



Office of Health Care Access Certificate of Need Application

Agreed Settlement

Applicants: Saint Francis Hospital and Medical Center and Hospital for Special Care

Docket Number: 03-30150

Project Title: Establish a 28 Bed Long Term Acute Care Hospital at Saint Francis Hospital and Medical Center as a Demonstration Project

Statutory Reference: Sections 19a-638 and 19a-639 of the Connecticut General Statutes

Filing Date: November 14, 2003

Hearing: Waived

Decision Date: January 16, 2004

Default Date: February 12, 2004

Staff Assigned: Harold M. Oberg and Paolo Fiducia

Project Description: Saint Francis Hospital and Medical Center (“SFHMC”) and Hospital for Special Care (“HSC”) (collectively known as “Applicants”) propose to establish a 28 bed Long Tem Acute Care Hospital (“LTAC”) at SFHMC as a demonstration project authorized by Public Act 03-275, at a total capital expenditure of \$2,102,718. The proposed LTAC will operate and function as a satellite facility of HSC, which will be responsible for the management and operation of the LTAC facility and will be the provider of patient services.

Nature of Proceedings: On November 14, 2003, the Office of Health Care Access (“OHCA”) received the Certificate of Need (“CON”) application of SFHMC and HSC to establish a 28 bed long term acute care hospital at SFHMC as a demonstration project authorized by Public Act 03-275, at a total capital expenditure of \$2,102,718. The Applicants are health care facilities or institutions as defined by Section 19a-630 of the Connecticut General Statutes (“C.G.S.”).

The Applicants requested a waiver of hearing for the CON application pursuant to Section 19a-643-45 of OHCA's Regulations, and claimed that the CON application is non-substantive as defined in Section 19a-643-95(3) of OHCA's Regulations. On November 18, 2003, the Applicants were informed that the CON application was eligible for consideration of waiver of hearing, and a notice to the public was published in the *Hartford Courant*. OHCA received no comments from the public during the public comment period concerning the Applicants' request for a waiver of hearing, and therefore on December 1, 2003, OHCA granted the Applicants' request for a waiver of hearing.

OHCA's authority to review and approve, modify or deny this proposal is established by Sections 19a-638 and 19a-639, C.G.S. The provisions of these sections as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

Clear Public Need

Impact of the Proposal on the Applicants' Current Utilization Statistics Proposal's Contribution to the Quality of Health Care Delivery in the Region Proposal's Contribution to the Accessibility of Health Care Delivery in the Region

1. Saint Francis Hospital and Medical Center ("SFHMC") is an acute care hospital located at 114 Woodland Street and 500 Blue Hills Avenue in Hartford, Connecticut. SFHMC's total licensed bed capacity of 682 licensed beds and bassinets includes 617 licensed beds and 65 licensed bassinets. (*November 14, 2003 CON Application, Page 110*)
2. Hospital for Special Care ("HSC") is a chronic disease hospital located at 2150 Corbin Avenue in New Britain, Connecticut. HSC's total licensed bed capacity includes 200 licensed chronic disease beds. (*November 14, 2003 CON Application, Page 111*)
3. Saint Francis Hospital and Medical Center and Hospital for Special Care (collectively known as "Applicants") are proposing to establish a 28 bed Long Term Acute Care Hospital ("LTAC") at SFHMC as a demonstration project authorized by Public Act 03-275, at a total capital expenditure of \$2,102,718. The proposed LTAC will be located on SFHMC's Woodland Street campus and will operate and function as a satellite facility of HSC, which will be responsible for the management and operation of the LTAC facility and will be the provider of patient services. (*November 14, 2003 CON Application, Pages 1 and 9*)
4. HSC is requesting an increase of 28 licensed beds to its current 200 chronic disease licensed beds for a total chronic disease licensed bed capacity of 228 licensed beds. HSC is certified for Medicare participation as a long term acute care hospital under Title XVIII of the Social Security Act. SFHMC is not requesting a change to its current licensed bed capacity as part of the CON proposal under Docket Number 03-30150. (*November 14, 2003 CON Application, Page 20*)

5. An LTAC is designed to serve inpatients who require long term hospitalization in an acute care setting. These patients can often have average lengths of stay in excess of 25 days, are medically complex, and can require extensive pulmonary, wound care, and rehabilitation services. At present, there are no LTAC providers operating a satellite facility within an acute care hospital in Connecticut. *(July 25, 2003 Letter of Intent, Project Description)*
6. Public Act 03-275, *An Act Concerning A Demonstration Project For Long-Term Acute Care Hospitals*, allows an existing Connecticut chronic disease hospital to establish and operate a Medicare-certified long term acute care hospital within a licensed short term acute care general hospital. The Applicants' proposed LTAC would be one of four LTAC demonstration projects authorized by the Public Act. *(November 14, 2003 CON Application, Pages 13, 14 and 35)*
7. In addition, each LTAC facility authorized and approved as a demonstration project must collect and report data concerning the demonstration project's impact on the quality of service, patient outcomes and cost-effectiveness. As defined in the Public Act, this data shall be reported in a manner prescribed by the Commissioner of Health Care Access and shall include, length of stay, number of intensive care days per patient, cost of stay, type of discharge, and any other data requested by the Commissioner. *(November 14, 2003 CON Application, Page 14)*
8. The Applicants anticipate that the proposed LTAC's patients will originate from the same towns as SFHMC's primary and secondary service area towns, which are as follows: Hartford, West Hartford, East Hartford, Bloomfield, Windsor, Windsor Locks, East Granby, Granby, Suffield, South Windsor, Simsbury, Canton, Avon, Farmington, Rocky Hill, Wethersfield, Newington, New Britain, Plainville, Cromwell, Berlin, Southington, Glastonbury, Marlborough, Hebron, Bristol, Burlington, Harwinton, Thomaston, Plymouth, Wolcott, East Windsor, Ellington, Somers, Stafford, Union, Enfield, Middletown, Meriden, Middlefield, Portland, East Hampton, Colebrook, Hartland, New Hartford, Norfolk, Barkhamsted, Torrington, Winchester, Manchester, Bolton, Andover, Vernon and Tolland. *(November 14, 2003 CON Application, Pages 43 and 44)*
9. In determining the patient need for an LTAC facility, SFHMC analyzed its FY 2002 inpatient discharge database and identified all 2002 discharges with a length of stay that was greater than the acute care hospital geometric mean length of stay. The initial criteria targeted discharges with a length of stay greater than or equal to 15 days for the respective DRG. All discharges to skilled nursing facilities and all patients under the age of 18 were excluded. In addition, OB/GYN DRGs, Psychiatric DRGs, Rehabilitation DRG 462, and DRGs 463-467 were eliminated from the database. As a result, 543 discharges (including 8,314 patient days) were identified by SFHMC as the potential LTAC patient population. *(November 14, 2003 CON Application, Page 9)*
10. HSC's physicians then reviewed each of the 543 discharges for their applicability as a potential LTAC patient and eliminated discharges from the database, either

because the length of stay was insufficient or the specific condition of the patient made them inappropriate for admittance to an LTAC facility. Subsequently, HSC's physicians identified the potential SFHMC LTAC patient population to be 188 discharges, 4,805 patient days, and an average length of stay of 25.6 days. HSC anticipates that these three utilization statistics will reflect the utilization volume in the first full year of operation of the LTAC facility. *(November 14, 2003 CON Application, Page 10)*

11. The Applicants estimate that this potential LTAC patient population plus inpatient transfers from other acute care hospitals in the region to the proposed LTAC would support a 28 licensed bed LTAC facility. The Applicants anticipate that SFHMC's affiliates, Eastern Connecticut Health Network and Hartford Hospital may choose to send patients to the proposed LTAC. All other acute care hospitals in the region will also be able to send patients to the LTAC facility, if the patients are deemed appropriate for admission based on HSC's admitting criteria established for the proposed LTAC *(November 14, 2003 CON Application, Pages 10 and 39)*
12. HSC projects the following inpatient utilization volume for the first three years of operation of the LTAC facility: *(November 14, 2003 CON Application, Page 11)*

Table 1: HSC's Projected Utilization for the LTAC Facility at SFHMC

Inpatient Units of Service	FY 2005	FY 2006	FY 2007
Admissions	141	202	222
Discharges	141	202	222
Patient Days	3,604	5,162	5,678
Average Length of Stay Days	25.6	25.6	25.6

13. HSC's fiscal year begins on April 1st and ends on March 31st. The LTAC facility is projected to be operational as of July 1, 2004, which is in HSC's FY 2005 and which will include 9 months of activity. The projected volume for FY 2006 and FY 2007 was calculated using a 10% increase in admissions and discharges for each year. The Applicants estimate that other area hospitals will begin to refer patients to the LTAC facility once it becomes established. *(November 14, 2003 CON Application, Page 11)*

14. HSC's calculation of the projected LTAC admissions/discharges for FY 2005, FY 2006 and FY 2007 is as follows: *(November 14, 2003 CON Application, Page 12)*

Table 2: Calculation of Projected LTAC Admissions/Discharges

Calculation of Projected LTAC Admissions/Discharges	Admissions/ Discharges
<u>LTAC FY 2005: July 1, 2004 to March 31, 2005</u>	
(188 Discharges/12 Months) x 9 Months (July 2004 to March 2005) =	<u>141</u>
Total FY 2005 Projected LTAC Admissions/Discharges	141
<u>LTAC FY 2006: April 1, 2005 to March 31, 2006</u>	
(188 Discharges/12 Months) x 3 Months (April 2005 to June 2005) =	47
188 Discharges + 10% Increase = 207 Discharges	
(207 Discharges/12 Months) x 9 Months (July 2005 to March 2006) =	<u>155</u>
Total FY 2006 Projected LTAC Admissions/Discharges	202
<u>LTAC FY 2007: April 1, 2006 to March 31, 2007</u>	
(207 Discharges/12 Months) x 3 Months (April 2006 to June 2006) =	52
207 Discharges + 10% Increase = 227 Discharges	
(227 Discharges/12 Months) x 9 Months (July 2006 to March 2007) =	<u>170</u>
Total FY 2007 Projected LTAC Admissions/Discharges	222

15. HSC's calculation of the projected LTAC patient days for FY 2005, FY 2006 and FY 2007 is as follows: *(November 14, 2003 CON Application, Pages 11 and 12)*

Table 3: Calculation of Projected LTAC Patient Days

Calculation of Projected LTAC Patient Days	Patient Days
<u>LTAC FY 2005: July 1, 2004 to March 31, 2005</u>	
(4,805 Patient Days/12 Months) x 9 Months (July 2004 to March 2005) =	<u>3,604</u>
Total FY 2005 Projected LTAC Patient Days	3,604
<u>LTAC FY 2006: April 1, 2005 to March 31, 2006</u>	
(4,805 Patient Days/12 Months) x 3 Months (April 2005 to June 2005) =	1,200
4,805 Patient Days + 10% Increase = 5,286 Patient Days	
(5,286 Patient Days/12 Months) x 9 Months (July 2005 to March 2006) =	<u>3,962</u>
Total FY 2006 Projected LTAC Patient Days	5,162
<u>LTAC FY 2007: April 1, 2006 to March 31, 2007</u>	
(5,286 Patient Days/12 Months) x 3 Months (April 2006 to June 2006) =	1,323
5,286 Patient Days + 10% Increase = 5,815 Patient Days	
(5,815 Patient Days/12 Months) x 9 Months (July 2006 to March 2007) =	<u>4,355</u>
Total FY 2007 Projected LTAC Patient Days	5,678

16. HSC's projected LTAC admissions/discharges, patient days and average length of stay by DRG grouping is as follows: *(November 14, 2003 CON Application, Page 12)*

Table 4: Projected LTAC Admissions/Discharges, Patient Days and ALOS by DRG Group

DRG Grouping	FY 2006 Adm./ Disch.	FY 2006 Patient s Days	FY 2006 ALOS Days	FY 2007 Adm./ Disch.	FY 2007 Patients Days	FY 2007 ALOS Days
Respiratory	39	1,172	30.1	43	1,292	30.1
Respiratory Non-COU	37	907	24.5	40	980	24.5
Orthopedic	17	408	24.0	19	456	24.0
Cent. Nervous System	9	231	25.7	9	231	25.7
Wound/Skin Care	6	152	25.3	7	177	25.3
Miscellaneous	5	134	26.8	6	162	26.8
Trauma	5	155	31.0	6	186	31.0
Post Operative	55	1,237	22.5	60	1,349	22.5
Infectious Diseases	29	766	26.4	32	845	26.4
Total DRG Grouping	202	5,162	25.6	222	5,678	25.6

17. HSC projects that the LTAC average length of stay will remain constant at 25.6 days for FY 2005, FY 2006 and FY 2007. *(November 14, 2003 CON Application, Page 12)*
18. SFHMC projects the following incremental decreases in inpatient utilization related to its patient days and average daily census due to the implementation and operation of the LTAC facility: *(November, 2003 CON Application, Pages 122 and 122A)*

Table 5: SFHMC's Projected Incremental Decreases in Inpatient Utilization

Inpatient Units of Service	FY 2004	FY 2005	FY 2006
<u>Patient Days</u>			
Medical and Surgical	(978)	(4,010)	(4,010)
Intensive Care	(224)	(917)	(917)
Other	0	0	0
Total Patient Days	(1,202)	(4,927)	(4,927)
<u>Average Daily Census</u>			
Medical and Surgical	(2.7)	(11.0)	(11.0)
Intensive Care	(0.6)	(2.5)	(2.5)
Other	0.0	0.0	0.0
Total Average Daily Census	(3.3)	(13.5)	(13.5)

19. The Applicants believe that the proposed LTAC will provide the following improvements to the delivery of inpatient care, patient outcome and patient access:
 - a. The proposed LTAC would benefit both HSC and SFHMC through improved clinical outcomes, increased physician and patient satisfaction, increased patient revenues and lower operating costs as well as reduced gridlock in SFHMC's critical care unit. *(November 14, 2003 CON Application, Page 10)*
 - b. The proposed LTAC would allow the Applicants the means to better serve a medically complex population of inpatients in a more appropriate and efficient manner. By transferring difficult to treat, long stay patients to the LTAC facility's specialized inpatient environment, intervening earlier with restorative

- therapeutic treatments, and applying state-of-the-art clinical protocols, patients could achieve better outcomes. *(July 25, 2003 Letter of Intent, Project Description)*
- c. It is expected that the presence of the LTAC facility will improve the inpatient care delivered to selected ventilator and medically complex patients. These patients will be transferred from SFHMC's ICU and medical-surgical units to the proposed LTAC much earlier in their inpatient stay. The LTAC facility will provide more focused medical care that should result in faster weaning from ventilators and more rapid improvement in the individual patient's recovery than is currently experienced by these patients in the general acute care hospital setting. *(November 14, 2003 CON Application, Pages 26 and 27)*
- d. The CON proposal will improve access to LTAC services, especially for residents of the greater Hartford area because it will enable these residents to receive LTAC services closer to home. Since the closest current LTAC providers are Hospital for Special Care located in New Britain and Gaylord Hospital located in Wallingford, the presence of an LTAC facility in Hartford will eliminate the need for additional driving times for the families of patients. The Applicants also anticipate that approximately 55% of the proposed LTAC's patients will be comprised of the elderly, and that an LTAC facility located in Hartford will eliminate the need for additional transportation, especially for the elderly spouses and relatives of LTAC patients. *(November 14, 2003 CON Application, Page 13)*
20. The Applicants expect that initially the most LTAC patients will be transfers from SFHMC's critical care and medical inpatient units. There will be no restrictions in admissions from other health care facilities. *(November 14, 2003 CON Application, Page 39)*
21. Presently, admission criteria to be implemented nationally for all LTAC facilities, is in the developmental phase. The proposed LTAC will conform to all admission criteria as it is developed and adopted by the Center for Medicare and Medicaid Services and the National Association of Long Term Hospitals. Because the proposed LTAC will operate as a satellite facility of HSC, it will conform to HSC's admission criteria. HSC is in the process of assisting in writing and developing new national admission criteria for LTAC facilities, which would be used for the proposed LTAC. *(November 14, 2003 CON Application, Page 17)*
22. The proposed LTAC satellite facility will be located on the third floor of building five on SFHMC's Woodland Street campus. SFHMC will be responsible for the facility renovations and capital expenditures for equipment and furniture associated with the initial establishment of the LTAC facility. Support space will also be developed as part of the CON proposal on the fourth floor above the proposed LTAC. HSC will enter into a lease agreement with SFHMC for the LTAC facility space and associated support space. *(July 25, 2003 Letter of Intent, Project Description)*
23. The building renovation work involved in the renovation of SFHMC's building five covers the entire 10,771 square feet of space on the third floor. The space to be

renovated for the 28 bed LTAC facility is currently used for offices and does not presently house patients. The area to be renovated on the fourth floor for support space covers 7,758 square feet of space. The usage of this floor space will not change and will remain as office space. *(November 14, 2003 CON Application, Page 26)*

24. The renovation of the space utilized for the LTAC facility and associated support space will not disrupt existing SFHMC operations as the space being renovated is not an active patient care unit, and the areas adjacent to this space are currently used for non-direct patient care services. *(November 14, 2003 CON Application, Page 26)*
25. The Applicants anticipate that the commencement of building renovations will occur in January 2004, the completion of building renovations and Department of Public Health licensure will occur in June 2004, and the commencement of operations of the proposed LTAC will occur in July 2004. *(November 14, 2003 CON Application, Page 27)*

**Financial Feasibility and Cost Effectiveness of the Proposal and its Impact on
the Applicants' Rates and Financial Conditions
Impact of the Proposal on the Interests of Consumers of Health Care Services
and the Payers for Such Services**

26. The total proposed capital expenditure of \$2,102,718 includes the following capital expenditure components: *(November 14, 2003 CON Application, Pages 23, 24 and 25)*

Table 6: Applicants' Total Proposed Capital Expenditure

Description	SFHMC	HSC	Total
Medical Equipment (Purchase)	\$ 446,237	\$ 297,808	\$ 744,045
Non-Medical Equipment (Purchase)	117,073	0	117,073
Building Renovations	1,111,600	130,000	1,241,600
Total Capital Expenditure	\$1,674,910	\$427,808	\$2,102,718

27. The Applicants' total proposed building renovation costs of \$1,241,600 include \$1,018,000 for building work costs, \$123,600 for architectural and engineering costs, and \$100,000 for contingency costs. *(November 14, 2003 CON Application, Page 26)*
28. The CON proposal's total capital expenditure of \$2,102,718 will be funded through an equity contribution of \$1,674,910 from SFHMC's operating funds, an equity contribution of \$282,808 from HSC's operating funds, and through grant funds to be received by HSC of \$145,000. Presently, HSC is soliciting funds from grantors to finance the \$145,000 cost of a Bernoulli ventilator management system. If unsuccessful in this solicitation, HSC will fund the Bernoulli system through an additional equity contribution. *(November 14, 2003 CON Application, Pages 28 and 30)*
29. SFHMC projects incremental revenue from operations, total operating expense and gains from operations associated with the CON proposal as follows: *(November 14, 2003 CON Application, Page 122)*

Table 7: SFHMC's Incremental Financial Projections for FY 2004, FY 2005 and FY 2006

Description	FY 2004	FY 2005	FY 2006
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Incremental Revenue from Operations	\$(472,909)	\$(2,236,126)	\$(2,135,542)
Incremental Total Operating Expense	(894,966)	(3,908,735)	(4,021,887)
Incremental Gain from Operations	\$ 422,057	\$ 1,672,609	\$ 1,886,345

30. SFHMC estimates that patient days and inpatient net revenue will be reduced for its inpatients transferred to the proposed LTAC. SFHMC also estimates that due to the reduction in patient days and inpatient services that are currently provided to patients that will be transferred to the proposed LTAC, operating expenses are projected to decrease for the variable cost portion or 50% of the total cost of providing these inpatient services. *(November 14, 2003 CON Application, Pages 128 and 129)*
31. HSC projects incremental revenue from operations, total operating expense and gains from operations associated with the CON proposal as follows: *(November 14, 2003 CON Application, Page 138)*

Table 8: HSC's Incremental Financial Projections for FY 2004, FY 2005, FY 2006, FY 2007

Description	FY 2004	FY 2005	FY 2006	FY 2007
Incremental Revenue from Oper.	\$ 0	\$4,525,410	\$6,680,842	\$7,489,186
Incremental Total Oper. Expense	0	4,456,855	6,352,408	6,890,019
Incremental Gain from Oper.	\$ 0	\$ 68,555	\$ 328,434	\$ 599,167

32. SFHMC's projected payer mix for the first three years of implementation and operation of the proposal is as follows: *(November 14, 2003 CON Application, Page 33)*

Table 9: SFHMC's Three-Year Projected Payer Mix

Payer	Year 1	Year 2	Year 3
Medicare	42.4%	42.1%	41.8%
Medicaid	16.7%	16.8%	16.9%
TriCare	0.2%	0.2%	0.2%
Total Government	59.3%	59.1%	58.9%
Commercial Insurers	35.9%	36.1%	36.2%
Self-Pay	2.0%	2.0%	2.0%
Workers Compensation	0.8%	0.9%	0.9%
Total Non-Government	38.7%	39.0%	39.1%
Uncompensated Care	2.0%	1.9%	2.0%
Total Payer Mix	100.0%	100.0%	100.0%

33. HSC's projected payer mix for the first three years of implementation and operation of the proposed LTAC is as follows: *(November 14, 2003 CON Application, Page 32)*

Table 10: HSC's Three-Year Projected Payer Mix

Payer	Year 1	Year 2	Year 3
Medicare	21.6%	23.2%	23.7%
Medicaid	54.4%	53.0%	52.6%
TriCare	0.0%	0.0%	0.0%

Total Government	76.0%	76.2%	76.3%
Commercial Insurers	22.4%	22.3%	22.2%
Self-Pay	1.6%	1.5%	1.5%
Workers Compensation	0.0%	0.0%	0.0%
Total Non-Government	24.0%	23.8%	23.7%
Uncompensated Care	0.0%	0.0%	0.0%
Total Payer Mix	100.0%	100.0%	100.0%

Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

The following findings are made pursuant to other principles and guidelines set forth in Section 19a-637, C.G.S.:

34. There is no State Health Plan in existence at this time. *(November 14, 2003 CON Application, Page 7)*
35. The Applicants have adduced evidence that this proposal is consistent with the Applicants' respective long-range plans. *(November 14, 2003 CON Application, Page 8)*
36. The Applicants have implemented various activities to improve productivity and contain costs involving group purchasing, energy conservation and the application of new technology. *(November 14, 2003 CON Application, Pages 18 and 19)*
37. The Applicants have no current teaching and research responsibilities that would be affected as a result of the proposal. *(November 14, 2003 CON Application, Page 20)*
38. The Applicants believe that there are distinguishing or unique characteristics of the patient/physician mix related to the Applicants' proposal. The LTAC patient population can be classified as inpatients that require long term hospitalization in an acute care setting requiring twenty-four hour on site physician availability. The physicians who will staff the proposed LTAC facility are unique for they will specialize in Physiatry (Rehabilitation Medicine), Pulmonology/Critical Care, and Infectious Diseases. *(November 14, 2003 CON Application, Page 20)*
39. The Applicants have sufficient technical, financial and managerial competence and expertise to provide efficient and adequate service to the public. *(November 14, 2003 CON Application, Pages 60 through 86 and November 20, 2003 Supplemental CON Application Filing, Pages 1 and 2)*

Rationale

Saint Francis Hospital and Medical Center ("SFHMC") and Hospital for Special Care ("HSC") (collectively known as "Applicants") are proposing to establish a 28 bed Long

Tem Acute Care Hospital ("LTAC") at SFHMC as a demonstration project authorized by Public Act 03-275, at a total capital expenditure of \$2,102,718. The proposed LTAC will be located on SFHMC's Woodland Street campus and will operate and function as a satellite facility of HSC, which will be responsible for the management and operation of the LTAC facility and will be the provider of patient services.

HSC is requesting an increase of 28 licensed beds to its current 200 chronic disease licensed beds for a total chronic disease licensed bed capacity of 228 licensed beds. HSC is certified for Medicare participation as a long term acute care hospital under Title XVIII of the Social Security Act. SFHMC is not requesting a change to its current licensed bed capacity as part of the CON proposal.

Public Act 03-275, *An Act Concerning A Demonstration Project For Long-Term Acute Care Hospitals*, allows an existing Connecticut chronic disease hospital to establish and operate a Medicare-certified long term acute care hospital within a licensed short term acute care general hospital. The Applicants' proposed LTAC would be one of four LTAC demonstration projects authorized by the Public Act.

The LTAC patient population can be classified as inpatients that require long term hospitalization in an acute care setting requiring twenty-four hour on site physician availability. The physicians who will staff the proposed LTAC facility are unique for they will specialize in Physiatry (Rehabilitation Medicine), Pulmonology/Critical Care, and Infectious Diseases. The proposed LTAC will conform to all admission criteria as it is developed and adopted by the Center for Medicare and Medicaid Services and the National Association of Long Term Hospitals. Because the proposed LTAC will operate as a satellite facility of HSC, it will conform to HSC's admission criteria. HSC is currently assisting in writing and developing new national admission criteria for LTAC facilities to be used for the proposed LTAC.

OHCA concurs with the Applicants' assertion that the proposed LTAC would benefit both HSC and SFHMC through improved clinical outcomes, increased physician and patient satisfaction, increased patient revenues and lower operating costs as well as reduced gridlock in SFHMC's critical care unit. OHCA also concurs with the Applicants' assertion that the proposed LTAC would allow the Applicants the means to better serve a medically complex population of inpatients in a more appropriate and efficient manner, and that by transferring difficult to treat, long stay patients to the LTAC's specialized inpatient environment, intervening earlier with restorative therapeutic treatments, and applying state-of-the-art clinical protocols, patients could achieve better outcomes.

The CON proposal will improve access to LTAC services especially for residents of the greater Hartford area because it will enable these residents to receive LTAC services closer to home, since the closest current LTAC providers are Hospital for Special Care located in New Britain and Gaylord Hospital located in Wallingford. The Applicants estimate that approximately 55% of the proposed LTAC's patients will be comprised of the elderly, and that an LTAC facility located in Hartford will eliminate the need for

additional transportation, especially for the elderly spouses and relatives of LTAC patients.

Therefore, OHCA finds that the Applicants have clearly demonstrated that the CON proposal is needed, that the proposed LTAC will enable the Applicants to provide improved inpatient services at a high level of quality, and that the CON proposal will improve the accessibility of these inpatient services in the greater Hartford region.

The CON proposal's total capital expenditure of \$2,102,718 will be funded through an equity contribution of \$1,674,910 from SFHMC's operating funds, an equity contribution of \$282,808 from HSC's operating funds, and through grant funds to be received by HSC of \$145,000. If unsuccessful in its grant funds solicitation, HSC will fund a Bernoulli ventilator management system through an additional equity contribution.

HSC projects incremental admissions/discharges associated with the CON proposal of 141 in FY 2005, 202 in FY 2006 and 222 in FY 2007, patient days of 3,604 in FY 2005, 5,162 in FY 2006 and 5,678 in FY 2007, and an average length of stay of 25.6 days in each of the three fiscal years. HSC also projects incremental operating gains of \$68,555, \$328,434 and \$599,167 for FY 2005, FY 2006 and FY 2007, respectively. SFHMC projects incremental operating gains of \$422,057, \$1,672,609 and \$1,886,345 for FY 2004, FY 2005 and FY 2006, respectively due primarily to achieving major cost efficiencies from the implementation and operation of the LTAC facility at SFHMC.

HSC's projected utilization volume upon which its favorable financial projections are based for the proposed LTAC appear likely to be achieved given the favorable LTAC facility utilization and reimbursement forecasts associated with the CON proposal that would continue in future years. SFHMC's financial projections associated with the CON proposal also appear likely to be achieved given the substantial cost efficiencies resulting from the operation of the LTAC facility at SFHMC. Therefore, OHCA finds that the CON proposal will not only improve the quality and the accessibility of the inpatient services currently provided to greater Hartford area residents but that the CON proposal is also both financially feasible and cost-effective.

ORDER

NOW, THEREFORE, the Office of Health Care Access ("OHCA") and Saint Francis Hospital and Medical Center and Hospital for Special Care (collectively known as "Applicants") hereby stipulate and agree to the terms of settlement with respect to the Applicants' request for a Certificate of Need ("CON") to establish a 28 bed Long Term Acute Care Hospital ("LTAC") at Saint Francis Hospital and Medical Center as a demonstration project authorized by Public Act 03-275, at a total capital expenditure of \$2,102,718, as follows:

1. The Applicants' request for a CON to establish a 28 bed LTAC at Saint Francis Hospital and Medical Center as a demonstration project authorized by Public Act 03-275, at a total capital expenditure of \$2,102,718, is hereby approved.
2. The Applicants shall not exceed the approved total capital expenditure of \$2,102,718. In the event that the Applicants learn of potential cost increases or expect that final project costs will exceed those approved, the Applicants shall file with OHCA a request for approval of the revised project budget.
3. Hospital for Special Care's total licensed bed capacity shall increase by 28 licensed beds, from 200 licensed chronic disease beds to 228 licensed chronic disease beds. The 28 additional licensed chronic disease beds shall be utilized by Hospital for Special Care to provide LTAC services at Saint Francis Hospital and Medical Center's Woodland Street campus. Saint Francis Hospital and Medical Center's total licensed bed capacity shall remain at 682 licensed beds and bassinets.
4. Saint Francis Hospital and Medical Center shall provide OHCA with control group discharge data reports for the LTAC on an annual basis. The control group discharge data elements and format requirements for these reports are presented in Attachment I.
5. Hospital for Special Care shall provide OHCA with discharge data reports for the LTAC on an annual basis. The discharge data elements and format requirements for these reports are presented in Attachment II.
6. The Applicants shall obtain all further required approvals of the Department of Public Health and all other local, state and federal agencies governing the licensure and operation of health care facilities, and the Applicants shall report to OHCA upon receiving such approvals.
7. OHCA and Saint Francis Hospital and Medical Center and Hospital for Special Care agree that this Agreed Settlement represents a final agreement between OHCA and Saint Francis Hospital and Medical Center and Hospital for Special Care with respect to this request. The signing of this Agreed Settlement resolves all objections, claims and disputes, which may have been raised by the Applicants with regard to Docket Number 03-30150.
8. This authorization shall expire on January 31, 2005. Should the Applicants' LTAC demonstration project not be completed by that date, the Applicants must seek further approval from OHCA to complete the project beyond that date.
9. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-642 and 19a-653 of the Connecticut General Statutes at the Applicants' expense, if the Applicants fail to comply with its terms.

Date

Duly Authorized Agent for
Saint Francis Hospital and Medical Center

Date

Duly Authorized Agent for
Hospital for Special Care

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on January 16, 2004.

Date

Cristine A. Vogel
Commissioner
Office of Health Care Access

CAV: ho

Office of Health Care Access

**Long Term Acute Care Hospital (LTAC)
Control Group Discharge Data Layout for Saint Francis Hospital and Medical Center**

#	Description	Field Name	Data Type
1	Facility Provider Number – The last 4 digits of the Medicare provider number for the unit of the transferring hospital.	facid	Char (4)
2	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. Format: string (20, zero filled to left if fewer than 20 characters)	mrn	Char(20)
3	Patient Control Number – unique number assigned by the facility to each patient’s individual encounter that distinguishes the medical and billing records of the encounter. Format: string (20, zero filled to left if fewer than 20 characters)	patcont	Char(20)
4	Social Security Number – patient’s SSN Format: string (9, hyphens are implied)	ssn	Char(9)
7	Admission date – the month, day, and year on which the patient, whose hospitalization is being recorded, was admitted to the transferring facility. Format: date (8, mm-dd-yyyy)	adat	Date
8	Discharge date – the month, day, and year on which the patient, whose hospitalization is being recorded, was transferred from the facility to the LTAC. Format: date (8, mm-dd-yyyy)	ddat	Date
9	Date of onset of ventilator dependence at the transferring hospital Format: date (8, mm-dd-yyyy). Blank if not applicable.	vent_dat	Date
10	Date of tracheostomy at the transferring hospital Format: date (8, mm-dd-yyyy). Blank if not applicable	trach_dat	Date
11	Admitting Diagnosis – the ICD-9-CM code for the condition reported or presented at the time of the hospitalization. Format: String (5, do not include decimal place -- decimal place is implied)	adx	Char(5)
46	Level of care prior to transfer to LTAC ICU - 1 Floor - 2	lcare	Char (1)
47	Cost - Total cost of hospitalization at acute care hospital Total charge may be extracted from acute care discharge data	cost	Num (6)

OHCA will extract additional information for the FY 2002 control group from the in-house Discharge Database System. The item numbers correspond to the same item numbers listed on the LTAC discharge data layout concerning transferring hospital data.

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**Long Term Acute Care Hospital (LTAC) Discharge Data Layout for
Hospital for Special Care**

#	Description	Field Name	Data Type	Source of Data
Transferring hospital data				
1	Facility Provider Number – The last 4 digits of the Medicare provider number for the unit of the transferring hospital.	facid	Char (4)	
2	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. Format: string (20, zero filled to left if fewer than 20 characters)	Mrn	Char(20)	
3	Patient Control Number – unique number assigned by the facility to each patient’s individual encounter that distinguishes the medical and billing records of the encounter. Format: string (20, zero filled to left if fewer than 20 characters)	patcont	Char(20)	
4	Social Security Number – patient’s SSN Format: string (9, hyphens are implied)	Ssn	Char(9)	
5	Date of birth – the month, day, and year of birth of the patient whose hospitalization is being recorded. Format: date (8, yyyy-mm-dd)	Dob	Date	*
6	Gender – Sex of patient. Male – M Female – F Undetermined – U	Sex	Char(1)	*
7	Admission date - the month, day, and year on which the patient, whose hospitalization is being recorded, was admitted to the transferring facility. Format: date (8, yyyy-mm-dd)	adat	Date	*
8	Discharge date – the month, day, and year on which the patient, whose hospitalization is being recorded, was transferred from the facility to the LTAC. Format: date (8, yyyy-mm-dd)	ddat	Date	*
9	Date of onset of ventilator dependence at the transferring hospital Format: date (8, yyyy-mm-dd). Blank if not applicable.	vent_dat	Date	*
10	Date of tracheostomy at the transferring hospital Format: date (8, yyyy-mm-dd). Blank if not applicable	trach_dat	Date	*
11	Admitting Diagnosis – the ICD-9-CM code for the condition reported or presented at the time of the hospitalization. Format: String (5, do not include decimal place -- decimal place is implied)	adx	Char(5)	
12	Principal Diagnosis – the ICD-9-CM code for the condition which is established after the study to be chiefly responsible for the encounter being recorded.	dx1	Char(5)	*

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	Format: String (5, do not include decimal place -- decimal place is implied)			
13	Secondary Diagnoses (dx2 through dx10) – the ICD-9-CM codes for the conditions, exclusive to the principal diagnosis, which exist at the time the patient was treated or which developed subsequently to the treatment and which affect the patient’s treatment for the encounter being recorded. Diagnoses which are associated with an earlier encounter and which have no bearing on the current encounter shall not be recorded as secondary diagnoses. Format: String (5, do not include decimal place -- decimal place is implied)	dx2	Char(5)	*
14	As defined in (13) above.	dx3	Char(5)	*
15	As defined in (13) above	dx4	Char(5)	*
16	As defined in (13) above	dx5	Char(5)	*
17	As defined in (13) above	dx6	Char(5)	*
18	As defined in (13) above	dx7	Char(5)	*
19	As defined in (13) above	dx8	Char(5)	*
20	As defined in (13) above	dx9	Char(5)	*
21	As defined in (13) above	dx10	Char(5)	*
22	E-code (ecode1 to ecode3) – The ICD-9-CM codes for external cause of injury, poisoning or adverse effect. Format: string (5, do not include decimal place -- decimal place is implied)	ecode1	Char(5)	
23	As defined in (22) above.	ecode2	Char(5)	
24	As defined in (22) above.	ecode3	Char(5)	
25	Principal Procedure – the ICD-9-CM code for the procedure most closely related to the principal diagnosis that is performed for the definitive treatment of the patient. Format: string (4, do not include decimal place -- decimal place is implied)	px1	Char(4)	*
26	Procedure Date– refers to the year, month and day on which the principal procedure was performed. . Format: date (8, yyyy-mm-dd)	Pxdate1	Date	*
27	Secondary Procedure (px2 –px10) – the means other significant procedures in addition to the principal procedure. These are to be reported with the date on which the procedure was performed codes for other significant procedures.	px2	Char(4)	*
28	Procedure Date– refers to the year, month and day on which the secondary procedure was performed. Format: date (8, yyyy-mm-dd)	Pxdate2	Date	*
29	As defined in (27) above.	px3	Char(4)	*
30	As defined in (28) above.	Pxdate3	Date	*
31	As defined in (27) above.	px4	Char(4)	*
32	As defined in (28) above.	Pxdate4	Date	*
33	As defined in (27) above.	px5	Char(4)	*

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34	As defined in (28) above.	Pxdate5	Date	*
35	As defined in (27) above.	px6	Char(4)	*
36	As defined in (28) above.	Pxdate6	Date	*
37	As defined in (27) above.	px7	Char(4)	*
38	As defined in (28) above.	Pxdate7	Date	*
39	As defined in (27) above.	px8	Char(4)	*
40	As defined in (28) above.	Pxdate8	Date	*
41	As defined in (27) above.	px9	Char(4)	*
42	As defined in (28) above.	Pxdate9	Date	*
43	As defined in (27) above.	px10	Char(4)	*
44	As defined in (28) above.	Pxdate10	Date	*
45	Diagnosis Related Group – category from set of clinically distinct categories developed by CMS as proxy for resource utilization assigned the patient.	drg	Char(3)	*
46	Level of care prior to transfer to LTAC ICU - 1 Floor - 2	lcare	Char (1)	
47	Cost - Total cost of hospitalization at acute care hospital Total charge may be extracted from acute care discharge data	cost	Num (6)	
48	Payment sources (Primary (ppayer), Secondary (spayer) and Tertiary (tpayer)) - the major payment sources that were expected at the time the dataset was completed, from the categories listed below: Self pay = A Worker's Compensation = B Medicare = C Medicaid = D Commercial Insurance Company = E Medicare Managed Care = F Medicaid Managed Care = G Commercial Insurance Managed Care = H CHAMPUS or TRICARE = I Other Government Payment = J Title V = Q No Charge or Free Care = R Other = M	ppayer	Char(1)	*
49	As defined in (49) above.	Spayer	Char(1)	*
50	As defined in (49) above.	Tpayer	Char(1)	*
LTAC Data				
51	Facility Provider Number – The last 4 digits of the Medicare provider number for the LTAC.	facid1	Char (4)	
52	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by an LTACH that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that LTAC. Format: string (20, zero filled to left if fewer than 20 characters)	mrn1	Char(20)	
53	Patient Control Number – unique number assigned by the LTAC to each patient's individual encounter that distinguishes the medical	patcont1	Char(20)	

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	and billing records of the encounter. Format: string (20, zero filled to left if fewer than 20 characters)			
54	Date of admission – Date patient was admitted to LTAC Format: date (8, yyyy-mm-dd)	adat1	Date	
55	Date of Discharge – Date patient was discharged from LTAC Format: date (8, yyyy-mm-dd)	ddat1	Date	
56	Admitting Diagnosis – the ICD-9-CM code for the condition reported or presented at the time of the hospitalization at the LTAC. Format: String (5, do not include decimal place -- decimal place is implied)	adx1	Char(5)	
57	Discharge Diagnosis - the ICD-9-CM code for the condition at the time discharge from the LTAC. Format: string (5, do not include decimal place -- decimal place is implied)	ddx	Char(5)	
58	Ventilator status at time of discharge from LTAC Weaned - 1 Not Weaned - 2 Not applicable - 3	ventstat	Char (1)	
59	Date weaned off ventilator at LTAC Format: date (8, yyyy-mm-dd). Blank if not applicable.	ventdate	Date	
60	Admission source – describes the circumstances associated with the patient’s admission, categories of which are defined below. (A) Intensive Care Unit 1 (B) Special Nursing Facility 2 (C) Intermediate Care Facility 3 (D) Host Acute Care Hospital 5 (E) Other Acute Care Hospital 6 (F) Specialty Facility collaborating in demo LTAC 7 (G) Inpatient Rehab Facility 8 (H) Other 9	asource1	Char(2)	
61	Disposition – the circumstances of the patient’s discharge, categories of which are defined below: Discharged to home or self care, (routine discharge) 01 Discharged or transferred to another short term general hospital for inpatient care 02 Discharged or transferred to a skilled nursing facility (SNF) 03 Discharged or transferred to an intermediate care facility (ICF) 04 Transferred to another type of institution for inpatient care 05 Discharged or transferred to a home under care of an organized home health service organization 06 Left or discontinued care against medical advice 07 Discharged or transferred to home under the care of a home IV Provider 08 Admitted as an inpatient to this hospital 09 Expired 20 Expired at home 40 Expired in a medical facility (e.g. hospital, SNF, ICF or free standing hospice) 41	pstat1	Char(2)	

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	Expired – place unknown	42			
	Hospice – home	50			
	Hospice – medical facility	51			
	Discharged or transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital	62			
	Discharged or transferred to Medicare certified long term care hospital (LTAC)	63			
	Discharged or transferred to a nursing facility certified under Medicaid but not certified under Medicare	64			
	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	65			
62	DNR – Do not resuscitate order signed. (1) No - 0 (2) Yes - 1		dnr	Char(1)	JCAHO Quality indicator
63	Functionality Scale (Zubrod) at time of discharge from LTAC Fully Active - 0 Restricted in strenuous activity -1 Ambulatory, capable of self-care but not work - 2 Bedridden 50% or more of the time, limited self-care - 3 Totally bedridden and disabled, no self care - 4 Expired - 5		scale1	Char (1)	To establish if progress has been made since transfer
64	Unscheduled readmissions to acute care hospital None - 0 Within 15 days for the same or a related condition - 1 Within 31 days for the same or related condition - 2 Within 72 days for the same or related condition - 3		readmit	Char(1)	JCAHO Quality indicator
65	Number of emergency transfers back to acute care hospital None - 0 1 - 1 2 - 2 3 or more - 3		emerg	Char(1)	JCAHO Quality indicator
66	Diagnosis Related Group – category from set of clinically distinct categories developed by CMS as proxy for resource utilization assigned the patient.		drg-ltac	Char(3)	
67	Cost of Hospitalization at LTAC		cost1	Num (6)	
Follow-up Data obtained at 3 months after discharge from LTAC by phone)					
68	Survival Alive – 1 Expired - 2		Surv1	Char (1)	
69	Cause of Death Not applicable - 0 Related to discharging diagnosis - 1 Unrelated to discharging diagnosis -2		cause1	Char(1)	
70	Current Disposition		Pstat2	Char(1)	

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	(as defined in 61)			
71	Functionality Scale (Zubrod) - current Fully Active - 0 Restricted in strenuous activity -1 Ambulatory, capable of self-care but not work - 2 Bedridden 50% or more of the time, limited self-care - 3 Totally bedridden and disabled, no self care - 4 Expired - 5	scale2	Char (1)	
72	Any readmissions since discharge None - 0 1 - 1 2 - 2 3 or More - 3	Postread1	Char(1)	
Follow-up Data obtained at One (1) year after discharge from LTAC by phone)				
73	Survival Alive - 1 Expired - 2	Surv2	Char (1)	
74	Cause of Death Not applicable - 0 Related to discharging diagnosis - 1 Unrelated to discharging diagnosis -2	Cause2	Char (1)	
75	Current Disposition (as defined in 61)	Pstat3	Char (1)	
76	Functionality Scale (Zubrod) - current Fully Active - 0 Restricted in strenuous activity -1 Ambulatory, capable of self-care but not work - 2 Bedridden 50% or more of the time, limited self-care - 3 Totally bedridden and disabled, no self care - 4 Expired - 5	Scale3	Char (1)	
77	Any readmissions since discharge None - 0 4 - 1 5 - 2 6 or More - 3	Postread2	Char(1)	

*** If acute care discharge data reporting is coordinated with LTAC data reporting, then OHCA can extract this information for an LTAC patient from the in-house Discharge Database System.**