charlotte	8	40
Citrus	3	1
Collier	8	9
DeSoto	8	9
Hamilton	3	1
Hardee	6	2
Highlands	6	21
Hillsborough	6	19
Lake	3	1
Lee	8	39
Manatee	6	110
Okeechobee	9	1
Pinellas	5	5
Polk	6	1
Sarasota	8	140
Unknown/Out of State		11
Total		**411**

Source: Florida Center for Health Information and Policy Analysis hospital discharge data.
* This facility changed ownership and is licensed as Complex Care Hospital at Ridgelake effective August 1, 2011.

The current bed complement with the average occupancy of acute care hospital and other forms of post-acute care (substitute care options when LTCH services are not desired or available) in District 8 is presented as follows:

Acute Care and Post-Acute Care Providers
District 8 Beds and Utilization
July 2010-June 2011

Facility Type	Total Beds District 8	Percent Occupancy
Acute Care	4,055	55.16%
Comprehensive Medical Rehabilitation	260	63.61%
Skilled Care Community Nursing Homes	7,008	82.24%

Source: *Florida Hospital Bed Need Projections & Service Utilization by District* published January 20, 2012 & *Florida Nursing Home Utilization by District & Subdistrict July 2010-June 2011* published September 30, 2011.

As previously noted, LTCHs are designed to treat patients with medical conditions requiring extended hospital-level services, for a period 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, CMR, SNFs or home health care in the service planning area (in whole or in part). However, despite claims that proposals are for

medically complex/unstable and multiple co-morbidity high acuity patients, neither co-batched applicant demonstrated through existing data-driven evidence that this patient population and their families:

- were unable to locate and access needed LTCHs outside of District 8
- burdened the existing District 8 acute care resources through extended acute care stays by quantifying the number of patients so impacting the existing acute care facilities; or
- received inappropriate care that lead to measurably poorer health care outcomes, a reported rate of re-admission or a mortality rate higher than is characteristic in this select population.

No objectively measurable, data-driven and case-specific evidence was provided to show harm or poor health care outcomes as a result of the treatment alternatives selected.

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 area. Despite projections to the contrary, is it more likely that the CON approved LTCH in District 8 will serve a larger area than proposed in their CON application. This is expected because of CMS stated plans to reform post-acute care based on MedPAC recommendations over the past several years that were discussed in detail above.

Discussions of the applicants' need analysis follows.

Landmark Hospital of Southwest Florida, LLC (CON #10137) states that it will provide intensive recovery services for those transferred from acute care hospitals, whose conditions are not appropriate for post-acute placement. The major programs that the hospital will provide are characterized as:

- Pulmonary and Mechanical Ventilator Management
- Complex Wound Care
- Hemodialysis and Infectious Disease Treatment

The applicant maintains that all of the above broad programs involve a variety of clinical professionals engaged in restorative and rehabilitative services. Twenty-four hour physician coverage is provided to ensure that changes in a patient's condition can be addressed quickly. Among the most frequent physician collaborators are cardiologists and pulmonologists as well as orthopedists and endocrinologists.

Landmark states that it provides 24-hour chaplain services to meet the spiritual needs of patients and their families. Additional supportive therapies are provided as well, including pet and music therapy.

The applicant notes it is aware of the federal moratorium on the construction of new long-term care hospitals and bed additions to existing long-term care hospitals. Landmark states that the proposed facility is based on the presumption that the moratorium will sunset on December 28, 2012. The applicant bases this presumption on its understanding that the purpose of the moratorium was to provide time for federal policy makers to study LTCHs further and develop recommendations regarding changes to current practices.

Landmark indicates that it is actively pursuing options outside of the moratorium to contain costs within its profession association, Acute Long Term Care Hospital Association. The applicant asserts that it is an advocate for implementing changes that would attain cost containment objectives allowing the expiration of the moratorium. Specifically creating distinctions so that LTCHs serve the most severely ill and eliminating providers who do not provide the intensity of care/focus to complex, severely ill patients. Examples include:

- Need for admission reflects clinical indicators based on current practice standards that include procedures provided by a registered nurse certified in critical care
- The patient's care requires involvement of one or more specialist or subspecialist
- Stressing direct admission from an acute care hospital's intensive care unit as the source of admission
- Attending physician's determination that the patient's condition is complex and that skilled nursing and comprehensive rehabilitation are ruled out as are other post-acute options. The LTCH option should remain an acute, not a post-acute care option.

The applicant states that in the event that the U.S. Congress extends the moratorium, Landmark understands that the federal moratorium will not permit the Agency for Health Care Administration to extend its CON termination date, should it have a valid CON. Landmark would do one of two things in the above situation:

1. Proceed in accordance with project completion forecast to open the hospital as of January 1, 2015, working under the assumption that the moratorium would sunset by that time. This choice clearly makes Landmark bear all risk and makes Landmark responsible for any future outcome.
2. Return the CON and re-apply in a later batching cycle under the resumption that a future termination date would accommodate the federal action with respect to the moratorium. Landmark understands that such an action would require demonstrated entitlement to a certificate of need and that the Agency for Health Care Administration would not be bound, influenced or otherwise enjoined to issue one to Landmark.

Landmark maintains that no prediction on the federal moratorium can be certain but it remains optimistic that LTCHs are important additions to the continuum of care and will remain necessary. The number of LTCH patients—highly complex, multiple systems involved and medically intensive—will not diminish but will grow. The applicant contends that it is the LTCH, one that evolves, adapts and adopts protocols/technologies that achieve treatment effectiveness and cost-containment that will meet the needs of these patients.

The applicant states that there is one LTCH in District 8, Complex Care Hospital at Ridgelake (an affiliate of Lifecare Hospitals) with a reported occupancy rate of 78 percent in CY 2010.[8] In addition, there is one approved LTCH project in District 8, Select Medical Corporation of Lee County whose assets were acquired by Promise Hospital of Lee, Inc. This project is pending and has approval for 60 beds LTCH in Lee County through CON #9715 issued December 14, 2007. The applicant notes that this project has not commenced construction and Promise continues to request and receive extensions on this CON. Landmark states that there is sufficient need for the proposed facility in addition to the Promise approved CON.

Landmarks cites that the statewide ratio of LTCH admission to acute care hospital admissions is 0.5 percent. District 8 and 10 are tied for the lowest ratio with 0.2 according and District 2 has the highest ratio with 0.9 percent, according to the applicant.

[8] This hospital was formerly known as HealthSouth Ridgelake Hospital (an affiliate of HealthSouth) and had a 77.61 percent occupancy rate in CY 2010.

The applicant states that there were 172,954 acute care discharges in District 8 during April 1, 2010 through March 31, 2011, but just 365 patients were admitted to LTCHs. Using the statewide 0.5 percent ratio, District 8 should have had at least 865 LTCH admissions. Landmark contends that this indicates a lack of access and availability of services for 500 persons. The applicant uses an estimated average length of stay of 30 days to produce 15,000 LTCH inpatient days—or an average daily census (ADC) of 41 persons throughout District 8 without access.

Landmark contends that in Florida, the wider availability of beds corresponded with increased use of LTCHs across the district. The applicant uses historical data, linear regression and trend line analysis to establish that beds have to be available and when they are, these beds are used. The applicant maintains that there is clear reduced access to LTCH services in District 8 as demonstrated by patterns of use by county residents. In addition, the discharge rate from LTCHs for patient origin place District 8 last among the 11 health care districts. The reviewer notes that the applicant does not document that the current providers are not serving the long-term care needs of District 8 patients.

Population Estimates and Dynamics

The applicant presents the Major Diagnostic Category (MDC) and counties of residence for patients aged 15 and older who were admitted at HealthSouth Ridgelake Hospital during April 1, 2010 through March 31, 2011.[9] Landmark then used January 2011 population estimates to calculate the use rate per 1,000 persons aged 15 years and older by their counties of residence. The applicant says that the data shows a lack of uniform access, which can be expected, given the location of the only LTCH in the district. Landmark contends this data confirms reduced access to LTCH services for residents within District 8 and being treated within the district—Lee County residents have the lowest access, followed by Charlotte and Collier County residents.[10] See the table below.

[9] At the time of the data reported, the LTCH had not changed ownership yet.
[10] The applicant's data shows that Hendry County residents have the lowest calculated rate, followed by Collier then Lee County residents.

Patients Aged 15 Years and Older by County of Residence in District 8* Treated at HealthSouth Ridgelake Hospital April 1, 2010 through March 31, 2011								
MDC	**Charlotte**	**Collier**	**Desoto**	**Hendry**	**Lee**	**Sarasota**	**All Other**	**Total**
00-MDC Not Assigned	2					4		6
01-Nervous System					1	1		2
04-Respiratory System	28	7	8	1	39	80	108	271
05-Circulatory System						1	2	3
06-Digestive System	2	1				4	9	16
07-Hepatobiliary System/Pancreas					2	1	1	4
08-Musculoskeletal/Conn Tissue	1				1	9	6	17
09-Skin, Subcutaneous Tissue & Breast	1		3			3	3	10
11-Kidney & Urinary Tract	1					6	1	8
17-Myeloproliferative & Neoplasm						1		1
18-Infectious & Parasitic Diseases	4	2	1		1	28	23	59
21-Injury, Poisonings & Toxic Effects					1	3	2	6
23-Factors Influencing Health Status	2					1	4	7
25-Human Immunodeficiency Virus							1	1
TOTAL	**41**	**10**	**12**	**1**	**45**	**142**	**160**	**411**
Percent of Total	10.0%	2.4%	2.9%	0.2%	10.9%	34.5%	38.9%	100%
Population 1/2011	146,893	278,548	28,062	30,993	517,353	341,732		
Rate/1,000 persons age 15+	**0.279**	**0.036**	**0.428**	**0.032**	**0.087**	**0.416**		

Source: CON application #10137, page 1-9.

*****Glades is not included above as no residents of that county were treated at this hospital.

Landmark maintains that it is an indication that HealthSouth Ridgelake Hospital is not functioning as an accessible district resource because the residents of all District 8 counties with the exception of Sarasota comprise only 26 percent of the cases treated at this LTCH. The applicant presents data on access for District 8 residents to LTCH services located anywhere in Florida resulting in the fact that the residents in the more southern counties of District 8 do not find the Sarasota LTCH accessible. See the table below.

Patients Aged 15 Years and Older by County of Residence in District 8 Treated at any LTCH in Florida April 1, 2010 through March 31, 2011								
MDC	**Charlotte**	**Collier**	**Desoto**	**Glades**	**Hendry**	**Lee**	**Sarasota**	**Total**
00-MDC Not Assigned	3	1		1	1	3	5	14
01-Nervous System						1	2	3
03-Ear, Nose, Mouth & Throat	1	1						2
04-Respiratory System	32	25	10	1	9	77	85	239
05-Circulatory System					2		2	4
06-Digestive System	2	1				1	4	8
07-Hepatobiliary System/Pancreas		1			1	2	1	5
08-Musculoskeletal/Conn Tissue	1					1	9	11
09-Skin, Subcutaneous Tissue & Breast	1		3				4	8
10-Endocrine, Nutritional & Metabolic			1			2		3
11-Kidney & Urinary Tract	1						6	7
17-Myeloproliferative & Neoplasm							1	1
18-Infectious & Parasitic Diseases	5	3	1		1	8	30	48
21-Injury, Poisonings & Toxic Effects		1				1	3	5
23-Factors Influencing Health Status	2				2		1	5
25-Human Immunodeficiency Virus						2		2
TOTAL	**48**	**33**	**15**	**2**	**16**	**98**	**153**	**365**
Percent of Total	13.2%	9.0%	4.1%	0.5%	4.4%	26.8%	41.9%	100%

Source: CON application #10137, page 1-11.

Landmark asserts that the hospital discharge data demonstrates that the District 8 resident outmigration to receive LTCH care is large, 114 persons or over 30 percent, clearly demonstrating reduced access to LTCH services within the district. The applicant presents data showing where District 8 residents received LTCH services during the 12 month period ending March 31, 2011, in the table below.

LTCH Services Utilized by District 8 Residents, Age 15 Years and Older April 1, 2010 through March 31, 2011				
Hospital	**Cases**	**Percent**	**ALOS**	
HealthSouth Ridgelake Hospital	251	68.8%	26.6	
Out-Migration Destinations	**Cases**	**Percent**	**ALOS**	**% Out Migr n=114**
Kindred Hospital-Bay Area (St Pete)	72	19.7%	46.7	63.2%
Kindred Hospital-Bay Area (Tampa)	7	1.9%	24.3	6.1%
Kindred Hospital-Central Florida	2	0.5%	21.5	1.8%
Kindred Hospital-North Florida	1	0.3%	22.0	0.9%
Kindred Hospital-S FL-Coral Gables	1	0.3%	27.0	0.9%
Kindred Hospital-S FL-Ft Lauderdale	1	0.3%	29.0	0.9%
Kindred Hospital Melbourne	1	0.3%	30.0	0.9%
Kindred Hospital Palm Beaches	7	1.9%	57.1	6.1%
Select Specialty Hospital Palm Beach	9	2.5%	16.2	7.9%
Select Specialty Hospital Miami	1	0.3%	23.0	0.9%
Sister Emmanuel Hospital Continuing Care	1	0.3%	55.0	0.9%
Specialty Hospital Jacksonville	1	0.3%	23.0	0.9%
UCH LTACH at Connerton	1	0.3%	40.0	0.9%
Sum of Out-Migration	**114**	**NA**	**42.0**	**100.0%**
Grand Total	365	100.0%	31.4	

Source: CON application #10137, page 1-12.

The applicant poses two possible explanations for the out-migration of residents:

- Too few beds exist (40), so that when a bed is needed it is not available given the facility's occupancy rate (above 75 percent)
- At 40 beds, the current LTCH is constrained by what types of conditions it can treat.

Regardless of the reason for the high out-migration, Landmark contends that its occurrence establishes that LTCH services are not uniformly available within the district with some residents without access to a different degree than other residents of District 8.

Landmark notes that the majority of District 8 out-migration was to District 6 at Kindred Hospital-Bay Area (72 of 114 patients, 63 percent). The average length of stay (ALOS) for these patients was 46.7 days, indicating that these were complex cases with high acuity. The applicant cites that this facility has 82 beds and a CY 2010 occupancy rate of 55.4

percent, indicating capacity exists to accommodate a request for a bed when needed. The District 8 LTCH facility had an ALOS of 26.6, indicating less acuity.

The applicant states that the out-migration data demonstrates that one hospital in District 8 with 40 beds cannot meet the complex needs of persons within the district as reflected in the length of stay. This out-migration pattern for District 8 differs from the experience of most health planning districts. See the table below.

Out-Migration for LTCH Services for Health Planning Districts in Florida
Residents Aged 15 Years and Older
April 1, 2010-March 31, 2011

Number of LTCH Cases Based on Patients' District of Residence

Hospital District	1	2	3	4	5	6	7	8	9	10	11	UNK	TOTAL
1	563	3	3				1		1			54	625
2	17	557	3	2			1		1			116	697
3	1	3	497	35	4	5	5		5	1		12	568
4	1	1	119	1,072	2	2	11	2	2			165	1,377
5	1	1	70	2	720	324	2	73	2		2	34	1,231
6		1	27	4	54	699	53	9	1	1	1	15	865
7	1	1	55	35	1	89	740	1	17	1		15	956
8			2		4	141		251	1			12	411
9					1	3	3	16	811	15	2	26	877
10		1	1	1	1	3	1	10	26	799	446	24	1,313
11						1	1	3	4	27	1,438	12	1,486
TOTAL	584	568	777	1,151	787	1,267	818	365	871	844	1,889	485	10,406
ALOS	26.2	28.3	27.7	29.6	32.3	32.0	29.8	31.4	30.6	31.3	28.5		
# Out-Migration	21	11	280	79	67	568	78	114	60	45	451		
Percent	3.6%	1.9%	36%	6.9%	8.5%	44.8%	9.5%	31.2%	6.9%	5.3%	23.9%		
ALOS within the District	25.7	27.3	27.5	29.2	31.5	36.3	27.9	26.6	30.8	31.8	27.4		
ALOS Out-Migration	37.5	82.3	28.1	34.2	40.8	26.6	47.8	42.0	28.7	22.8	31.7		

Source: CON application #10137, page 1-14.

Landmark states that according to the data above, District 8 ranks last in terms of the number of persons treated in LTCH facilities. The applicant also cites that District 8 residents experienced the third longest ALOS at 31.4 days—longer lengths of stay reflect both higher severity and increased age.

The applicant notes that only two districts had higher ALOS for residents that out-migrated for LTCH services than District 8 residents. The 114 District 8 cases that out-migrated for LTCH care had an ALOS of 42.0 days compared to patients that remained in District 8 for LTCH care with an ALOS of 26.6 days. Landmarks states that this data demonstrates that the current capability within District 8 is not sufficient in size or in complexity of care. Therefore, the applicant asserts, the proposed facility would markedly enhance access and availability of care.

Landmark presents population estimates by county for District 8. See the table below.

Population Estimates for Counties of District 8 Age 65 Years and Older 2012 and 2015-2017 (first three years of operation)*				
County	**January 2012**	**January 2015**	**January 2016**	**January 2017**
Charlotte	148,085	155,344	157,711	160,009
Collier	281,944	303,090	310,451	317,615
DeSoto	28,041	28,969	29,289	29,574
Glades	9,611	9,846	9,903	9,957
Hendry	31,046	32,335	32,795	33,221
Lee	526,307	571,746	587,300	602,528
Sarasota	344,806	362,674	368,680	374,656
Total	1,369,840	1,464,004	1,496,129	1,527,560
Net Increase from the Previous Year				
Charlotte	1,192	2,530	2,367	2,298
Collier	3,396	7,623	7,361	7,164
DeSoto	-21	340	320	285
Glades	35	77	57	54
Hendry	53	471	460	426
Lee	8,954	16,034	15,554	15,228
Sarasota	3,074	6,306	6,006	5,976
Total	16,683	33,381	32,125	31,431
Percent Increase from the Previous Year				
Charlotte	0.8%	1.7%	1.5%	1.5%
Collier	1.2%	2.6%	2.4%	2.3%
DeSoto	-0.1%	1.2%	1.1%	1.0%
Glades	0.4%	0.8%	0.6%	0.5%
Hendry	0.2%	1.5%	1.4%	1.3%
Lee	1.7%	2.9%	2.7%	2.6%
Sarasota	0.9%	1.8%	1.7%	1.6%
Total	1.2%	2.3%	2.2%	2.1%

Source: CON application #10137, page 1-17.
*Applicant included first three years of operation as the proposed facility will not be profitable until year three.

Landmark next presents population estimates by District 8 county for the age cohort 65 years of age and older. This data shows large gains and much higher proportionate increases above the rate for the district. Patient 65 years and older comprise 70 percent of LTCH cases and population growth in that age cohort creates demand for care. These population estimates show that growth will continue, further exacerbating the disparity in access and availability of LTCH services in District 8 with just one 40-bed hospital. See the table below.

Population Estimates for Counties of District 8 Age 65 Years and Older 2012 and 2015-2017 (first three years of operation)				
County	**January 2012**	**January 2015**	**January 2016**	**January 2017**
Charlotte	57,859	62,062	63,752	65,536
Collier	83,949	93,766	97,511	101,353
DeSoto	6,480	6,993	7,176	7,353
Glades	2,165	2,280	2,323	2,370
Hendry	4,451	4,847	4,972	5,084
Lee	155,833	176,668	184,353	192,205
Sarasota	127,797	139,828	144,446	149,286
Total	438,534	486,444	504,533	523,187
Net Increase from the Previous Year				
Charlotte	900	1,459	1,690	1,784
Collier	2,093	3,500	3,745	3,842
DeSoto	92	181	183	177
Glades	26	38	43	47
Hendry	75	141	125	112
Lee	4,880	7,434	7,685	7,852
Sarasota	2,847	4,198	4,618	4,840
Total	10,913	16,951	18,089	18,654
Percent Increase from the Previous Year				
Charlotte	1.6%	2.4%	2.7%	2.8%
Collier	2.6%	3.9%	4.0%	3.9%
DeSoto	1.4%	2.7%	2.6%	2.5%
Glades	1.2%	1.7%	1.9%	2.0%
Hendry	1.7%	3.0%	2.6%	2.3%
Lee	3.2%	4.4%	4.3%	4.3%
Sarasota	2.3%	3.1%	3.3%	3.4%
Total	2.6%	3.6%	3.7%	3.7%
Percent of Total Population that are Persons Aged 65 Years and Older				
Charlotte	39.1%	40.0%	40.4%	41.0%
Collier	29.8%	30.9%	31.4%	31.9%
DeSoto	23.1%	24.1%	24.5%	24.9%
Glades	22.5%	23.2%	23.5%	23.8%
Hendry	14.3%	15.0%	15.2%	15.3%
Lee	29.6%	30.9%	31.4%	31.9%
Sarasota	37.1%	38.6%	39.2%	39.8%
Total	32.0%	33.2%	33.7%	34.2%

Source: CON application 10137, pages 1-17 and 1-18.

Availability, Utilization and Quality of Like Services in District 8

Landmark provides the use rate per 1,000 persons of LTCH services, inside or outside of the district, demonstrating a low use rate—the lowest of all health planning districts. See the table below.

Use Rates for LTCH Services for Ages 15+ and 65+ for Health Planning Districts of Residence April 1, 2010-March 31, 2011									
District	**15+ Pop.**	**Rate/ 1,000**	**# LTCH Beds**	**# LTCH Beds/ 100,000**	**Dischg/ Bed**	**65+ Pop.**	**Rate/ 1,000**	**# LTCH Beds/ 100,000**	**Dischg/ Bed**
1	581,199	1.0048	54	9.3	10.8	98,966	3.8195	54.5642	7.0000
2	610,606	0.9302	59	9.7	9.6	98,966	3.8599	59.6164	6.4746
3	1,374,792	0.5652	75	5.5	10.4	373,599	1.2982	20.0750	6.4667
4	1,616,085	0.7122	187	11.6	6.2	314,039	2.5092	59.5467	4.2139
5	1,151,309	0.6836	180	15.6	4.4	306,540	1.6703	58.7199	2.8444
6	1,795,640	0.7056	175	9.7	7.2	370,376	2.1897	47.2493	4.6343
7	1,907,606	0.4288	135	7.1	6.1	308,427	1.5855	43.7705	3.6222
8	1,353,157	0.2697	40	3.0	9.1	427,621	0.5987	9.3541	6.4000
9	1,570,633	0.5546	130	8.3	6.7	430,205	1.4737	30.2182	4.8769
10	1,404,154	0.6011	194	13.8	4.4	253,599	2.4369	76.4987	3.1856
11	2,057,175	0.9182	129	6.3	14.6	371,058	4.3848	34.7655	12.6124
TOTAL	15,422,356	0.6747	1,358	8.8	7.7	3,361,577	2.1707	40.3977	5.3733

Source: CON application #10137, page 1-19.

The applicant cites that District 8's use rate of 0.2697 per 1,000 persons is more than one and one half times lower than the next lowest in District 7—if District 8 had the same use rate as District 7 then it would have 580 instead of 365 admissions. Landmark contends that use-rate is one component in District 8's under-service, the other variable is bed supply. District 8 has the lowest bed supply of all health planning districts. The applicant maintains that this data demonstrates that District 8 residents do not have similar access to LTCH services as those who reside in other districts. The reviewer notes that the applicant does not provide documentation that District 8 and Collier County residents are unable to access long-term care services.

Landmark employs the statewide use rate and bed supply based on the elderly age cohort resulting in an estimate for LTCH services in District 8 of 928 admissions and a bed supply of 172.

The applicant provided the following information to show the occupancy rates of LTCH beds for the most recent five calendar years by each of the 11 health planning districts. See the table below.

Pattern of Utilization of LTCHs in all Health Planning Districts CY 2006-2010													
		Health Planning District											
CY	**Factor**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**State**
2006	# of Lic Beds	0	59	75	187	82	175	75	40	0	194	129	1,016
	Patient Days	0	9,115	7,593	42,207	19,561	37,234	14,178	9,838	0	44,208	40,614	224,548
	Occupancy	0.0%	60.8%	63.6%	64.3%	65.4%	58.3%	97.1%	67.4%	0.0%	62.4%	87.2%	66.2%
2007	# of Lic Beds	54	59	75	187	130	175	75	40	60	194	129	1,178
	Patient Days	837	11,094	9,181	44,828	20,711	38,475	19,533	10,147	305	43,870	41,006	239,987
	Occupancy	11.7%	54.7%	46.0%	65.5%	58.5%	60.1%	71.2%	69.3%	4.4%	61.8%	86.9%	62.7%
2008	# of Lic Beds	54	59	75	187	130	175	75	40	130	194	129	1,248
	Patient Days	3,617	13,808	12,304	44,668	21,731	34,638	21,970	9,054	2,437	43,109	41,708	249,044
	Occupancy	21.1%	63.9%	44.8%	65.3%	49.1%	54.1%	80.0%	62.0%	8.8%	60.7%	88.3%	57.8%
2009	# of Lic Beds	54	59	75	187	180	175	135	40	130	194	129	1,358
	Patient Days	10,863	17,160	14,326	42,960	24,703	34,564	21,198	10,176	18,493	44,041	42,243	280,727
	Occupancy	55.1%	79.7%	52.3%	62.9%	52.1%	54.1%	72.5%	69.7%	39.0%	62.2%	89.7%	61.4%
2010	# of Lic Beds	54	59	75	187	180	175	135	40	130	194	129	1,358
	Patient Days	14,770	18,394	14,514	42,407	36,606	33,045	24,889	11,331	26,616	43,054	41,621	307,247
	Occupancy	74.9%	85.4%	53.0%	62.1%	55.7%	51.7%	50.5%	77.6%	56.1%	60.8%	88.4%	62.0%

Source: CON application #10137, page 1-21.

Landmark states that the statewide occupancy rate of 62 percent for calendar year 2010, below the planning standard of 75 percent appears to indicate an available capacity of approximately 500 beds. The reviewer notes that the Agency does not have a planning standard of occupancy for LTCHs. This planning standard was established by Landmark. The applicant contends that this can be a misleading assumption as the ALOS for patients in a LTCH varies considerably typically on the high side. Data shows that the ALOS for CY 2010 was 30 days and the median was 29.7 days with a standard deviation of 3.1 days. For the one LTCH in District 8 the ALOS for CY 2010 was 31.8. Therefore Landmark contends that occupancy in this type of extended stay service may not the best measure of available capacity.

The applicant indicates that location does influence use along with the number of beds available. Regionalization of LTCH services is difficult in practice, asserts Landmark, because of the generally advanced age and serious conditions of the patients admitted. The applicant cites that residents in Sarasota, the county where the LTCH is located in District 8, had the highest access. Patients may decline LTCH admission if distance and time to travel are perceived as too great resulting in some negative consequences, such as:

- If the patient is a Medicare beneficiary, the hospital will be reimbursed an outlier payment if the patient remains in an acute care hospital. This is insufficient to cover the cost of care, creating a loss for the hospital.

- Remaining in a hospital may not be the most effective and efficient use of resources for a patient that is appropriate for LTCH admission. Generally such patients remain in intensive care, with the result that this resource may not afford the necessary access to rehabilitative and restorative therapies as frequently or of a duration that would otherwise be provided in a less restrictive, intensive care room.
- A single acute care hospital generally has too few such patients to have a critical mass that would support a dedicated unit and staff to care for them. Each hospital, with such cases, disproportionately creates expenses which, if all such patients were located together, could be reduced through enhanced efficiency.
- A few LTCH appropriate patients at one hospital means that expertise and treatment protocols for the LTCH patient may not be the most effective or efficient to produce the same results in the same time period that an LTCH can achieve. For highly complex patients that already present needs for expensive staff and other resources, the LTCH is the preferred environment of care.

Landmark notes that there is local interest in having Landmark as a LTCH provider, emphasizing need for LTCH services in light of current limited access to residents of Collier County. The applicant cites Dr. Allen Weiss', President and CEO of NCH Healthcare, letter of support.

The applicant states that the sole provider of LTCH services in District 8, Complex Care Hospital at Ridgelake, received The Joint Commission accreditation and Gold Seal Approval. All of the LTCH hospitals who treated District 8 residents that out-migrated for care also attained The Joint Commission accreditation and Gold Seal Award.

Landmark states that its current LTCH facilities have The Joint Commission accreditation and Gold Seal Approval. The applicant maintains that the proposed project will be at the same high level as the current Landmark Hospitals and those others that provide care to residents of District 8. Landmark states that the proposed project will assure the community standard of care for highly complex, seriously ill patients will persist.

Medical Treatment Trends

The applicant indicates that treatment for seriously ill persons remains a focus as data continues to show that the largest proportion of the Medicare budget is spent on persons in the last year of life. Landmark identifies three approaches that define the health care system:

- Prevention of chronic illness and debilitation
- Intervention to delay the onset of chronic conditions or to manage them when identified
- Treatment in settings that create efficiencies and economies.

Landmark states that the LTCH has emerged as another treatment location for highly complex, multiple system failures or involvements following episodic hospitalization. The role of the LTCH is to accept patients whose conditions meet medical necessity for acute admission whose recovery will require a mix of therapies and treatments over time. By accepting transfers from many hospitals, the LTCH has a critical mass of patients and staff that can operate more efficiently.

The applicant states that LTCHs are under study as their numbers increase. This research questions the amount of saving that can be achieved mixed with the expected high mortality rate of LTCH patients, given their advanced age and complications. Landmark cites two such studies, *Long-term Acute Care Hospitalization After Critical Illness* and *Post-ICU Mechanical Ventilation at 23 Long-Term Care Hospitals.* The first study did not produce clear results, "whether these hospitals meaningfully improve outcomes for either patient group [reference most severely ill versus less severely ill] is unknown" but do point out that incentives exist to transfer severely ill patient to free up intensive care beds.[11] The second study found that more than half of the ventilator-dependent survivors of catastrophic illness were transferred from the ICU were successfully weaned in the LTCH setting.[12]

Landmark provides Florida data for LTCHs' discharge disposition for all cases, not those on mechanical ventilation. See the table below.

[11] *Long-term Acute Care Hospitalization After Critical Illness* (Kahn, Benson et al. **JAMA**; 20103030(22); 2253-2259).
[12] *Post-ICU Mechanical Ventilation at 23 Long-Term Care Hospitals* (Scheinhorn, Hassenpflug et al. **Chest**; 131 (1), January 2007).

LTCH Patient Discharge Disposition Florida and District 8 April 1, 2010-March 31, 2011							
Statewide Age Cohort							
Discharge Status	**15-24**	**25-44**	**45-64**	**65-74**	**75+**	**Total**	**Percent**
01-Discharged Home	10	66	179	107	92	454	4.4%
02-DC to short term general hospital	13	59	406	422	449	1,349	13.0%
03-DC to Medicare SNF	12	118	826	1,028	1,650	3,634	34.9%
04-DC to intermediate care facility		1	4	5	17	27	0.3%
05-DC to cancer/children's facility			1	1	1	3	0.0%
06-DC to home health care	16	148	520	462	498	1,644	15.8%
07-Left AMA	2	15	17	14	20	68	0.7%
20-Deceased	3	34	319	562	1,129	2,047	19.7%
50-DC to Hospice home		1	22	35	83	141	1.4%
51-DC to Hospice facility		6	63	104	255	428	4.1%
62-DC to inpatient rehab facility	9	42	177	161	145	534	5.1%
63-DC to Medicare cert LTC hospital		4	12	12	22	50	0.5%
65-DC to Psych hospital/unit			2	1	1	4	0.0%
10-DC to another type not in list			2	7	14	23	0.2%
Total	**65**	**494**	**2,550**	**2,921**	**4,376**	**10,406**	**100.0%**
District 8 Age Cohort							
01-Discharge Home		1	4	1	1	7	1.9%
02-DC to short term general hospital		1	24	19	23	67	18.4%
03-DC to Medicare SNF	3	7	27	37	43	117	32.1%
06-DC to home health care			8	11	8	27	7.4%
07-Left AMA			1			1	0.3%
20-Deceased		1	2	25	32	60	16.4%
50-DC to Hospice home			1			1	0.3%
51-DC to Hospice facility			2	2	3	7	1.9%
62-DC to inpatient rehab facility	1	3	21	21	12	58	5.9%
63-DC to Medicare cert LTC hospital					3	3	0.8%
70-DC to another type not in list			2	5	10	17	4.7%
Total	**4**	**13**	**92**	**121**	**135**	**365**	**100.0%**

Source: CON application #10137, page 1-28.

Another national comprehensive study discussed by the applicant, *Long-Term Care Hospital Payment System Monitoring and Evaluation, Phase II Report,* identifies that DRG 475, Respiratory System Diagnosis with Ventilator Support, is the most common admission at LTCHs.[13] The second most frequent admission was DRG 249, After Care Musculoskeletal System & Connective Tissue. Landmark presents the top 25 DRGs treated at Florida LTCHs, pointing out that the Florida experience departs from the national findings. See the table below.

[13] *Long-Term Care Hospital Payment System Monitoring and Evaluation, Phase II Report* (Gage, Pilkauskas et al., RTI International, CMS Contract NO. 500-00-0024-TO#20, January 2007: RIT Project Number 07964.020).

The applicant states that the applicability to Florida's LTCHs with respect to some national findings demonstrates how discrepant the provisions of LTCH services are within the nation. Landmark contends that clearly, the implications for costs, margins and payment rates with such variability can raise concern.

Top 25 DRGs Treated at Florida LTCHs with ALOS April 1, 2010-March 31, 2011			
DRG	**Cases**	**Percent**	**ALOS**
Grand Total	10,406	100.0%	29.7
Respiratory System Diagnosis with Ventilator Support 96+ Hours	2,079	20.0%	40.6
Pulmonary Edema & Respiratory Failure	1,325	12.7%	21.0
Septicemia or Severe Sepsis without MV 96 Hours with MCC	493	4.7%	21.3
Respiratory System Diagnosis with Ventilator Support <96 Hours	350	3.4%	14.4
Respiratory Infections & Inflammations with MCC	292	2.8%	21.9
Aftercare with CC/MCC	226	2.2%	20.7
Other Respiratory System O.R. Procedures with MCC	223	2.1%	66.0
Septicemia or Severe Sepsis with MV 96+ Hours	223	2.1%	40.5
Skin Ulcers with MCC	192	1.8%	26.4
Chronic Obstructive Pulmonary Disease with MCC	180	1.7%	18.9
Trach with MV 96+ Hours or PDX EXC Face, Mouth & Neck without Major O.R.	164	1.6%	63.3
Postoperative & Post-Traumatic Infections with MCC	158	1.5%	24.7
Osteomyelitis with MCC	154	1.5%	28.4
Respiratory Infections & Inflammations with CC	133	1.3%	18.9
Complications of Treatment with MCC	130	1.2%	33.2
Renal Failure with MCC	126	1.2%	23.6
Skin Ulcers with CC	125	1.2%	22.7
Infectious & Parasitic Diseases with O.R. Procedure with MCC	122	1.2%	55.9
Simple Pneumonia & Pleurisy with MCC	117	1.1%	18.5
Other Circulatory System Diagnoses w MCC	115	1.1%	23.3
Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC	115	1.1%	72.4
Skin Graft and/or Debrid for Skin Ulcer or Cellulitis with MCC	105	1.0%	43.8
Chronic Obstructive Pulmonary Disease W CC	103	1.0%	15.8
Heart Failure & Shock with MCC	97	0.9%	20.9
Aftercare, Musculoskeletal System & Connective Tissue with MCC	88	0.8%	24.3
Subtotal	7,432	71.4%	31.3

Source: CON application #10137, page 1-30.

Landmark states that residents from District 8 needing LTCH services follow a similar pattern as above of clinical conditions.

The above mentioned study, *Long-Term Care Hospital Payment System Monitoring and Evaluation, Phase II Report*, mentions that because all LTCHs must be licensed as acute hospitals in the state in which they operate it is difficult to determine levels of care associated with LTCH admissions.[14] This study did develop recommendations for identifying patients appropriate for admission to LTCHs.[15] These are as follows:

- The primary diagnosis must be medical, not physical functioning or psychiatric.
- The cases must be medically complex, defined broadly to include conditions with severe medical complications, co-morbidities, or system failures and together represent a complicated, severely ill patient.
- Require LTCHs to discharge those not having diagnostic procedures or improving with treatment.
- Develop criteria to measure medical severity for hospital admission.
- Develop a Technical Advisory Group (TAG) composed of physicians who treat medically complex patients to develop a set of criteria and measures.
- Collect data and analyze it.
- Require LTCHs to collect and submit functional impairment measures as well as physiologic measures on all patients receiving physical, occupational or speech/language pathology services.

Landmark states that LTCHs in Florida strive to be the place for severely ill, medically complex patients. A mix of therapies and services are offered, the conditions admitted are life-threatening and life-limiting, with 70 percent over age 65. The applicant indicates that within these parameters, Florida LTCHs operate in concert with the recommendations of the abovementioned report.

Landmark states that the proposed facility for Collier County will direct care to the most severely ill patients, with most receiving mechanical ventilation. The applicant's goal is to wean patients from the ventilator. To achieve its goal, Landmark adopts the latest in advances that have demonstrated success. Landmark contends there is sufficient need for the Lee County 60-bed LTCH and its project.

[14] Since the study was published, medical severity is now a feature in the DRG schema as a parameter to distinguish cases in the future.
[15] Tables of Characteristics were presented in Section 6, "Recommendations of the Report".

The applicant maintains that it provides 24-hour physician coverage--unusual in the LTCH industry and a higher standard of care. Landmark also accommodates clinical research and internships.

Many protocols and patient care standard of practice evolve over time for the severely ill with life-threatening conditions. Landmark maintains that its staff participates in techniques and studies which advance from research and improve the practice of care in the hospital. Current areas on interest include, but are not limited to the following:

- Techniques and new applications of research in wound care, recently adopting the use of platelet-rich plasma therapy in place of negative-pressure wound therapy.
- Implementation of the **InTouch Health** ® RP-7 robot, which is controlled by a board-certified physician that makes rounds. The robot is not a substitute for doctors, but allows staff to interface with a live board-certified physician for routine issues after hours with the on-call physician available for emergencies.
- Investigation into the implementation of the Electronic Health Record. Interface technology allows the physician to have the record convert basics for billing, and also access the latest information regarding standards of practice and "diagnostic trees" for treatment.

Landmark states that innovation that enhances the ability to efficiently manage severe cases improves the provision of care and allows staff to be effective in applying treatments timely, appropriately and consistently. The applicant strives to be among the first to use technologies as both clinical staff extenders and cost-containment modalities.

Market Conditions

The applicant notes that the development of LTCHs gained momentum and mushroomed in the late 1990s and into the new millennium. Florida's development was slowed, in part due to the certificate of need requirements and due to the definition of the LTCH as regional service with a geographical boundary, the health planning district.

Landmark cites that federal initiatives also slowed the development of LTCHs, these include:

- The development and refinement of LTCH-DRG prospective payment rates.

- The concept of a hospital within a hospital, permitting an acute care hospital to lease a floor or area of the hospital to a LTCH and the subsequent refinements and limitations on the hospital within a hospital to restrict admissions from the host hospital, requirement of complete separation of ownership and medical staffs and limitations on the services purchased from the host hospital.
- Enactment of a three-year moratorium, beginning December 29, 2007, on enrolling any new LTCHs, creating LTCH satellite hospitals or adding LTCH beds. This moratorium was extended by the Affordable Care Act from December 29, 2010 to December 29, 2012.

The applicant states that since the moratorium has been in place, federal spending on LTCHs has been flat. The industry's rapid growth from fewer than 10 hospitals in the 1980s to treating 200,000 patients a year (with 130,000 of those being Medicare beneficiaries)—Medicare costs are estimated to be $4.8 billion in 2010, up from $400 million in 1993. Landmark states that profit margins on Medicare in LTCHs are about six percent, on the other side at general acute care hospitals, the losses on Medicare patients run about six percent. The applicant notes that Dr. Christopher Cox, an associate professor of critical care medicine at Duke University, states that Medicare reimbursement rules encourage the development of LTCHs, receiving payment on the basis of diagnosis rather than the cost of care.

Landmark asserts that the direction that policy makers will pursue in the future direction of LTCHs is cost of care. For example, LTCH appropriate patients who remain in the acute care setting create loss as the Medicare outlier payment is insufficient to cover the cost of care. Hospitals therefore incur losses since Medicare does not cover the full cost of care. The applicant cites *Post-ICU Mechanical Ventilation at 23 Long-Term Care Hospitals* again, noting the authors' assumptions that the weaning from mechanical ventilation as part of the cost of care in the LTCH would be far less than it would be in the ICUs at acute care hospitals. Landmark contends that this illustrates the economy of care afforded by the LTCHs.

The applicant states that what providers charge differs from costs as well as from what payers will reimburse under negotiated rates. Medicare is the primary payer for LTCH services with commercial insurers a distant second. Landmark notes that charges vary by payers and variations exist in the charge per day. See the table below.

Charges Statewide by Payer for LTCHs April 1, 2010 to March 31, 2011					
Payer	**Cases**	**Percent**	**ALOS**	**Total Charge/Case**	**Total Charge/Day**
Charity	49	0.5%	34.9	$172,167	$4,939
Commercial	2,396	230%	35.5	$186,776	$5,266
Government	13	0.1%	42.0	$204,841	$4,877
Medicaid	149	1.4%	36.6	$161,982	$4,424
Medicare	7,632	73.3%	26.8	$120,178	$4,489
Self/Other	125	1.2%	80.0	$490,277	$6,128
Workers Comp	42	0.4%	43.9	$179,873	$4,095
Grand Total	10,406	100.0%	29.7	$141,148	$4,756

Source: CON application #10137, page 1-37.

The reviewer notes that the above table represents charges statewide. Based on the Florida Hospital Uniform Reporting System (FHURS) 2010 Actual Reports, the breakdown for actual payments to LTCHs is as follows: Medicare 79.5 percent, Medicaid 1.8 percent, HMO-PPO 14.9 percent, commercial insurance 2.4 percent and charity 1.4 percent.

Landmark indicates that information available from the CMS website reported that in 2010 Medicare spent $5.2 billion on LTCHs with 134,700 cases at an average payment of $38,600. The standardized cost per discharge was $26,600 and $36,251, respectively for high-margin and low-margin profitable LTCHs. Medicare payment per discharge was $38, 557 for high profit-margin, LTCHs and $38,137 per discharge for the low-profit margin LTCHs. Within the high-profit margin LTCHs, 90 percent were for-profit compared to 64 percent for-profit LTCHs in the low-profit margin group.

The applicant reviewed the available data for Florida LTCHs for 2009 on the Group 12, Long-Term Care Hospitals. Landmark notes that the mean standard cost per adjusted admission across all payers was $35,619-higher than that reported for the high margin LTCHs and just slightly higher than that reported for the low margin hospitals. The applicant identifies that Florida's mean cost per adjusted admission is much higher at admission, $45,724, than is the Medicare cost per discharge in either group. Landmark states that Florida's LTCHs do treat a higher intensity, severely ill patient group with multiple complexities—it follows that the costs would be higher. See the table below.

Florida LTCH Reported Costs Calendar Year 2009							
	Standard Cost/Adj Adm.	**Cost/Adj. Admits**	**Bed Size**	**ADC**	**Medicaid & Charity**	**ALOS**	**LTCH Case Mix**
Mean	$35,619	$45,724	62.4	38.8	2.94%	30	1.2813
Median	$33,634	$45,764	57.0	36.09	2.53%	29.7	1.2992
S.D.	6.121	8.688	26.6	15.94	1.80%	3.1	0.1334

Source: CON application #10137, page 1-38.

Landmark states that the federal government did make downward adjustments in payments to LTCHs as a cost-controlling mechanism. The LTCH PPS federal rate for FY 2011 is $39,599.95, effective after October 1, 2010—reflecting a downward adjustment as contained in the Affordable Care Act. The applicant cites other adjustments: MS-LTC-DRG Grouper version 28 (up from 27), a fixed loss amount of $18,785, the labor share of 75.271 percent and cost to charge ratio (CCR) ceiling of 1.231. Landmark contends that greater risk for costs is placed on LTCHs with these changes.

Bed Need Analysis

The applicant states that several methods were applied to forecast the demand expected for LTCH services in District 8. The first method was the use rate—discharges per 1,000 persons aged 15 and older. Landmark applies the statewide average and statewide median rates to future population estimates for District 8 to gauge demand for LTCH services. The statewide average and median were figured using previously introduced information on LTCH services by persons aged 15 and older, rates of use discussed earlier in the application and on page 24 of this State Action Agency Report. The applicant provides the statewide use rate applied to District 8 population estimates for years 2015 to 2018 to forecast the cases, patient days, ADC and beds needs at the 75 percent occupancy standard. See the table below.

Forecasted LTCH Cases per Year Using the Statewide Use Rate District 8 Future Population Estimates Ages 15 Years and Older January 2015-January 2018				
Number of Cases Statewide Use Rate of .6747/1,000 Persons				
County	**January 2015**	**January 2016**	**January 2017**	**January 2018**
Charlotte	105	106	108	109
Collier	204	209	214	219
DeSoto	20	20	20	20
Glades	7	7	7	7
Hendry	22	22	22	23
Lee	386	396	407	417
Sarasota	245	249	253	257
District 8	988	1,009	1,031	1,051
Number of Patient Days Statewide Use Rate, ALOS=29.7				
County	**January 2015**	**January 2016**	**January 2017**	**January 2018**
Charlotte	3,113	3,160	3,206	3,251
Collier	6,073	6,221	6,365	6,505
DeSoto	580	587	593	598
Glades	197	198	200	201
Hendry	648	657	666	674
Lee	11,457	11,769	12,074	12,373
Sarasota	7,267	7,388	7,508	7,627
District 8	29,337	29,980	30,610	31,228
Average Daily Census				
County	**January 2015**	**January 2016**	**January 2017**	**January 2018**
Charlotte	9	9	9	9
Collier	17	17	17	18
DeSoto	2	2	2	2
Glades	1	1	1	1
Hendry	2	2	2	2
Lee	31	32	33	34
Sarasota	20	20	21	21
District 8	80	82	84	86
Beds Needed at 75% Occupancy Standard				
County	**January 2015**	**January 2016**	**January 2017**	**January 2018**
Charlotte	11	12	12	12
Collier	22	23	23	24
DeSoto	2	2	2	2
Glades	1	1	1	1
Hendry	2	2	2	2
Lee	42	43	44	45
Sarasota	27	27	27	28
District 8	107	110	112	114

Source: CON application #10137, pages 1-40 and 1-41.

Landmark notes that looking at the results for the two southernmost counties—Collier and Lee—a demand of 64 beds is generated by January 2015. The applicant provides identical information using the median (District 5's use rate) instead of the statewide use rate. See the table below.

Forecasted LTCH Cases per Year Using the Median Use Rate District 8 Future Population Estimates Ages 15 Years and Older January 2015-January 2018				
Number of Cases **District 5 Use Rate, .6836/1,000 Persons**				
County	**January 2015**	**January 2016**	**January 2017**	**January 2018**
Charlotte	106	108	109	111
Collier	207	212	217	222
DeSoto	20	20	20	20
Glades	7	7	7	7
Hendry	22	22	23	23
Lee	391	401	412	422
Sarasota	248	252	256	260
District 8	1,001	1,023	1,044	1,065
Number of Patient Days **District 5 Use Rate, ALOS=32.3**				
County	**January 2015**	**January 2016**	**January 2017**	**January 2018**
Charlotte	3,430	3,482	3,533	3,583
Collier	6,692	6,855	7,013	7,168
DeSoto	640	647	653	659
Glades	217	219	220	221
Hendry	714	724	734	742
Lee	12,624	12,968	13,304	13,634
Sarasota	8,008	8,141	8,273	8,404
District 8	32,326	33,035	33,729	34,410
Average Daily Census				
County	**January 2015**	**January 2016**	**January 2017**	**January 2018**
Charlotte	9	10	10	10
Collier	18	19	19	20
DeSoto	2	2	2	2
Glades	1	1	1	1
Hendry	2	2	2	2
Lee	35	36	36	37
Sarasota	22	22	23	23
District 8	89	91	92	94
Beds Needed at 75% Occupancy Standard				
County	**January 2015**	**January 2016**	**January 2017**	**January 2018**
Charlotte	13	13	13	13
Collier	24	25	26	26
DeSoto	2	2	2	2
Glades	1	1	1	1
Hendry	3	3	3	3
Lee	46	47	49	50
Sarasota	29	30	30	31
District 8	107	110	112	114

Source: CON application #10137, pages 1-42 and 1-43.

The applicant maintains that using the District 5 median use rate the ADC estimates for District 8 increase by nine persons over the average daily census when using the statewide use rate. Landmark contends that employing the statewide (average) or District 5 (median) use rate to approximate demand is realistic given that the District 8 rate is so far below the rest of the districts' experience. The applicant indicates that the above data confirms the following points:

- The current number of LTCH beds in District 8 (40 beds) is too few to meet demand.
- By January 2015, modeling indicates that at least 107 to 118 beds are needed to achieve some parity with the rest of the health care planning districts with respect to access to the service.
- Over the period 2015 to 2018 demand increases, roughly adding approximately two to three beds a year, just to remain at an occupancy standard of 75 percent. Therefore, the demand persists and the current LTCH is already above 75 percent, insufficient under either use rate.

Landmark contends that with this health care service, supply is integral to demand—unless the supply exists, no service can be delivered. The applicant maintains that as the supply increases so does use because providers become aware of the options. Landmark provides data applying each health care planning district's bed rate to the population estimate for persons aged 15 and above for January 2015. See the table below.

Bed Supply Forecast for District 8 Based on Each Health Planning District's Bed to Population Ratio Applied to January 2015 Population Estimates for District 8

Apply the District Bed Rate of...	LTCH Beds Forecasted for District 8	Less Licensed LTCH Beds	Less Approved LTCH Beds	Net Beds Needed for District 8	Net Beds Needed @ 75% Occupancy*
District 5	229	40	60	129	172
District 10	202	40	60	102	136
District 4	169	40	60	69	93
District 6	143	40	60	43	57
District 2	141	40	60	41	55
District 1	136	40	60	36	48
District 9	121	40	60	21	28
District 7	104	40	60	4	5
District 11	92	40	60	-8	-11
District 3	80	40	60	-20	-27
District 8	43	40	60	-57	-76
State	129	40	60	29	39
Median	136	40	60	36	48
Average	133	40	60	33	44

Source: CON application #10137, page 1-44.
*Note: The applicant chose this occupancy standard.

The applicant contends that the data above clearly shows the discrepancies in the availability of LTCH beds. District 5's beds rate when applied to District 8 forecasted population results in a gross bed need of 229 LTCH beds, while the current bed rate for District 8 produces a gross need of 43. Landmark maintains that knowing District 8's use and bed rates are the lowest among the districts, the results in the net beds needs at 75 percent occupancy standard column reflects marked variability. The applicant concludes that looking at the last three rows in the above table—the state, median and average bed rates return a final need for District 8 of 39, 48 or 44 beds beyond the number of licensed and approved LTCH beds. Landmark stated that the proposed 50-bed facility is within these parameters.

Landmark tested the accuracy of its bed analysis with a regression equation. Using the equation y=b=mx yielded 9,846 patient days that a 50-bed LTCH would return based on the state's historical experience among LTCHs in the 11 health planning districts.[16] The applicant then performed a linear trend line using the same historical data, returning 10,738.17 LTCH patient days. Both of these equations, Landmark maintains, indicate the reasonableness of the 50 beds proposed.

The applicant forecasts approximately 9,100 patient days in the second year of operations. From historical data, the 9,100 forecasted patient days would generate 62 LTCH beds, based on the regression formula. Using a linear trend line, a calculation of 81.20982 LTCH beds were generated using 9,100 patient days—indicating that the statewide experience with patient days would produce a higher expected number of beds. Landmark explains this phenomenon by the fact that the statewide numbers of LTCH beds are associated with lower numbers of patient days.

Landmark asserts that the above data confirms that the 50 LTCH beds sought are within reasonable parameters and reflect the statewide experience among the 11 health planning districts. The result of increasing the number of beds within District 8 improves access and availability making the district in closer parity with the others.

[16] In this equation, "y" is the predicted value, "b" is the intercept, "m" is the slope and "x" is the known variable from which "y" will be calculated.

The applicant states that it used the District 5 use rate, as it represents the calculated median experience and could be considered conservative. This rate was applied to forecasted population estimates for those aged 15 years and older in District 8 for the calendar year 2015-2017 to generate the gross numbers of LTCH cases. The applicant then assumed a market share.

Utilization Forecast for Landmark Hospital of Southwest Florida			
Factor	**Year 1: CY 2015**	**Year 2: CY 2016**	**Year 3: CY 2017**
Gross Cases, District 8	1,001	1,023	1,044
Market Share	17%	27%	40%
Hospital Cases	170	283	427
Occupancy	30%	50%	74%
ALOS	32	32	32
ADC	15	25	37

Source: CON application #10137, page 1-48.

Landmark cites Governor Rick Scott's mandate to create and sustain jobs in Florida noting the Creation and Economic Growth Agenda he signed into law on March 28, 2012. The applicant asserts that the proposed project will create jobs. Landmark states that there are 142 FTEs associated with the proposed project with an average salary with benefits of about $65,000 a year.[17] Most of these jobs are in professional and technical fields. Landmark indicates that the impact of the proposed project would be $9.2 million in rough terms added to the local economy in the form of permanent jobs.

The applicant maintains that the proposed project will also employ trades and journeymen. Steven's Construction Company in Collier County estimate an average daily work force of 51 throughout a year at 2,080 hours/man at an average wage of $45 per hour. This results in an estimate of $4.5 million in wages to workers. Landmark estimates a total of $850,613 in permits, impact fees and other costs paid to Collier County and the City of Naples government. The applicant states that the indirect workforce associated with the hospital will also increase jobs in the area.

Kindred Hospitals East, LLC (CON #10138):

Population Demographics and Dynamics

Kindred states that Collier County, the primary service area (PSA), contains a population of 236,484 with 87,409 (37 percent) age 65+. The population is expected to increase 11 percent in the next five years and the 65+ population is expected to have a 17 percent increase over the same time period. The applicant identifies Lee and Hendry County as the secondary service area for the proposed facility and cites a current

[17] The applicant's Schedule 6 year three projections actually show 141 FTEs for the project.

65+ population of 241,412 (24 percent of total population) that is expected to increase to 286,370 (19 percent) over the next five years. See the table below.

Population Estimates for Primary, Secondary and District Area 2012 and 2017

County	1/1/2012 Total Population	1/1/2017 Total Population	Total Population % Change	1/1/2012 65+ Population	1/1/2017 65+ Population	Total 65+Population % Change
Primary Service Area						
Collier	326,484	363,068	11.2%	87,409	102,304	17.0%
Secondary Service Area						
Lee	633,147	726,611	14.8%	149,378	178,691	19.6%
Hendry	38,859	40,874	5.2%	4,625	5,375	16.2%
Service Area Total	998,490	1,130,553	13.2%	241,412	286,370	18.6%
Remaining District 8 Counties						
Charlotte	161,143	170,827	6.0%	55,421	60,909	9.9%
DeSoto	34,711	36,836	6.1%	6,273	6,955	10.9%
Glades	12,828	14,122	10.1%	2,797	3,278	17.2%
Sarasota	383,289	409,298	6.8%	120,874	136,027	12.5%
District 8 Total	1,590,461	1,761,636	10.8%	426,777	493,539	15.6%

Source: CON application #10138, page 4.

The applicant contends that with the increase in the senior population, the financial and capacity burdens on short-term hospitals from long-term patients will continue to increase. Kindred asserts that the need for long-term care hospital services in Collier County will exceed the capabilities of existing LTCH facilities in the district thereby creating a substantial unmet need in the delivery of health care in District 8.

Availability, Utilization and Quality of Like Services in the District

Kindred states that only one LTCH exists in District 8, Complex Care Hospital at Ridgelake, a 40-bed LTCH in Sarasota County with an average 12-month occupancy of over 71 percent.

The applicant indicates that Complex Care Hospital at Ridgelake is approximately two hours away from the southern portion of the district. Kindred states that this necessitates traveling long distances for extended periods of time for patients, their families and physicians causing a great burden. The applicant maintains that a patient's interaction with family and their own physician is significant to the rehabilitation process and denying it can damage that patient's quality of care.

Kindred states that it demonstrates in its bed need analysis that the existing facility in Sarasota and the approved 60-bed facility in Lee County do not have sufficient capacity to meet the current need nor the increasing need for LTCH services.[18] The applicant maintains that the

[18] Kindred's bed need analysis on page 13-14 of CON application #10138 states that there is an unmet need of 43 LTCH beds in the District in 2017.

proposed facility in Collier County will significantly improve the availability of needed LTCH services to residents of District 8. The reviewer notes that the applicant does not provide documentation that District 8 or Collier County residents are unable to obtain long-term care services.

The applicant maintains that short-term acute care hospitals are not the ideal setting for the treatment of medically complex patients for two reasons:

- LTCH appropriate patients reduce the short-term hospital's ability to care for acute patients admitted from the emergency room that need intensive care services.
- The cost to provide care to medically-complex patients is higher than caring for these patients in a long-term care hospital.[19]

Kindred asserts that comprehensive medical rehabilitation facilities are not an appropriate option for treating LTCH patients because they cannot withstand three or more hours of therapy a day and are not stable enough to be managed by a physician whose specialty is physical medicine. Neither is a SNF, the applicant states, an appropriate setting for LTCH patients as these facilities are restricted to serving less medically complex cases with more stable patients.

The applicant provides a table to illustrate the difference in services offered in LTCHs, rehabilitation hospitals and SNFs.

[19] Kindred cites page 11 of a Quality and Social Responsibility Report published annually by Kindred and included in Appendix of CON application #10138.

LTCH Comparison to Rehab Hospitals and SNFs			
	LTCH	**Rehab Hospital**	**SNFs**
License	Acute hospital	Rehabilitation hospital	Skilled nursing facility
Medicare Certification	Long-term hospital	Rehabilitation hospital	Skilled nursing facility
Admitting Criteria	Meets acute criteria	75% falls into case mix groups for rehab	Meets chronic care criteria
Length of Stay	Minimum 25 days Kindred ALOS 28	Typically 12-18	Typically Medicare 25-35 days
Physician Involvement	Care directed by multiple medical sub specialties; daily visits	Care directed by physical medicine physician	Physician visits weekly/monthly
Manage Critically Ill Patients	Yes; telemetry monitoring, intravenous pressors, dialysis	No	No
Patient Characteristics	Typically after illness from respiratory disease, stroke or infection; many concurrent illnesses	Typically after knee, hip or back surgery	Frequently requires therapy services to increase mobility
Vent Weaning	Vent weaning-major focus; established programs	Rare but vent weaning possible in facilities with vent program	Primarily maintenance rather than weaning
Respiratory Therapy 24 hours/ 7 days in-house	Yes	No	No
Rehab Therapy	Approximately one hour per patient day	Three hours per patients day in at least two disciplines	Approximately 1.5 hours per patient day in at least two disciplines

Source: CON application #10138, page 7.

Kindred states that the proposed facility's goal is to resolve or stabilize the patient's multiple problems at the same time as they are receiving rehabilitative services and then ultimately discharge them to a lower level setting such as a skilled nursing facility, rehabilitation hospital or home.

Medical Treatment Trends

The applicant states that it treats the very sickest patients who require the most intensive and life-saving medical interventions. These patients have three to six concurrent active diagnoses and have suffered an acute episode on top of several chronic illnesses. Kindred uses patient screening to evaluate the appropriateness of patients, dictating that long-term acute care is comparable to a traditional acute hospital level of care and address each patient's needs for high intensity of services because of an intense severity of illness.

Kindred contends that the predominance of LTCHs throughout the country is due in part to the following factors:

- Federal recognition of the special role that LTCHs play in the health care continuum as reflected in the separate certification category for LTCHs and their separate reimbursement system.
- The increasing need of short-term hospitals for discharge options for their medically-complex long-term patients. This need has especially grown since federal reimbursement changes made it financially unfeasible for most nursing facilities to provide care to ventilator patients and other high-acuity patients.
- Increasing awareness and understanding of LTCH by physicians, hospital discharge planners and other medical professionals—especially a greater understanding of the benefits that LTCHs provide to their medically complex patients.

The applicant asserts that the given inadequate supply of long-term care hospital beds in District 8 creates financial losses for short-term hospitals and limits the level of care that patients care receive. Kindred maintains that its facilities are a cost-effective means of providing the most appropriate, high quality services to the medically complex patient.

Kindred provides a detailed listing of the services it currently provides to LTCH patients on pages 8-10 of CON application #10139, these include:

- Respiratory services
- IV services
- Surgical services
- Neurological services
- Skin services
- Renal services
- Cardiac services
- Additional services

The applicant states that Kindred hospitals employ aggressive therapy on various fronts to improve patient outcomes as well as the psychosocial needs of patients and families. Kindred maintains that the types of medical conditions that necessitate long-term hospitalization are those that warrant hospital level services but do not heal rapidly or repair quickly. The applicant asserts that it has developed the expertise to successfully care for the catastrophically ill, medically complex patient outside of the traditional intensive care unit.

Kindred states that its ICU services are a vital part of the service offering at the proposed facility that ensures patients receive the highest-quality, most clinically appropriate care for medically-complex conditions. The reviewer notes that the architectural review for this proposed facility

found the ICU patient bedroom clearance requirements insufficient to meet the minimum clearances—a significant impact on the proposed facility.

Market Conditions

The applicant indicates that the need for LTCH services in District 8 far exceeds the current supply of long-term care hospital beds. Kindred notes that the only LTCH in District 8 is approximately two hours away from the southern portion of the district and contends that physicians in the southern area of the district are not able to access the LTCH continuum of care. The reviewer notes that the applicant does not provide documentation regarding lack of access to long-term care for District 8 and Collier County residents.

Kindred cites the letters of support included in Appendix 4 of CON application #10138 as further documentation of the need for a Kindred LTCH in Collier County. The applicant submitted 143 unduplicated letters of support for the project, 140 letters were form letters. These letters represented a number of health care providers including: physicians, nurses, case managers and other therapists.

Kindred contends that the previously discussed population increase in Collier County will result in greater demand for LTCH services. The proposed facility will increase the availability of these services and ease the burden of travel on patients, families and physicians.

Bed Need Analysis

Kindred estimated long-term bed need based on the acute care discharges and days occurring to residents of the service area. The applicant analyzed individual-level patient discharge data for the 12 months ending September 2011 for all hospitals in the State of Florida. Kindred used this information to identify the number of actual short-term acute care hospital patients and patient days which could be served by the proposed long-term hospital.

The applicant used three patient characteristics in this analysis:

- Diagnosis
- Age
- Length of Stay.

Kindred considered patients to be appropriate for long-term hospital care if they are:

- Residents of Collier, Lee or Hendry County
- Eighteen years of age or older
- Not assigned to an omitted Diagnosis Related Group (DRG)
- Have a short-term hospital length of stay that exceeds their DRG-specific national geometric mean length of stay by at least 16 days (referral period [four days] + LTCH minimum length of stay [12 days]).

The applicant states that it estimates that during the 12 months ending September 2011, there were approximately 20,147 potential long-term care hospital days provided in the 10 short-term acute care hospitals in Collier, Lee and Hendry Counties. Kindred maintains that an additional 3,096 potential long-term care hospital days were produced by service area residents treated in short-term acute care hospitals elsewhere in Florida. This results in a potential long-term care hospital average daily census for District 8 to 64.

Kindred states that 150 residents of the service area received LTCH hospital services elsewhere in the state of Florida—despite the significant distance and cost involved—producing 5,041 long-term care hospital days. The applicant contends that it is reasonable to assume that the identified patients would return to the service area for LTCH care if such a facility existed there. This results in a potential long-term care hospital ADC of 14.

The applicant cites the expected 13.2 percent population growth in the service area over the next five years and applies it the current potential ADC, this results in a potential long-term care hospital ADC of 10.

Kindred then applies the long-term hospital target occupancy of 85 percent to the potential long-term care hospital bed need for CY 2017 equaling 103 beds. Subtracting the already approved LTCH project in Lee County for 60 beds, the applicant produces an estimated net bed need in CY 2017 of 43 beds. See the table below.

Bed Need Analysis Chart		
	Potential Hospital Days	**Potential ADC**
Current patients in short-term acute care hospitals	23,243	64
Current patients seeking LTCH care outside Collier, Lee or Hendry County	5,041	14
Total	28, 284	78
The expected population growth for the service area of 13.2% multiplied by total potential ADC from above		10
Added to total potential ADC from above for CY 2017 potential ADC		88
CY 2017 potential ADC divided by target long-term care hospital occupancy of 85%		103 beds
Subtract 60 potential LTCH beds for CON-approved project in Lee County		43 LTCH bed need in Collier, Lee and Hendry Counties

Source: CON reviewer based on information in the narrative on pages 13-14 of CON application #10138.

Kindred concludes that by using reasonable assumptions and actual discharge data for the residents of Collier, Lee and Hendry Counties, the above analysis clearly demonstrates that there is more than sufficient need to justify and support the 40-bed long-term care hospital proposed by herein.

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(1)(a) and (b), Florida Statutes.

There is one licensed LTCH with 40 licensed beds and one CON approved LTCH with 60 approved beds in District 8. The licensed LTCH, Complex Care Hospital at Ridgelake, had an occupancy level of 71.29 percent in the 12-month period ending June 2011. The 60-bed CON approved LTCH is not under construction at this time.

Landmark Hospital of Southwest Florida, LLC (CON #10137) states that, as discussed in the need analysis, District 8 ranked last with respect to:

- The discharge rate to LTCHs
- The number of LTCH beds
- The number of LTCH beds per 1,000 persons aged 15 and older
- The discharges per LTCH bed
- With respect to benchmarking using the elderly population.

The applicant also asserts that reduced availability of LTCH services in District 8 was associated with reduced access.

Landmark uses other rates to further illustrate the lack of availability within District 8. Using the statewide average rate of 40.3977 for "beds per 100,000 population", the applicant yielded 173 LTCH beds to attain parity with the state for District 8. Therefore, Landmark concludes that too few LTCH beds exist in District 8 and that more are required to assure better availability of LTCH services. The applicant maintains that the proposed 50-bed facility is within the conservative parameters to improve availability.

The applicant states that the severities of LTCH patients' conditions require attention to the quality of offered services in light of the possibility of mortality. The central issue is where to place patients in an environment that houses a critical mass of patients to make treatment less costly and maximize limited health care dollars. Therefore, the applicant concludes that accreditation with The Joint Commission and Gold Seal approval is important to ensuring the best care occurs. Landmark makes and continues to make this a condition of operation.

Landmark maintains that one of the many distinguishing features that it will bring to the state is the use of the **InTouch Health** ® robot, which extends the ability of the on-call physician to engage interactively in real time with patients or staff. The applicant states that it is also evaluating a nuanced platform that uses the iPad to create an electronic health record.

Landmark contends that only 40 LTCH beds in District 8 are a barrier for residents in the southern-most parts of the district as these beds are located in Sarasota County. These beds are too distant to be a reasonable referral and placement for residents in Lee and Collier County. Landmark indicates that travel distances to LTCH services are problematic for both the patient as well as the patient's friends and family. Travel for family and friends raise concern for a variety of reasons, including:

- Elderly persons traveling by car over distances when tired, or making frequent trips (perhaps in peak times) increases the probability of accidents.
- Stress on the family as time is required to travel—the greater the distance, the more time is required. The desire to see the family member also may create stress to accommodate work schedules, time out and visitation with the hospitalized family member.
- Increased costs to the family for travel and loss of wages if leave is required to be taken without pay.

The applicant maintains that the transport of LTCH patients over distance can pose problems even with emergency vehicles due to the unstable nature of the patients. Additionally, the source of a majority of LTCH patients' are transferred directly from acute care hospitals by medical transport. Landmark asserts that using medical transports, specifically if emergency vehicles provide it, take the vehicles away from the county—making them unavailable for a period of time until the vehicles return. This creates greater stress on the existing system to cover transports locally. The reviewer notes that the applicant does not provide documentation of any current logistical issue within Collier County as regards to emergency transportation.

Landmark also states that in certain months of the year as well as certain times of the day, traveling in District 8 can take much longer between points of service due to traffic congestion. The impact of traffic congestion would be negative of transporting fragile, unstable patients.

Given that the LTCH patient has high acuity, the applicant states that the probability of mortality is also greater. The fragility of the patients' condition increases the stress on family to visit and participate in the care and comfort thereby making geographic accessibility an important variable. Landmark contends that a LTCH within closer proximity to Collier County is justified and would have a positive impact toward improving access further. The applicant maintains that the approved 60-bed facility by Promise Hospital of Lee, Inc. will be located in Lee County, further improving access to the District 8 population. Landmark contends there is sufficient need for the Lee County LTCH and its project.

Landmark indicates that Medicare is the major payer for LTCH patients since 70 percent of patients are 65 years of age and older. The applicant contends that statewide 73 percent of Florida's LTCH cases' care is reimbursed by Medicare, with commercial insurers at 23.3 percent. See the table below.

Charges Statewide by Payer for LTCHs April 1, 2010 to March 31, 2011					
Payer	**Cases**	**Percent**	**ALOS**	**Total Charge/Case**	**Total Charge/Day**
Charity	49	0.5%	34.9	$172,167	$4,939
Commercial	2,396	23.0%	35.5	$186,776	$5,266
Government	13	0.1%	42.0	$204,841	$4,877
Medicaid	149	1.4%	36.6	$161,982	$4,424
Medicare	7,632	73.3%	26.8	$120,178	$4,489
Self/Other	125	1.2%	80.0	$490,277	$6,128
Workers Comp	42	0.4%	43.9	$179,873	$4,095
Grand Total	**10,406**	**100.0%**	**29.7**	**$141,148**	**$4,756**

Source: CON application #10137, page 3-7.

The reviewer notes that the above table represents charges statewide. Based on the Florida Hospital Uniform Reporting System (FHURS) 2010 Actual Reports, the breakdown for actual payments to LTCHs is as follows: Medicare 79.5 percent, Medicaid 1.8 percent, HMO-PPO 14.9 percent, commercial insurance 2.4 percent and charity 1.4 percent.

The applicant maintains that Medicare drives policies on reimbursement and the MS-LTCH-DRGs are dominant in creating the parameter for payment that commercial insurers (which include managed care options) adopt. Landmark contends that since federal policies require that LTCHs be licensed as acute care hospitals in the state in which they operate and that MS-LTCH-DRGs drive payment—financial access in large part will be based upon the age and clinical factors for ensuring admission. The applicant notes that financial penalties are imposed for short-stays and readmissions, therefore the prevailing practice is to follow Medicare eligibility and payment requirements to their fullest.

Kindred Hospitals East, LLC (CON #10138) contends that the proposed facility will increase availability and accessibility, improve efficiency of the services and enhance the overall quality of the continuum of care in District 8.

The applicant maintains that the current LTCH facility in Sarasota County is approximately two hours away from the southern portion of the district causing a burden on patients, families and patient's physicians. Kindred states that denying a patient geographic accessibility to interaction with family and physicians can be damaging to the patient's quality of care. The applicant contends that even with the construction of Promise of Lee's 60 CON-approved LTCH beds, there is an estimated net bed need of 43 beds in District 8.

Kindred maintains that short-term acute care facilities, SNFs and other subacute providers are not appropriate settings for long-term care hospital patients. The applicant contends that its long-term care facilities don't compete but complement the existing health care providers. Kindred states that the proposed facility will work with local providers to offer a continuum of care within the community.

The applicant states that the proposed facility will improve efficiency of services as it works with area providers to integrate a continuum of care to promote efficient use of area resources and placement of patients in the most appropriate setting. Kindred maintains that the establishment of the proposed facility will promote efficient access to area residents needing long-term hospital services.

Kindred cites its larger health care company stating that the proposed facility will have improved efficiency because it will be able to utilize centralized services at the corporate office such as purchasing, project management, clinical/quality management, medical records and many other services. This results in significant cost savings to the facility and to patients.

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(1) (c), Florida Statutes.

Landmark Hospital of Southwest Florida, LLC (CON #10137) states that it is an affiliate of Landmark Holdings of Missouri, LLC an operator of LTCHs through affiliates. The applicant includes two articles citing Landmark Hospital of Joplin's ability to continue operations during a blizzard and a multiple-vortex tornado due to successful disaster planning and preparations.

The applicant maintains that all established affiliates of Landmark Hospitals are accredited by The Joint Commission with commendation. The proposed facility will follow the same pattern and engage in the same preparations to achieve this distinction. Landmark asserts that practice patterns are established to ensure the highest clinical standards in nursing, clinical and medical care. The applicant states that corporate-wide performance benchmarks and standards are enforced through a continuous quality improvement system.

Landmark states that it strives to improve quality and outcomes through the implementation of procedures and technologies. Some recent developments that make staff more effective and enhance patient's outcomes include:

- Techniques and new applications of research in wound care, adopting the use of platelet-rich plasma therapy in place of negative-pressure wound therapy.
- Implementation of the **InTouch Health** ® RP-7 robot, which is controlled by a board-certified physician that makes rounds. The robot is not a substitute for doctors, but allows staff to interface with a live board-certified physician for routine issues after hours with the on-call physician available for emergencies.
- Investigation into the implementation of the Electronic Health Record. Interface technology allows the physician to have the record convert basics for billing, and also access the latest information regarding standards of practice and "diagnostic trees" for treatment.

The applicant states that it will deploy a range of innovations to allow staff to become more effective in patient care and management, and as an outcome, contain health care costs.

Landmark states that it selected Hunton Brady Architects to design the proposed facility as this firm has forward-thinking designs in health care. The proposed facility will be similar to Hunton Brady's Florida Hospital at Wesley Chapel, utilizing an arc design. This design affords greater patient privacy and creates a "back of the house" access capability that also enhances patient privacy. The design has all private rooms with handicap accessible bathroom situated close to the bed and sleep-in accommodations for families. Landmark notes that the footwall is designed for future communication equipment that will allow patients to have access to family members and other information.

The applicant indicates that Landmark's response to the Joplin, Missouri tornado and blizzard demonstrates its disaster planning and adequate follow-through that creates a safe and secure environment. Landmark indicates that this proposed environment of care includes structures that support social interaction and socialization, the practice of self-determination and choice while allowing for a variety of options in treatment and daily routines.

Landmark states that it uses the collaborative care quality of care model, based upon a multidisciplinary team approach. The applicant will develop detailed care plans using an integrated medical record, so that each member of the multidisciplinary team will have access to the work of other professionals.

Pre-admission screenings and admission determinations, notes the applicant, are made based upon pre-set criteria and guidelines for the provision of long-term care. InterQual criteria is used to determine the appropriateness of patient admission and continued hospital stay. Landmark asserts that daily physician rounds are required. The six major InterQual subsets treated by the applicant are:

- Ventilator weaning
- Respiratory complex
- Other medically complex
- Infectious diseases
- Wound/skin
- Cardiovascular/peripheral vascular.

Landmark indicates that a plan of care is initiated for each patient within 24 hours of admission and within the first week of admission the transdisciplinary care team will meet formally to incorporate evaluations of various disciplines and further develop the plan. Patients and their families are offered opportunities to attend transdisciplinary team conferences or family conferences during treatment at the hospital. Landmark states that upon discharge patients are provided the opportunity to choose continuum of care placement or services. When home is the possible discharge destination, information is gathered regarding the home environment and conducting home evaluations.

Landmark maintains that the quality improvement process involves leaders of all levels of the organization to establish priorities for performance improvement with the governing board retaining the ultimate authority. Priorities for this plan include patient health outcomes and high-volume, high-risk and/or problem-prone processes. The hospital collects data on the following measures:

- Performance improvement priorities
- Operative or other procedures
- Adverse events related to using moderate sedation
- The use of blood and blood components

- All reported and confirmed transfusion reactions
- The results of resuscitation
- Significant medication errors
- Significant adverse drug reactions
- Patient perceptions of the safety and quality of care, treatment and services (including pain management).

The applicant states that Landmark hospitals utilize clinical practice and evidence-based guidelines when designing or improving processes. Annually, Landmark hospitals provide governance with written reports on items such as the following:

- All system or process failures
- Number and type of sentinel events
- Whether the patients and the families were informed of the event
- All actions taken to improve safety (proactive and in response to actual occurrence)
- The determined number of distinct improvement projects to be conducted
- The results of the analyses related to adequacy of staffing.

Landmark also has organizational education requirements, environmental safety activities, surveillance activities, emergency management activities and infection control activities as part of its performance improvement plan.

The applicant maintains that the structure, function, activities and accomplishments of the performance improvement plan are reviewed at least annually to assure that the program is achieving its objectives, is demonstrating impact and is consistent with federal/state regulations as well as The Joint Commission requirements. The reappraisal process takes into account evidence of substantial impact and other internal and external information reflecting the plan's effectiveness.

Landmark hospitals have adopted benchmarks that are used in the industry to measure performance as well as factors that are followed to ensure that care meets standards. The applicant uses a performance improvement dashboard to track quality improvement and safety indicators. Landmark includes the 2011 performance improvement dashboard for Landmark Hospital of Athens beginning on page 4-13 of CON application #10137. Extracts from it appear below:

- Ventilator Weaning Rate 86%
- Catheter Associated UTI Rate (goal: <4) 0.79
- Central Line Infection Rate 0.7
- Ventilator Acquired Pneumonia Rate 1.7
- Wound Volume Healing Rate 75%
- Percent Discharged Home 11.9%
- Percent Discharge Home w/Home Health 31.8%

The applicant contends that the above information reflects its ability to deliver the highest quality of services in the clinical and medical management of patients in the long-term care hospital. Landmark states that it demonstrates consistency with and conformity to the statutory criterion to provided quality care.

Kindred Hospitals East, LLC (CON #10138) states that it is committed to providing high quality patient care and outstanding customer service. The applicant maintains that it is driven by its commitment to its mission and values. Kindred states that its management philosophy is simple, "focus on people, on quality and customer service, and our business results will follow."

The applicant indicates that all Kindred LTCHs are accredited by the Joint Commission, meet all conditions of participations for the Medicare program as overseen by the National Centers for Medicare and Medicaid Services and are licensed and inspected by state regulatory authorities. Kindred states that it has operated LTCHs in Florida for 20 years demonstrating a long history of providing high quality long-term acute care services throughout the state.

Kindred includes its annual *Quality and Social Responsibility Report* in Appendix 3 of CON application #10139. This report outlines the company's continued commitment to improving person-centered care coordination. The applicant states that in 2011, Kindred's long-term acute care hospitals continued to outperform national benchmarks in many key quality indicators while caring for sicker patients. Kindred maintains that its performance has resulted in decreased length of stay, fewer readmissions to general acute care hospitals and more patients going home sooner at a lower cost to the health care system.

Kindred has 10 licensed LTCHs in Florida with a total of 745 licensed beds. Agency data obtained April 19, 2012 indicates that Kindred affiliated hospitals had 29 substantiated complaints during the previous 36 months. A single complaint can encompass multiple complaint categories. The table below has these listed by complaint categories.

Kindred Substantiated Complaint Categories in the Past 36 Months	
Complaint Category	**Number Substantiated**
Nursing Services	18
Quality of Care/Treatment	14
Resident/Patient/Client Assessment	7
Infection Control	4
Plan of Care	2
Admission, Transfer & Discharge Rights	2
Administration/Personnel	1
Restraints/Seclusion General	1
Physical Environment	1
Unqualified Personnel	1

Source: Agency for Health Care Administration complaint records.

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 (1)(d), Florida Statutes.

Landmark Hospital of Southwest Florida, LLC (CON #10137) is a development stage enterprise. The audited financial statements of the applicant for the period ending January 31, 2012 were analyzed for the purpose of evaluating the applicant's ability to provide operational funding necessary to implement the project. The applicant indicated that Carter Validis Mission Critical REIT (REIT) and Medistar Corporation of Houston Texas will finance the construction of the hospital, own the hospital and lease it to the applicant.

Capital Requirements:
The applicant indicates on Schedule 2 capital projects totaling $22.1 million which includes this project.

Available Capital:
The applicant indicates on Schedule 3 that funding for the project will be provided by the REIT. The REIT provided no proof of available funding. As of January 31, 2012, the applicant had $2.1 million in working capital, and a $2.6 million line of credit from Montgomery Bank for working capital, as well as a $1.8 million line of credit for equipment purchases.

Staffing:

See the table below.

Landmark Hospital of Southwest Florida, LLC Staffing Patterns for Year One and Year Two of Operations		
	Year One FTEs Ending 12/31/2015	**Year Two FTEs Ending 12/31/2016**
Administration		
Chief Executive Officer	1.0	1.0
Chief Clinical Officer	1.0	1.0
Director of Quality	1.0	1.0
Director of Human Resources	1.0	1.0
Business Office Liaison	1.0	1.0
Director of HIM	1.0	1.0
HIM Assistant	1.0	1.0
TOTAL	**7.0**	**7.0**
Physicians		
Medical Director	1.0	1.0
Hospitalist	2.0	4.0
Total	**3.0**	**5.0**
Nursing		
RNs	26.0	40.0
Nurse Manager	--	1.0
Nurses Aides	6.0	10.0
Wound Care Nurse	1.0	1.0
TOTAL	**33.0**	**52.0**
Ancillary		
Physical Therapist	1.0	1.0
Speech Therapist	--	1.0
Occupational Therapist	--	1.0
Respiratory Therapist	6.0	10.0
TOTAL	**7.0**	**18.1**
Dietary		
Dietary Supervisor	1.0	1.0
Cooks	1.0	1.0
Dietary Aides	1.0	2.0
TOTAL	**3.0**	**4.0**
Social Services		
Social Service Director	1.0	1.0
Activity Director	1.0	1.0
Activities Assistant	1.0	2.0
Other	--	--
Total	**3.0**	**4.0**
Housekeeping		
Housekeeping Supervision	1.0	1.0
Housekeepers	3.0	5.0
Total	**4.0**	**6.0**
Other		
Respiratory Manager	1.0	1.0
Clinical Educator	1.0	1.0
Total	**2.0**	**2.0**
Plant Maintenance		
Maintenance Supervisor	1.0	1.0
Maintenance Assistance	1.0	2.0
Other: Security	3.0	4.0
TOTAL	**5.0**	**7.0**
GRAND TOTAL	**68.0**	**100.0**

Source: CON application #10138, Schedule 6.

The applicant notes that staffing patterns and the number of FTEs are based on the historical experience of management.

Conclusion:
Funding for this project and the capital budget is entirely dependent on a third party's ability to fund the construction of the hospital. It is the applicant's plan to lease the land and buildings from the third party.

Kindred Hospitals East, LLC (CON #10138): The audited financial statements of the applicant were reviewed for the period ending December 31, 2011, for the purpose of evaluating the applicant's ability to provide the capital and operational funding necessary to implement the project. The applicant indicated that its parent company, Kindred Healthcare, Inc. (parent), would provide funding for this project. Therefore, we have also evaluated the parent's December 31, 2011, 10-K to evaluate the parent's ability to fund the project.

Short-Term Position - Applicant:
The applicant's current ratio of 2.2 is slightly above average and indicates current assets are approximately 2.2 times current liabilities, a good position. The working capital (current assets less current liabilities) of $77.0 million is a measure of excess liquidity that could be used to fund capital projects. The ratio of cash flow to current liabilities of 0.2 is well below average and a weak position which may indicate difficulties in securing future debt. Overall, the applicant has an adequate short-term position (See Table 1).

Short-Term Position – Parent:
The parent's current ratio of 1.5 is slightly below average and indicates current assets are approximately 1.5 times current liabilities, an adequate position. The working capital (current assets less current liabilities) of $384.4 million is a measure of excess liquidity and is sufficient to cover the capital budget multiple times. The ratio of cash flow to current liabilities of 0.2 is well below average and a weak position. Overall, the parent has an adequate short-term position. (See Table 1).

Long-Term Position—Applicant:
The ratio of long-term debt to net assets of 0.0 is well below average and indicates the applicant has equity to acquire future debt financing against if necessary, a good position (apparently all long-term debt is held by the parent). The ratio of cash flow to assets of 5.1 percent is below average and a weak position. The most recent year the applicant reported a net operating loss of $40,099,916, which resulted in a negative 6.1 percent operating margin, a weak position. Overall, the applicant has a moderately weak long-term position. (See Table 1).

Long-Term Position – Parent:
The ratio of long-term debt to net assets of 1.5 is above average and indicates that long-term debt exceeds equity, a weak position. The ratio of cash flow to assets of 3.7 percent is below average and a weak position. The most recent year had revenues in excess of expenses of negative $53.5 million, which resulted in a negative 1.0 percent operating margin. Overall, the parent has a weak long-term position. (See Table 1)

TABLE 1
Kindred Hospitals East, LLC (Applicant)
Kindred Healthcare, Inc. (Parent)

	Applicant 12/31/11	Parent 12/31/11
Current Assets (CA)	$140,798,848	$1,233,282,000
Cash and Current Investment	$220,308	$41,561,000
Total Assets (TA)	$279,715,108	$4,138,493,000
Current Liabilities (CL)	$63,772,299	$848,923,000
Total Liabilities (TL)	$67,968,453	$2,817,952,000
Net Assets (NA)	$211,746,655	$1,320,541,000
Total Revenues (TR)	$659,072,439	$5,521,763,000
Interest Expense (Int)	$9,693,120	$80,919,000
Excess of Revenues Over Expenses (ER)	($40,068,948)	($53,481,000)
Cash Flow from Operations (CFO)	$14,213,871	$153,706,000
Working Capital	$77,026,549	$384,359,000

FINANCIAL RATIOS

	Applicant 12/31/11	Parent 12/31/11
Current Ratio (CA/CL)	2.2	1.5
Cash Flow to Current Liabilities (CFO/CL)	0.2	0.2
Long-Term Debt to Net Assets (TL-CL/NA)	0.0	1.5
Times Interest Earned (ER+Int/Int)	1.0	0.3
Net Assets to Total Assets (NA/TA)	75.7%	31.9%
Operating Margin (ER/TR)	-6.1%	-1.0%
Return on Assets (ER/TA)	0.0%	-1.3%
Operating Cash Flow to Assets (CFO/TA)	5.1%	3.7%

Capital Requirements:
Schedule 2 indicates total capital projects of $50,928,366, which includes the CON subject to this review.

Available Capital:
While the applicant is an on-going corporation, it states on Schedule 3, funding for this project will be operating cash flows from the applicant's parent company, Kindred Healthcare, Inc.

In support of its ability to fund the project, the applicant provided a letter of financial commitment from the parent company and a copy of Kindred Healthcare, Inc.'s 10-k filing with the Securities and Exchange Commission. According to the audit, the parent has working capital available of $384.4 million and cash flow from operations of $153.7 million. Staff has been notified that that the architectural plans for the hospital as filed must undergo significant modifications to be acceptable. The effect on cost and scheduling is unknown and it is unclear if a material change in cost would impact the applicant's decision to go forward. However, the parent could fund a six fold increase in the capital budget through working capital alone and therefore, would likely be able to fund this project even if the cost increased materially.

Staffing:

See the table below.

	Year One FTEs Ending 12/31/2015	Year Two FTEs Ending 12/31/2016
Administration		
Administrator	1.0	1.0
Chief Clinical Officer	1.0	1.0
Director of Human Resources	1.0	1.0
Controller	1.0	1.0
Secretary/Admin Assistants	2.0	2.0
Other: Accounting, Case Management, Purchasing, et al	17.0	21.0
TOTAL	**23.0**	**27.0**
Physicians		
Medical Director	Contracted Service	Contracted Service
Nursing		
RNs	11.0	22.9
LPNs	3.2	6.8
Nurses Aides	5.9	12.6
Wound Care	0.7	1.4
Nurse Administrators	7.0	9.0
Other: Non-productive time	1.8	3.8
TOTAL	**29.6**	**56.5**
Ancillary		
Respiratory Therapist	5.9	12.0
Other: Non-productive time	0.5	1.1
Other: Pharmacy, Radiation, Laboratory, Dialysis	3.0	5.0
TOTAL	**9.4**	**18.1**
Dietary		
Dietary Supervisor	1.0	1.0
Dietician	1.0	2.0
Cooks	2.0	2.0
Dietary Aides	2.0	3.0
TOTAL	**6.0**	**8.0**
Housekeeping		
Housekeeping Supervision	Contracted Service	Contracted Service
Housekeepers	Contracted Service	Contracted Service
Laundry		
Laundry Supervisor	Contracted Service	Contracted Service
Laundry Aides	Contracted Service	Contracted Service
Plant Maintenance		
Director of Plant Operations	1.0	1.0
Maintenance Assistant	1.0	1.0
TOTAL	**2.0**	**2.0**
GRAND TOTAL	**70.0**	**111.5***

Source: CON application #10138, Schedule 6.
*This number totals 111.6.

The applicant notes that the majority of FTEs required by the implementation of the proposed project are direct care givers consisting of a mix of RNs, LPNs and CNAs based on hours per patient day basis. Non-clinical and clinical staffing levels, wage rates and compensation were based upon similar factors at Kindred Hospital Bay Area-St. Petersburg, a similar Kindred hospital.

Kindred states that there will be physical, rehab and occupational therapists working in the hospital but that these will technically be employees of RehabCare Services Division, an operating diving of Kindred Healthcare. Therefore, this is a contracted service.

Conclusion:
Funding for this project and the entire capital budget should be available as needed.

d. What is the immediate and long-term financial feasibility of the proposal? ss. 408.035(1)(f), 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.

It should be noted that currently, a moratorium exists on new LTCH beds. The Affordable Care Act extended the moratorium (with few exceptions) from December 28, 2010 until December 28, 2012. These provisions of the Act are scheduled to sunset at that time. If the moratorium is once again extended then these projects will not be permitted to go forward and thus not be feasible.

Landmark Hospital of Southwest Florida, LLC (CON #10137):
Projected net revenue and expenses of the applicant will be compared to hospitals in the Long Term Acute Care Group (Group 12). An intensity factor of 1.0774 was calculated for the applicant by taking the projected average length of stay indicated and dividing it by the weighted average length of stay for the peer group. This methodology is used to adjust the

group values to reflect the intensity of the patient as measured by length of stay. Per diem rates are projected to increase by an average of 3.1 percent per year. Inflation adjustments were based on the new CMS Market Basket, 4th Quarter, 2011.

Gross revenues, net revenues, and costs were obtained from Schedules 7 and 8 in the financial portion of the application and compared to the control group as a calculated amount per adjusted patient day. For the total hospital comparison, we used the applicant's historic adjustment factor for patient days.

Projected net revenue per adjusted patient day (NRAPD) of $1,737 in year one and $1,784 in year two is between the control group median and highest values of $1,416 and $1,885 in year one and $1,459 and $1,941 in year two. With net revenues falling between the median and highest level, the facility is expected to consume health care resources in proportion to the services provided. (See Table 1).

Anticipated costs per adjusted patient day (CAPD) of $2,191 in year one and $1,889 in year two is between the control group median and highest values of $1,378 and $2,929 in year one and $1,420 and $3,017 in year two. With projected cost falling between the median and highest level, the facility is expected to spend on health care in proportion to the services provided. Costs appear to be reasonable. (See Table 2). The applicant is projecting a decrease in CAPD between year one and year two of $302, or 13.8 percent. It should be noted that this application is for a new facility. The first year of operation has a below average occupancy rate. The low occupancy rate decreases economies of scale and as the occupancy rate increases, CAPD would be expected to decrease.

The year two projected operating loss for the hospital of $963,600 computes to an operating margin per adjusted patient day of a negative $105 or a negative 5.9 percent which is between the control group lowest and median values of a negative $1,208 and $9. The applicant projects being profitable by year three. The year three projected operating income for the hospital of $1,179,431 computes to an operating margin per adjusted patient day of $87 or 4.9 percent which is between the control group median and highest values of $9 and $189. Operating income appears reasonable. (See Table 2).

TABLE 1

Landmark Hospital of Southwest Florida, LLC

CON #10137 **2010 DATA Peer Group 12**	Dec-16 YEAR 2 ACTIVITY	YEAR 2 ACTIVITY PER DAY	VALUES ADJUSTED FOR INFLATION Highest	 Median	 Lowest
ROUTINE SERVICES	16,735,704	1,830	2,617	1,386	513
INPATIENT AMBULATORY	0	0	11	0	0
INPATIENT SURGERY	0	0	0	0	0
INPATIENT ANCILLARY SERVICES	0	0	5,504	3,527	1,375
OUTPATIENT SERVICES	0	0	7	0	0
TOTAL PATIENT SERVICES REV.	16,735,704	1,830	7,437	5,013	1,888
OTHER OPERATING REVENUE	0	0	13	3	0
TOTAL REVENUE	16,735,704	1,830	7,442	5,017	1,889
DEDUCTIONS FROM REVENUE	425,304	47	0	0	0
NET REVENUES	16,310,400	1,784	1,941	1,459	693
EXPENSES					
ROUTINE	4,243,000	464	694	408	182
ANCILLARY	5,448,000	596	505	374	224
AMBULATORY	0	0	0	0	0
TOTAL PATIENT CARE COST	9,691,000	1,060	0	0	0
ADMIN. AND OVERHEAD	3,616,000	395	0	0	0
PROPERTY	3,967,000	434	0	0	0
TOTAL OVERHEAD EXPENSE	7,583,000	829	2,108	693	281
OTHER OPERATING EXPENSE	0	0	0	0	0
TOTAL EXPENSES	17,274,000	1,889	3,017	1,420	687
OPERATING INCOME	-963,600	-105	189	9	-1,208
		-5.9%			
PATIENT DAYS	9,143				
ADJUSTED PATIENT DAYS	9,143				
TOTAL BED DAYS AVAILABLE	18,250		VALUES NOT ADJUSTED FOR INFLATION		
ADJ. FACTOR	1.0000				
TOTAL NUMBER OF BEDS	50		Highest	Median	Lowest
PERCENT OCCUPANCY	50.10%		91.7%	61.8%	19.2%
PAYER TYPE	PATIENT DAYS	% TOTAL			
SELF PAY	232	2.5%			
MEDICAID	0	0.0%	7.2%	1.5%	0.0%
MEDICAID HMO	314	3.4%			
MEDICARE	6,312	69.0%	88.5%	61.1%	48.6%
MEDICARE HMO	0	0.0%			
INSURANCE	2,146	23.5%			
HMO/PPO	0	0.0%	49.4%	34.6%	1.3%
OTHER	139	1.5%			
TOTAL	9,143	100%			

TABLE 2

Landmark Hospital of Southwest Florida, LLC

CON #10137	Dec-17	YEAR 3	VALUES ADJUSTED		
2010 DATA Peer Group 12	YEAR 3	ACTIVITY	FOR INFLATION		
	ACTIVITY	PER DAY	Highest	Median	Lowest
ROUTINE SERVICES	24,893,121	1,837	2,696	1,427	529
INPATIENT AMBULATORY	2,918	0	12	0	0
INPATIENT SURGERY	0	0	0	0	0
INPATIENT ANCILLARY SERVICES	0	0	5,669	3,633	1,416
OUTPATIENT SERVICES	0	0	7	0	0
TOTAL PATIENT SERVICES REV.	24,896,039	1,837	7,660	5,164	1,945
OTHER OPERATING REVENUE	0	0	14	3	0
TOTAL REVENUE	24,896,039	1,837	7,666	5,168	1,946
DEDUCTIONS FROM REVENUE	632,608	47	0	0	0
NET REVENUES	24,263,431	1,791	2,000	1,502	713
EXPENSES					
ROUTINE	6,476,000	478	715	421	187
ANCILLARY	7,945,000	586	521	385	231
AMBULATORY	0	0	0	0	0
TOTAL PATIENT CARE COST	14,421,000	1,064	0	0	0
ADMIN. AND OVERHEAD	4,621,000	341	0	0	0
PROPERTY	4,042,000	298	0	0	0
TOTAL OVERHEAD EXPENSE	8,663,000	639	2,172	714	289
OTHER OPERATING EXPENSE	0	0	0	0	0
TOTAL EXPENSES	23,084,000	1,704	3,107	1,462	707
OPERATING INCOME	1,179,431	87	189	9	-1,208
		4.9%			
PATIENT DAYS	13,549				
ADJUSTED PATIENT DAYS	13,549				
TOTAL BED DAYS AVAILABLE	18,250		VALUES NOT ADJUSTED		
ADJ. FACTOR	1.0000		FOR INFLATION		
TOTAL NUMBER OF BEDS	50		Highest	Median	Lowest
PERCENT OCCUPANCY	74.24%		91.7%	61.8%	19.2%

PAYER TYPE	PATIENT DAYS	% TOTAL			
SELF PAY	344	2.5%			
MEDICAID	0	0.0%	7.2%	1.5%	0.0%
MEDICAID HMO	465	3.4%			
MEDICARE	9,353	69.0%	88.5%	61.1%	48.6%
MEDICARE HMO	0	0.0%			
INSURANCE	3,180	23.5%			
HMO/PPO	0	0.0%	49.4%	34.6%	1.3%
OTHER	207	1.5%			
TOTAL	13,549	100%			

Conclusion:
Assuming that the REIT has adequate funding for the land acquisition and construction of the facility and that the LTCH bed moratorium is not extended, this project appears to be financially feasible.

Kindred Hospitals East, LLC (CON #10138): The applicant will be compared to hospitals in the Long Term Acute Care Group (Group 12). An intensity factor for comparative purposes of 1.1246 was calculated based on the ratio of average length of stay for all Kindred long-term care hospitals in the group, to the weighted average length of stay for the group as a whole. We used the existing Kindred hospitals average length of stay as a proxy for the applicant since average length of stay for this project was not included in the application. This methodology is used to adjust the group values to reflect the intensity of the patient as measured by length of stay. Per diem rates are projected to increase by an average of 3.1 percent per year. Inflation adjustments were based on the new CMS Market Basket, 4nd Quarter, 2011.

Gross revenues, net revenues, and costs were obtained from Schedules 7 and 8 in the financial portion of the application and compared to the control group as a calculated amount per adjusted patient day.

Projected net revenue per adjusted patient day (NRAPD) of $1,572 in year one and $1,765 in year two falls between the control group median and highest values of $1,475 and $1,952 in year one, and $1,519 and $2,011 in year two, respectively. With net revenues falling between the median and highest level, the facility is expected to consume health care resources in proportion to the services provided. (See Table 2).

Anticipated costs per adjusted patient day (CAPD) of $2,708 in year one and $1,755 in year two is between the control group median and highest values of $1,439 and $3,057 in year one and $1,482 and $3,149 in year two. With projected cost between the median and highest value in the control group in year one, costs appear reasonable (See Table 2). The applicant is projecting a decreased CAPD between year one and year two from $2,708 to $1,755, or 35.2 percent. It should be noted that this application is for a new facility. The first year of operation has a below average occupancy rate. The low occupancy rate decreases economies of scale and as the occupancy rate increases, CAPD would be expected to decrease.

The year two projected operating income for the project of $94,701 computes to an operating margin per adjusted patient day of $9, or 0.5 percent, which equals the control group's median value of $9. With a

projected operating margin equaling the median value in the control group, the operating margin appears reasonable and efficient.

TABLE 2

Kindred Hospitals East **CON #10138** **2010 DATA Peer Group 12**	Dec-16 YEAR 2 ACTIVITY	YEAR 2 ACTIVITY PER DAY	VALUES ADJUSTED FOR INFLATION Highest	 Median	 Lowest
ROUTINE SERVICES	93,389,262	9,050	2,732	1,446	536
INPATIENT AMBULATORY	0	0	12	0	0
INPATIENT SURGERY	0	0	0	0	0
INPATIENT ANCILLARY SERVICES (P)	0	0	5,745	3,681	1,435
OUTPATIENT SERVICES (Q)	0	0	8	0	0
TOTAL PATIENT SERVICES REV. (R)	93,389,262	9,050	7,762	5,233	1,971
OTHER OPERATING REVENUE	0	0	14	3	0
TOTAL REVENUE	93,389,262	9,050	7,768	5,237	1,972
DEDUCTIONS FROM REVENUE	75,179,980	7,286	0	0	0
NET REVENUES	18,209,282	1,765	2,011	1,519	723
EXPENSES					
ROUTINE	3,780,710	366	719	426	190
ANCILLARY	4,430,264	429	523	390	234
AMBULATORY	0	0	0	0	0
TOTAL PATIENT CARE COST	8,210,974	796	0	0	0
ADMIN. AND OVERHEAD	6,631,658	643	0	0	0
PROPERTY	3,271,949	317	0	0	0
TOTAL OVERHEAD EXPENSE (V)	9,903,607	960	2,201	723	293
OTHER OPERATING EXPENSE	0	0	0	0	0
TOTAL EXPENSES	18,114,581	1,755	3,149	1,482	723
OPERATING INCOME	94,701	9	189	9	-1,208
		0.5%			
PATIENT DAYS	10,319				
ADJUSTED PATIENT DAYS	10,319				
TOTAL BED DAYS AVAILABLE	14,600		VALUES NOT ADJUSTED FOR INFLATION		
ADJ. FACTOR	1.0000				
TOTAL NUMBER OF BEDS	40		Highest	Median	Lowest
PERCENT OCCUPANCY	70.68%		91.7%	61.8%	19.2%
PAYER TYPE	PATIENT DAYS	% TOTAL			
SELF PAY	0	0.0%			
MEDICAID (BA)	107	1.0%	7.2%	1.5%	0.0%
MEDICAID HMO	0	0.0%			
MEDICARE (AW)	6,007	58.2%	88.5%	61.1%	48.6%
MEDICARE HMO	2,182	21.1%			
INSURANCE	1,911	18.5%			
HMO/PPO (BF)	0	0.0%	49.4%	34.6%	1.3%
OTHER	112	1.1%			
TOTAL	10,319	100%			

Conclusion:
Assuming the applicant will be able to obtain funding for the project, the 40-bed LTCH appears to be financially feasible.

e. Will the proposal foster competition to promote quality and cost-effectiveness? ss. 408.035 (1)(e), Florida Statutes.

Currently, a moratorium exists on new LTCH beds. The Affordable Care Act extended the moratorium (with few exceptions) from December 28, 2010 until December 28, 2012. These provisions of the Act are scheduled to sunset at that time. If the moratorium is once again extended (and assuming the CON is granted), the applicants will have to commence construction of the facility with hopes that the moratorium will be lifted by completion date or forfeit the CON and re-apply if and when the moratorium is lifted.

Competition to promote quality and cost effectiveness is driven primarily by the best combination of high quality and fair price. Competition forces entities to ultimately increase quality and reduce charges/cost in order to remain viable in the market. The health care industry has several factors that limit the impact competition has to promote quality and cost-effectiveness. These factors include a disconnect between the payer and the end user of health care services as well as a lack of consumer friendly quality measures and information. These factors make it difficult to measure the impact this project will have on competition to promote quality and cost effectiveness. However, we can measure the potential for competition to exist in a couple of areas.

Landmark Hospital of Southwest Florida, LLC (CON #10137):

Provider-Based Competition:
The applicant is applying to establish a new 50-bed long-term care hospital in District 8. There is one existing long-term care hospital in District 8 with a total of 40 long-term care beds. In addition, CON #9715 was granted for a 60-bed LTCH in Lee County. This CON was granted in 2007 and is still active. Therefore, this project would over double the number of active beds and be a 50 percent increase in the approved beds in the area.

Price-Based Competition:
The impact of the price of services on consumer choice is limited to the payer type. Most consumers do not pay directly for hospital services. Rather, they are covered by a third party payer. The impact of price-based competition would be limited to third party payers that negotiate

price for services, namely managed care organizations. Therefore, price competition is limited to the share of patient days that are under managed care plans. The applicant is projecting 23.5 percent of patient days from managed care payers with 72.4 percent of patient days expected to come from fixed price government payer sources (Medicare and Medicaid) (Table 2).

Conclusion:
The potential for provider based competition will increase. However, price-based competition will likely be limited.

Kindred Hospitals East, LLC (CON #10138):

Provider-Based Competition:
The applicant is applying to establish a new 40-bed long-term care hospital in District 8. There is one existing long-term care hospital in District 8 with a total of 40 long-term care beds. In addition, CON #9715 was granted for a 60-bed LTCH in Lee County. This CON was granted in 2007 and is still active.

Therefore, this project would double the number of active beds and be a 40 percent increase in the approved beds in the area.

Currently, a moratorium exists on new LTCH beds. The Affordable Care Act extended the moratorium (with few exceptions) from 12/28/2010 until 12/28/2012. These provisions of the Act are scheduled to sunset at that time. If the Act is once again extended (and assuming the CON is granted), the applicant will have to commence construction of the facility with hopes that the moratorium will be lifted by completion date or forfeit the CON and re-apply if and when the moratorium is lifted.

Price-Based Competition:
The impact of the price of services on consumer choice is limited to the payer type. Most consumers do not pay directly for hospital services. Rather, they are covered by a third party payer. The impact of price-based competition would be limited to third party payers that negotiate price for services, namely managed care organizations. Therefore, price competition is limited to the share of patient days that are under managed care plans. The applicant is projecting 18.5 percent of patient days from managed care payers with 80.3 percent of patient days expected to come from fixed price government payer sources (Medicare and Medicaid) (Table 2).

f. Are the proposed costs and methods of construction reasonable? Do they comply with statutory and rule requirements? ss. 408.035 (1) (h), Florida Statutes; Ch. 59A-3 or 59A-4, Florida Administrative Code.

The architectural reviews of the applications shall not be construed as in-depth efforts to determine complete compliance with all applicable codes and standards. The final responsibility for facility compliance ultimately rests with the owner.

Landmark Hospital of Southwest Florida, LLC (CON #10137): The 50-bed freestanding LTCH will be designed as a three story building of FBC Type IA and NFPA Type I (443). Both construction types are suitable for the proposed facility. According to the narrative the building will be fully sprinklered.

All of the 50-bed LTCH patient rooms are private and exceed the minimum size requirements for new hospitals. Each patient room has a private toilet room with a lavatory and a shower. It appears that all of the new patient rooms have been made handicapped accessible. The patient support spaces appear to meet all of the space requirements of the current edition of the Florida Building Code (FBC).

According to the application and the submitted plans, this new hospital will consist of a 30-bed medical/surgical unit, a 10-bed critical care unit (CCU) and a 10-bed ICU--all located on level two. The plan provides all the required support spaces, such as nurse stations, soiled utility, clean utility, nourishment room, medication room, staff lounge/locker and toilets. All of these spaces appear to be adequately sized and positioned within the unit. There is also a speech therapy room and multi-purpose room, located on this level.

Plans show two isolation rooms in the ICU unit. There is no indication of an isolation room in the medical/surgical unit; a minimum of one isolation room is needed to be in compliance with the guidelines for design and construction of health care facilities.

The operating suite contains one operating room, a three-bed post anesthesia care unit and a control/nursing station. All other supporting service elements appear to be provided for in this operating suite.

In addition, all of the supporting service areas such as physical therapy, emergency, a small lab, CT scan room, administration, medical records, dining, dietary, maintenance, storage, other spaces and utilities as required by the required codes have all been provided for a 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.

The cost estimated for the construction of the new LTCH appears to be reasonable in comparison to similar projects. The time schedule for construction, from the time of building permit to final inspection, seems reasonable. The project is well designed and should meet or exceed code requirements.

Although the area of ICU patient rooms is adequate some design modification is needed to provide the required head clearance. Additional exit for the dining room is required to be in compliance with Florida Building Code.

The plans submitted with this application were schematic in detail with the expectation that they will necessarily be revised and refined during the design development (preliminary) and contract document stages.

Kindred Hospitals East, LLC (CON #10138): The 40-bed freestanding long-term care hospital will be designed as a three-story building. The application does not specify construction types for the facility nor the minimum codes and standards that will apply. The disaster preparedness requirement must be a key criteria in selecting a site, building design and construction.

All 40-bed LTCH patient rooms including the 10-bed ICU unit are private and appear to exceed the minimum size requirements for new hospitals. Each of the patient rooms, except the ICU rooms, have private toilet rooms with a lavatory and a shower. It appears that all of the new bed rooms are meant to be made handicapped accessible. The plans do not designate required isolation rooms.

According to the application and the submitted plan, this new hospital will consist of two patient (second and third) floors with a 10-bed ICU on the third floor. Both nursing units will be supported from large centralized nursing stations.

The ICU unit contains 10 beds, none of which appear to meet the minimum clearances. Additionally, toilets have not been separated from patient rooms as required by the guidelines for design and construction of health care facilities. The plan provides all the required support spaces, such as soiled utility, clean utility, nourishment room and medication room. All of these spaces appear to be adequately sized and positioned within the unit.

There are supporting service areas on the first floor such as administration, dietary, maintenance, storage, pharmacy, therapy, radiology and other support spaces have been provided. The insufficient information provided on the plan makes it impossible for the reviewer to tell if the supporting service spaces will meet all of the space requirements of the current edition of the required codes.

The applicant provides no information regarding building materials, structural, finish, and mechanical/electrical systems. The plans submitted with this application do not indicate smoke compartmentalization and are not to scale as required by Schedule 9 item #6.

Compared to similar projects, the proposed cost estimate for the construction of Kindred's new LTCH is considerably high. The time schedule for construction, from the time of building permit to final inspection, is reasonable.

The ICU patient bedroom clearance requirements would have a significant impact on the proposed facility.

Additional information regarding construction type, compartmentalization and separation of hazardous areas is needed to make a determination of code compliance.

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 (1)(i), Florida Statutes.

According to the 2010 Hospital Financial Data Report, reporting the most recent data available, LTCHs in the state averaged 1.8 percent Medicaid patient days and 1.4 percent charity patient days.

Landmark Hospital of Southwest Florida, LLC (CON #10137) states that it was created recently and that the projections for the proposed facility are based both on the Florida experience as well as the experience of other Landmark Hospital's affiliates.

The applicant indicates that the 2012 Long Term Care Group financial data reported in the Agency's *FY 2009 Hospital Financial Data* publication shows a mean of 2.94 percent and median of 2.53 percent for Medicaid and Charity Care—with a standard deviation of 1.8 percent. Landmark maintains that the proposed facility will exceed the statewide experience. The reviewer notes that the *FY 2010 Hospital Financial Data* shows a mean of 3.2 percent and median of 3.4 percent for Medicaid, Medicaid HMO and charity care.

Landmark provides projected patient days by payer for the first three years of operation. See the table below.

Projected Patient Days by Payer for Landmark's Proposed LTCH
January 2015-December 2017

Payer	Patient Days			Distribution of Days
	Year One (2015)	Year Two (2016)	Year Three (2017)	
Medicare	3,929	6,312	9,353	69.03%
Medicaid/HMO	195	314	465	3.43%
Commercial Insurance	1,336	2,146	3,180	23.47%
Self-Pay/Charity	145	232	344	2.54%
Other	87	139	207	1.53%
Total	5,692	9,144	13,549	100.00%

Source: CON application #10137, page 9-1.

The applicant states that it is willing to condition approval of CON #10137 on the projected 2.54 percent charity care. However, Landmark states that the combined charity and Medicaid percentage projection is 5.97 percent—above the LTCH group mean and median. The applicant concludes by stating that the approval of this application assures access to long-term acute care services for Medicaid patients as well as the medically indigent.

Kindred Hospitals East, LLC (CON #10138) states that it has a history of providing health services to Medicaid patients and the medically indigent. The applicant indicates that six of nine (see footnote below) Kindred LTCHs in Florida exceeded the median Medicaid and charity percentage of 3.39 percent.[20] Kindred commits to provide a combined

[20] The reviewer notes that the *FY 2010 Hospital Financial Data* shows a median of 3.4 percent for Medicaid, Medicaid HMO and charity care. Five of 10 Florida Kindred facilities exceeded the median. One met this median. Four Kindred facilities did not.

two percent Medicaid and charity days showing its dedication to continue its focus on providing high quality medical care to such patients who many not otherwise have access to this care.

The applicant states that charity days occur after a patient has exhausted both Medicare and Medicaid benefits. Kindred maintains that the proposed facility in Collier County will continue to care for patients after their Medicare and Medicaid benefits expire—as the number of Medicaid patients increases, the likelihood of charity care days will also increase. The proposed facility will not discriminate or deny any individual access to care or services regardless of his/her ability to pay.

Below are Kindred's projected patient days by payer for the first two years of operation. See the table below.

Projected Patient Days by Payer for Kindred's Proposed LTCH January 2015-December 2016

Payer	Patient Days		Percent of Days		
	Year One (2015)	Year Two (2016)	Year One (2015)	Year Two (2016)	Corrected Year Two Percentages*
Medicare/Medicare HMO	3,824	8,189	79.5%	170.1%	79.4%
Medicaid	45	107	0.9%	1.0%	1.0%
Commercial Insurance	890	1,911	18.5%	39.7%	18.5%
Charity Care	55	112	1.1%	1.1%	1.1%
Total	4,814	10,319	100.0%	211.9%	100.0%

Source: CON application #10138 Schedule 7A.
*Kindred's Schedule 7A showed the percentages in the year two percent of days column. The reviewer corrected these to reflect a percentage out of one hundred.

F. SUMMARY

Landmark Hospital of Southwest Florida, LLC (CON #10137) proposes to establish a 50-bed long-term care hospital in District 8, Collier County. The applicant did not include potential sites for the proposed facility.

The proposed hospital involves 56,809 GSF of new construction. Total project cost per bed is $442,496. Total construction cost is estimated to be $13,480,000 and total project cost is $22,124,800.

As a condition of approval, the applicant agrees to provide a minimum of 2.54 percent of the facility's total annual patient days to charity.

Kindred Hospitals East, LLC (CON #10138) proposes to establish a 40-bed LTCH to be located in Collier County, District 8. The applicant did not include potential sites for the proposed facility.

The proposed hospital involves 56,581 GSF of new construction. Total cost per bed is $873,033. Total construction cost is estimated to be $17,075,774 and total project cost is $34,921,329.

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

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.

Neither applicant demonstrated objectively measurable and fact-based evidence to show that patients were unable to access needed services or were harmed or their health care outcomes were worsened as a result of their chosen treatment regimen.

Landmark Hospital of Southwest Florida, LLC (CON #10137) concludes that the state, median and average bed rates return a final need for District 8 of 39, 48 or 44 beds beyond the number of licensed and approved LTCH beds.

The applicant maintains that the result of increasing the number of beds within District 8 improves access and availability making the district in closer parity with the others. Landmark states that there is clear reduced access to LTCH services in District 8 as demonstrated by patterns of use by county residents.

Landmark indicates that data show that patients 65 years and older comprise 70 percent of LTCH cases and population growth in that age cohort creates demand for care. These population estimates show that growth will continue, further exacerbating the disparity in access and availability of LTCH services in District 8 with just one 40-bed hospital.

Kindred Hospitals East, LLC (CON #10138) contends that as result of the increase in the senior population, the financial and capacity burdens on short-term hospitals from long-term patients will continue to increase. Kindred asserts that the need for long-term care hospital (LTCH) services in Collier County will exceed the capabilities of existing LTCH facilities in the district thereby creating a substantial unmet need in the delivery of health care in District 8.

The applicant asserts that the inadequate supply of long-term care hospital beds in District 8 creates financial losses for short-term hospitals and limits the level of care that patients receive. Kindred maintains that its facilities are a cost-effective means of providing the most appropriate, high quality services to the medically complex patient.

Kindred projects a net LTCH bed need in CY 2017 of 43 beds.

Quality of Care:

Landmark Hospital of Southwest Florida, LLC (CON #10137) states that it is an affiliate of Landmark Holdings of Missouri, LLC an operator of LTCHs through affiliates. The applicant provides a reasonable description of its quality of care mechanisms.

Kindred Hospitals East, LLC (CON #10138) states that it has operated LTCHs in Florida for 20 years demonstrating a long history of providing high quality long-term acute care services throughout the state.

Kindred has 10 licensed LTCHs in Florida with a total of 745 licensed beds. Agency data obtained April 19, 2012 indicates that Kindred affiliated hospitals had 29 substantiated complaints during the previous 36 months.

Cost/Financial Analysis

Landmark Hospital of Southwest Florida, LLC (CON #10137): Funding for this project and the capital budget is entirely dependent on a third party's ability to fund the construction of the hospital. It is the applicant's plan to lease the land and buildings from the third party.

Assuming that the REIT, the third party, has adequate funding for the land acquisition and construction of the facility and that the LTCH bed moratorium is not extended; this project appears to be financially feasible.

Kindred Hospitals East, LLC (CON #10138) Funding for this project and the entire capital budget should be available as needed.

Assuming the applicant will be able to obtain funding for the project and that the LTCH moratorium is not extended, this project appears to be financially feasible.

Architectural Analysis:

Landmark Hospital of Southwest Florida, LLC (CON #10137): This new hospital will be designed as a three-story building of FBC Type IA and NFPA Type I (443)—both suitable for the proposed facility. The building will be fully sprinklered.

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.

The cost estimated for the construction of the new LTCH appears to be reasonable in comparison to similar projects. The time schedule for construction, from the time of building permit to final inspection, seems reasonable. The project is well designed and should meet or exceed code requirements.

Kindred Hospitals East, LLC (CON #10138): The application does not specify construction types for the facility nor the minimum codes and standards that will apply. The disaster preparedness requirement must be a key criteria in selecting a site, building design and construction.

Compared to similar projects, the proposed cost estimate for the construction of the proposed new LTCH is considerably high. The time schedule for construction, from the time of building permit to final inspection, is reasonable.

The ICU unit contains 10 beds, none of which appear to meet the minimum clearances. Additionally, toilets have not been separated from patient rooms as required by the guidelines for design and construction of health care facilities. The ICU patient bedroom clearance requirements would have a significant impact on the proposed facility.

Additional information regarding construction type, compartmentalization and separation of hazardous areas is needed to make a determination of code compliance.

G. RECOMMENDATION

Deny CON #10137 and CON #10138.

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: _____

_____
James B. McLemore
Health Services and Facilities Consultant Supervisor
Certificate of Need

_____
Jeffrey N. Gregg, Director
Florida Center for Health Information and Policy Analysis