STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

UNIVERSITY COMMUNITY HOSPITAL,	)	
	)	
Petitioner,	)	
	)	
vs.	)	CASE NO. 92-5107
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent.	)	
	)	

RECOMMENDED ORDER

This case was heard by Eleanor M. Hunter, the Hearing Officer designated by the Division of Administrative Hearings, on January 25 -26, 1993, in Tallahassee, Florida.

APPEARANCES

For Petitioner, Community Hospital:	Cynthia S. Tunnicliff, Attorney W. Douglas Hall, Attorney Carlton, Fields, Ward, Emmanuel, Smith & Cutler, P.A. Post Office Drawer 190 Tallahassee, Florida 32302
For Respondent, Agency for Health Care Administration:	Lesley Mendelson, Senior Attorney Agency for Health Care Administration 2727 Mahan Drive Tallahassee, Florida 32308

STATEMENT OF THE ISSUE

Whether University Community Hospital should be issued Certificate of Need Number 6936 to convert 20 acute care beds to 20 comprehensive medical rehabilitation beds.

PRELIMINARY STATEMENT

On February 7, 1992, the Department of Health and Rehabilitative Services, the agency responsible for the administration of the Certificate of Need ("CON") program prior to the Agency for Health Care Administration ("AHCA"), published a fixed need pool of zero for additional comprehensive medical rehabilitation beds in District 6. District 6 includes Hillsborough, Manatee, Polk, Hardee and Highlands Counties.

In March 1992, University Community Hospital ("UCH") filed a letter of intent to file an application for a CON to convert 20 medical/surgical acute care beds to 20 comprehensive medical rehabilitation beds. The application was filed and reviewed, and the agency published its intent to deny the application

which had subsequently been numbered CON 6936. Vol. 18, No. 29, Florida Administrative Weekly, July 17, 1992. A timely filed petition, challenging the intent to deny CON 6936, was forwarded to the Division of Administrative Hearings and initiated these proceedings.

At the final hearing, UCH presented the testimony of Brigitte Shaw, the hospital's planner; Sandra Williams, its Vice President for Fiscal Services and an expert in health care finance; and Scott L. Hopes, expert in health care planning. UCH's Exhibits 1-8 were received into evidence, with ruling reserved on a proffered Exhibit 9. On February 3, 1993, AHCA filed a Notice of Withdrawal of Objection to Exhibit 9, which was received in evidence. AHCA presented the testimony of Jon Cooper, expert in architecture, and Alberta Granger, expert in health planning related to CON review, and Exhibits 1-7 which were received in evidence.

Subsequent to the hearing on February 3, 1993, AHCA filed a Request For Official Recognition of Winter Haven Hospital v. Department of Health and Rehabilitative Services, DOAH Case No. 85-4133 (HRS Final Order 9/8/86). In that case, the Department of Health and Rehabilitative Services ("HRS") approved the conversion of 24 medical/surgical beds at Winter Haven Hospital to comprehensive medical rehabilitation beds, conditioned on the filing by Winter Haven of a request to delicense an additional 16 medical/surgical beds.

FINDINGS OF FACT

1. UCH is a 424 bed acute care hospital located in northern Hillsborough County. UCH is the applicant for CON Number 6936 to convert 20 medical/surgical acute care beds to 20 comprehensive medical rehabilitation ("CMR") beds. Its service area is northern Hillsborough and eastern Pasco Counties.

2. AHCA is the successor to HRS as the designated agency to administer the CON laws.

3. UCH currently operates 404 acute care beds and 20 skilled nursing beds. Its services include an emergency room, open heart surgery, obstetrics, and a home health agency.

4. From 1982 to 1990, UCH operated an inpatient comprehensive rehabilitation unit, certified by HRS and recognized by the Federal Health Care Finance Administration ("HCFA") as a 9-bed unit in 1984, and as an 18-bed unit from 1985 through 1988. Substantial renovation of the unit's sixth floor south wing, in 1987 and 1988, was intended to meet the standards of the Commission on Accreditation of Rehabilitation Facilities ("CARF"). UCH was never actually CARF accredited.

5. After the enactment of a CMR rule, HRS preliminarily determined that UCH was a "grandfathered" 9-bed provider of CMR services. That preliminary determination was successfully challenged in University Community Hospital v. Department of Health and Rehabilitative Services, 11 FALR 1150 (HRS Final Order 2/13/89), and the unit was closed in 1990. In September 1990, UCH applied for CON 6412 to convert 20 acute care beds to 20 CMR beds. That application was denied. University Community Hospital v. Department of Health and Rehabilitative Services, et al., 14 FALR 1899 (HRS Final Order 4/15/92).

NEED IN RELATION TO STATE AND LOCAL HEALTH PLAN

6. Five preferences in the 1989 Florida State Health Plan relate to CMR programs and are applicable to the review of the UCH application.

7. The first preference relates to applicants proposing the conversion of excess acute care beds to establish a distinct rehabilitation unit within a hospital. AHCA agrees that the UCH application is consistent with this preference.

8. The second preference, favoring applicants proposing specialty inpatient or outpatient rehabilitation services not currently offered in the district, it not met. In District VI, three CMR providers have a total of 112 licensed beds, 111 beds in operation: 59 at Tampa General Hospital in Hillsborough County, 24 at Winter Haven Hospital in Polk County, and 28 at L.W. Blake in Manatee County.

9. The third preference applies to the teaching hospitals. UCH is not a teaching hospital although it does have contracts with teaching institutions to allow students to gain clinical experience at UCH. See, Subsection 408.035(1)(g), Fla. Stat. (1992 Supp.).

10. The fourth preference, is for applicants with a history of providing a disproportionate share of charity care and Medicaid patient days. The preference specifically requires qualifying hospitals to meet Medicaid disproportionate share hospital criteria. UCH is not a disproportionate share provider, and does not meet this preference.

11. The fifth preference, for applicants with an existing comprehensive outpatient rehabilitation facility ("CORF"), is met. UCH planner's testimony was not refuted and AHCA concedes that UCH offers a number of therapies to outpatients.

12. The June 1990 District VI Allocation Factors Report, prepared by the Health Council of West Central Florida, Inc., is the local health plan applicable to the review of this application.

13. The first preference favors disproportionate share providers, and does not support the UCH application. See, Finding of Fact 10.

14. UCH is entitled to the second local preference for the conversion of existing medical/surgical beds. See, Finding of Fact 7.

15. The fourth preference is for existing providers of fewer than 20 beds seeking to add more beds and is, therefore, not applicable to the UCH application.

POPULATION CONDITIONS AND NEED

16. The third local preference, for additional rehabilitation services if existing ones are not meeting community needs, is the essence of the UCH claim that its services are needed. The local factor is also directly related to the criteria of Subsection 408.035(1)(b), Florida Statutes, and Florida Administrative Code, Rule 59C-1.039(2)(b). The rule is as follows:

1. Historic, current and projected incidence and prevalence of disabling conditions and chronic illness in the population in the Department service district by age and sex group;

2. Trends in utilization by third party payers;

3. Existing and projected inpatients (e.g., orthopedic, stroke and cardiac cases) in need of rehabilitation services; and

4. The availability of specialized staff.

17. Based on rule methodology for computing numeric need, there is zero need for additional CMR beds in District VI. That methodology is based on the assumption that there will be 3.9 CMR beds needed for every 1000 acute care discharges.

18. In terms of population conditions, UCH has urged the consideration of the actual statewide use rate of 8.46 CMR admissions for every 1000 acute care admissions, which would equate to a need for an additional 132 beds in the District. In District VI, there are 6.67 CMR admissions for every 1000 acute care admissions which, considering projected population increases, equates to a need for 80 additional beds. According to UCH, CMR bed availability is a factor in determining utilization

19. In District VI, there are 7 CMR beds per 100,000 people. UCH points to the actions of AHCA in approving an increase from 8 to 12 CMR beds per 100,000 people in District IX in the absence of any published numeric need.

20. AHCA emphasizes that empty CMR beds exist in District VI, which had 1990-1991 occupancy rates of 72.07 percent, below the 85 percent minimum for approval of new beds absent not normal circumstances. Tampa General's rate was 82.77 percent, but Winter Haven's was 50.82 percent and L. W. Blake in Manatee County was 67.36 percent occupied. As AHCA also indicated, population projections and numeric need are calculated to determine future need.

21. UCH has demonstrated that the geographic and economic accessibility of Winter Haven in Polk County is limited for patients from the UCH area. In part, the limitations result from the requirement of third party payers for CARF accredited facilities, when intense, inpatient rather than outpatient CMR services are needed. Winter Haven is not CARF accredited. In addition, during the time there was a low rate of utilization at Winter Haven, some licensed beds were not in service due to construction. Utilization in the first quarter of 1992 reached just under 80 percent at Winter Haven. UCH also claims that AHCA approved beds at Winter Haven based on the geographic inaccessibility of beds in Tampa. AHCA filed a Request for Official Recognition on February 3, 1993, which shows the award of beds to Winter Haven resulted from a stipulated settlement. UCH's Exhibit 9 does include the distance to Tampa as one of several factors considered in the agency's approval of the stipulated settlement with Winter Haven.

22. L. W. Blake in Manatee County is also geographically inaccessible for Hillsborough County patients and their families, particularly the elderly proposed to be served by UCH. In addition, L.W. Blake's utilization increased to an average of 84 percent in the first quarter of 1992.

23. Tampa General has 59 of its 60 CMR beds in service. All rooms at Tampa General are semi-private, necessitating same gender placements, except one isolation room. In addition, patients with similar injuries are grouped together. Tampa General is a regional referral center for vocational rehabilitation and a state designated center for head and spinal cord injuries. These factors limit the availability of Tampa General's beds to serve District VI residents, as does its occupancy rate of 85 percent. In the past, when UCH operated and then closed a CMR unit, there was no statistical impact on Tampa General. Currently, Tampa General has a waiting list and patients average a 9 day wait.

24. For the reasons identified by UCH, including geographic and economic inaccessibility, the district incidence of CMR admissions as compared to acute care admissions, UCH has provided sufficient, credible evidence of the need for the services proposed by UCH in additional CMR beds in District VI.

25. AHCA has amended its CMR rule to better predict need. Although it is not applicable to computing numeric need for this cycle, AHCA asserts that its new rule methodology is the alternative which should be used rather than other factors, such as the ratio of CMR beds to acute care admissions, or population. Under the new rule methodology, there is no numeric need for additional CMR beds in District VI. Assuming arguendo, that AHCA is correct, the other factors related to the accessibility and availability of services at the three existing providers could not be disregarded.

PROJECT COSTS AND FINANCIAL FEASIBILITY

26. In this application, UCH proposes to operate a 20-bed CMR unit in the renovated space of the sixth floor south wing. That space currently is being used as an overflow area for 30 medical/surgical beds.

27. UCH estimates total project costs of $248,596, with major expenses for consulting, legal, and accounting expenses, and $67,496 of the total or $3.66 per square foot for redecorating the renovated wing. No additional construction is anticipated. AHCA acknowledges that UCH has the funds to finance the project, but asserts that the costs are understated by $150,000 due to the failure of UCH to include construction costs to bring the wing into compliance with the Americans with Disabilities ACT ("ADA"). UCH notes, and AHCA concedes, that the rule requiring compliance with ADA standards was not adopted until a year after this application was filed. In addition, ADA compliance is required for new construction, not redecorating.

28. AHCA also criticized UCH for omiting the cost of relocating 10 medical/surgical beds, after the conversion of 20 of the existing 30 beds to CMR beds. UCH asserts that the conversion or relocation of the 10 beds is properly an expense item in the project which would utilize the 10 beds and is included in other pending CON applications for difference services. Other CON projects however, are not certain to be approved. If none are, UCH's expert planner testified that the 10 beds will be located in a general surgical area which is being redecorated. UCH also maintains that as long as it can bring the CMR beds on line within the total project costs within the application, it should be allowed to do so, even if that involves shifting amounts among the various expense items. AHCA has not estimated the cost of relocating the 10 beds, nor contradicted UCH's alternative plans for covering that cost. UCH's projected total project costs are, therefore, accepted as reasonable.

29. AHCA agrees that UCH could profitably operate a CMR unit, particularly, as proposed to provide stroke and orthopedic services to medicare patients. When UCH operated an 18-bed unit, occupancy ranged from 77 percent to 84 percent, with 80 to 85 percent of the patients transferring from UCH acute care beds. Projected charges, deductions from revenue, payor mix, and expenses are reasonable.

30. AHCA did not dispute UCH's assertions that its proposal is the most cost-effective alternative for increasing district CMR beds, because no other provider could initiate such services without substantial construction costs, and that utilization of CMR beds is increasing.

ADDITIONAL CON CRITERIA AND CMR PROGRAM REQUIREMENTS

31. UCH, as acknowledged by AHCA, has a history of providing quality care and is accredited by the Joint Commission on Hospital Accreditation.

32. UCH has a staff physiatrist to serve as CMR Medical Director. The types of therapists needed to provide a coordinated multidisciplinary approach to rehabilitation are already on staff at UCH. The staffing and renovations of the wing in the late 1980's indicate that UCH will meet the requirements for CARF accreditation.

33. UCH does not propose to offer CMR services as a joint venture with any other health care facility, nor does it propose to offer a service which is not available in adjacent districts. In fact, AHCA notes that District V providers had occupancy rates of 53.31 percent for 1990-1991. The agency's rule, however, places at issue the historic, current and projected population conditions in the Department service district by age and sex group.

CONCLUSIONS OF LAW

34. The Division of Administrative Hearings has jurisdiction over this matter. Subsection 408.039(5), Florida Statutes.

35. The applicant has the burden of establishing entitlement to a CON as the result of balanced consideration of the statutory and rule criteria. Balsam v. Department of Health and Rehabilitative Services, 486 So.2d 1341 (Fla. 1st DCA 1986), and Collier Medical Center Inc. v. Department of Health and Rehabilitative Services, 462 So.2d 83 (Fla. 1st DCA 1985).

36. In substantial portion, AHCA's position that the UCH application should be denied is based on the absence of numeric need, even under its newly adopted methodology, and on the prior denial of a virtually identical UCH application.

37. The prior UCH application was considered in University Community Hospital vs. Department of Health and Rehabilitative Services, 14 FALR 1899 (HRS Final Order 4/15/92). UCH proposed to convert 20 acute care beds to 20 CMR beds for approximately $617,674. The hearing officer in that case found, among other virtually similar facts, the following distinguishable facts:

> UCH did not disclose in its application the capital budget items reflected in its 1990-91 capital equipment budget.
>
> * * *

> 25. Neither applicant has documented that existing providers who concentrate in the treatment of rehabilitation patients are not currently meeting the needs of the community, in order to be entitled to the third [local health plan] preference.
>
> * * *
>
> The projected costs, however, are predicated on an unproven assumption that the space intended to house the CMR unit has already been renovated for rehabilitation services and that no additional dollars are required to be spent. Because UCH did not demonstrate that the space, as currently designed, is adequate to accommodate a 20-bed CMR unit, UCH has not shown that its projected costs are reasonable. UCH may have to redesign its CMR unit to comply with CARF standards, thereby incurring additional, unanticipated costs.
>
> * * *
>
> 47. Tampa General presented credible evidence that a CMR program at UCH would take 107 patients from Tampa General in its first year of operation alone, assuming UCH attains its projected occupancy, resulting in a loss to Tampa General of nearly $1.8 million.
>
> * * *
>
> 61. Neither applicant addressed unique incidence or prevalence in the district as required by Subparagraph (2)(b)1 of the rule. Instead, UCH used national incidence rates and applied them to the population of District VI.
>
> * * *
>
> and,
>
> 73. In summary, the applicants meet very few of the factors, standards and criteria of Rule 10-5.039, F.A.C. Those few factors do not demonstrate a need for additional CMR beds in District VI.

38. In this case, there was no allegation that UCH did not disclose a complete list of its capital projects planned, pending, approved or underway. There was creditable evidence that more CMR beds will result in greater utilization of the service. There was no evidence to dispute UCH's assertion that it can become CARF accredited within the projected project costs.

39. No evidence was presented that Tampa General will be impacted adversely by the establishment of CMR services at UCH.

40. UCH demonstrated, using district usage rates, that a need exists in the district for additional CMR beds.

41. In this case, on balance, the evidence supports the approval of the UCH application to meet a need for additional CMR beds in District VI.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a Final Order be entered issuing Certificate of Need No. 6936 to University Community Hospital to convert 20 medical/surgical acute care beds to 20 comprehensive medical rehabilitation beds in District VI.

DONE and ENTERED this 19th day of October, 1993, at Tallahassee, Florida.

ELEANOR M. HUNTER
Hearing Officer
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-1550
(904) 488-9675

Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of October, 1993.

APPENDIX TO CASE NO. 92-5107

University Community Hospital

1. Accepted in Findings of Fact 1 and 3.
2. Accepted in Finding of Fact 1.
3. Accepted in Finding of Fact 4.
4. Accepted in Finding of Fact 5.
5. Accepted in Finding of Fact 5.
6. Accepted in Finding of Fact 4.
7. Accepted in Findings of Fact 1 and 5.
8. Accepted in Finding of Fact 29.
9. Accepted in Finding of Fact 29.
10. Accepted in Finding of Fact 6.
11. Accepted in Preliminary Statement.
12. Accepted in Preliminary Statement.
13. Accepted in Finding of Fact 17.
14. Accepted in Finding of Fact 18.
15. Accepted in Finding of Fact 18.
16. Accepted in Finding of Fact 18.
17. Accepted in or subordinate to Finding of Fact 19.
18. Subordinate to Finding of Fact 19.
19. Accepted in Findings of Fact 20 through 24.
20. Accepted in Finding of Fact 16.
21. Subordinate to Finding of Fact 21.
22. Subordinate to Finding of Fact 21.
23. Accepted in Finding of Fact 29.
24. Accepted in part and rejected in part in Findings of Fact 6-16.
25. Accepted in Finding of Fact 8.
26. Accepted in Finding of Fact 20.
27. Accepted in Finding of Fact 20.

28. Accepted in Finding of Fact 21.
29. Subordinate to Finding of Fact 21.
30. Accepted in Finding of Fact 22.
31. Accepted in Finding of Fact 22.
32. Accepted in Finding of Fact 24.
33. Subordinate to Finding of Fact 24.
34. Subordinate to Finding of Fact 24.
35. Subordinate to Finding of Fact 24.
36. Accepted in Finding of Fact 23.
37. Subordinate to Finding of Fact 23.
38. Subordinate to Finding of Fact 23.
39. Subordinate to Finding of Fact 23.
40. Subordinate to Finding of Fact 23.
41. Subordinate to Finding of Fact 23.
42. Accepted in Finding of Fact 23.
43. Subordinate to Finding of Fact 23.
44. Subordinate to Finding of Fact 23.
45. Subordinate to Finding of Fact 23.
46. Subordinate to Finding of Fact 23.
47. Subordinate to Finding of Fact 24.
48. Subordinate to Finding of Fact 24.
49. Subordinate to Finding of Fact 24.
50. Subordinate to Finding of Fact 24.
51. Accepted in Findings of Fact 7 and 27.
52. Accepted in Finding of Fact 29.
53. Accepted in Finding of Fact 29.
54. Accepted in Finding of Fact 29.
55. Accepted in Finding of Fact 30.
56. Accepted in Finding of Fact 27.
57. Accepted in Findings of Fact 26 and 28.
58. Subordinate to Finding of Fact 27.
59. Accepted in Finding of Fact 27.
60. Accepted in Finding of Fact 27.
61. Accepted in Finding of Fact 27.
62. Accepted in Findings of Fact 31 and 32.
63. Subordinate to Finding of Fact 1.
64. Accepted in Findings of Fact 27 and 32.
65. Subordinate to Finding of Fact 27.
66. Subordinate to Finding of Fact 30.
67. Subordinate to Finding of Fact 30.
68. Accepted.
69. Accepted in Finding of Fact 32.
70. Accepted and subordinate to Finding of Fact 1.

Agency For Health Care Administration

1. Accepted in Findings of Fact 1 and 3.
2. Accepted in Findings of Fact 1 and 3.
3. Accepted in Finding of Fact 1.
4. Accepted in Finding of Fact 4.
5. Accepted in Finding of Fact 5.
6. Accepted in Finding of Fact 6.
7. Accepted in Findings of Fact 1 and 4.
8. Accepted in Findings of Fact 26 and 28.
9. Accepted in Finding of Fact 27.
10. Accepted in Finding of Fact 32.
11. Accepted in Finding of Fact 1.

12. Accepted in Finding of Fact 29.
13. Accepted in Finding of Fact 5.
14. Accepted in Finding of Fact 6.
15. Accepted in Finding of Fact 7.
16. Accepted in Finding of Fact 8.
17. Accepted in Finding of Fact 9.
18. Accepted in Finding of Fact 10.
19. Rejected in Finding of Fact 11.
20. Accepted in Finding of Fact 12.
21. Rejected in Finding of Fact 16.
22. Accepted in Finding of Fact 13.
23. Accepted in Finding of Fact 14.
24. Rejected in Findings of Fact 20 and 22.
25. Accepted in Finding of Fact 15.
26. Subordinate to Finding of Fact 32.
27. Accepted in Finding of Fact 19.
28. Accepted in Finding of Fact 21.
29. Rejected in Findings of Fact 20-23.
30. Accepted in Finding of Fact 17.
31. Accepted in Findings of Fact 8, 17 and 19.
32. Accepted in Finding of Fact 17.
33. Accepted in Finding of Fact 16.
34. Accepted in Finding of Fact 16.
35. Rejected in Findings of Fact 20-23.
36. Rejected in Findings of Fact 20-23.
37. Accepted in Finding of Fact 18.
38. Rejected in Finding of Fact 24.
39. Accepted in Finding of Fact 18.
40. Accepted in Finding of Fact 25.
41. Rejected in Finding of Fact 24.
42. Accepted in Finding of Fact 16.
43. Accepted in relevant part in Finding of Fact 21.
44. Accepted in Finding of Fact 16.
45. Conclusion Rejected in Findings of Fact 20-23 and 29.
46. Accepted in Finding of Fact 16.
47. Accepted in Finding of Fact 32.
48. Accepted in Finding of Fact 20.
49. Accepted in Finding of Fact 20.
50. Rejected in Finding of Fact 29.
51. Accepted in Findings of Fact 29 and 4.
52. Rejected in Finding of Fact 29.
53. Accepted in Finding of Fact 21.
54. Subordinate to Findings of Fact 21-24.
55. Accepted in Findings of Fact 21-24.
56. Accepted in Findings of Fact 21-24.
57. Subordinate to Finding of Fact 24, and Accepted in Finding of Fact 33.
58. Accepted in Findings of Fact 4, 21 and 32.
59. Rejected in Findings of Fact 4, 21, and 32.
60. Subordinate to Finding of Fact 21.
61. Subordinate to Finding of Fact 21.
62. Accepted in Finding of Fact 33.
63. Accepted in Finding of Fact 33.
64. Accepted in Finding of Fact 9.
65. Accepted in Finding of Fact 9.
66. Subordinate to Finding of Fact 29.
67. Subordinate to Finding of Fact 29.

68. Subordinate to Finding of Fact 29.
69. Accepted in Finding of Fact 29.
70. Rejected in relevant part in Findings of Fact 27 and 28.
71. Rejected in Findings of Fact 27.
72. Subordinate to Finding of Fact 21.
73. Accepted in Finding of Fact 23.
74. Rejected in Finding of Fact 27.
75. Accepted in Finding of Fact 29.
76. Issue not reached. See Finding of Fact 27.
78. Issue not reached. See Finding of Fact 27.
79. Issue not reached. See Finding of Fact 27.
80. Accepted in relevant part in Finding of Fact 28.
81. Subordinate to Finding of Fact 29.
82. Rejected in Findings of Fact in 21-24.
83. Rejected in Finding of Fact 23.
84. Accepted, except last sentence in Findings of Fact 21-24.

COPIES FURNISHED:

Sam Power, Agency Clerk
Agency for Health Care Administration
The Atrium, Suite 301
325 John Knox Road
Tallahassee, Florida 32303

Lesley Mendelson, Senior Attorney
Agency for Health Care Administration
325 John Knox Road, Suite 301
Tallahassee, Florida 32303-4131

Cynthia S. Tunnicliff, Esquire
Post Office Box 190
Tallahassee, Florida 32302

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions to this Recommended Order. All agencies allow each party at least 10 days in which to submit written exceptions. Some agencies allow a larger period within which to submit written exceptions. You should contact the agency that will issue the final order in this case concerning agency rules on the deadline for filing exceptions to this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.