STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

BETHESDA MEMORIAL HOSPITAL, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	CASE NO. 95-0730
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION, and NME HOSPITAL, INC., d/b/a DELRAY COMMUNITY HOSPITAL,	)	
	)	
Respondents.	)	
	)	

RECOMMENDED ORDER

This case was consolidated with Division of Administrative Hearings Case No. 95-2649RX and heard by Hearing Officer Eleanor M. Hunter, on June 12-16, 1995, in Tallahassee, Florida.

APPEARANCES

For Petitioner, Bethesda Memorial Hospital, Inc.:	Kenneth G. Hoffman, Attorney W. David Watkins, Attorney Oertel, Hoffman, Fernandez & Cole, P.A. Post Office Box 6507 2700 Blair Stone Road Tallahassee, Florida 32314-6507
For Respondent, Agency For Health Care Administration:	John Gilroy, Attorney Agency For Health Care Administration 2727 Mahan Drive Fort Knox Building 3, Suite 3431 Tallahassee, Florida 32308-5403
For Respondent, NME Hospitals, Inc., d/b/a Delray Community Hospital:	C. Gary Williams, Attorney Michael J. Glazer, Attorney MacFarlane, Ausley, Ferguson & McMullen Post Office Box 391 227 South Calhoun Street Tallahassee, Florida 32302

STATEMENT OF THE ISSUES

Whether the application of Delray Community Hospital for a certificate of need to add 24 acute care beds meets, on balance, the applicable criteria for approval.

PRELIMINARY STATEMENT

The Agency For Health Care Administration ("AHCA") preliminarily approved Certificate of Need ("CON") Application Number 7872 to authorize NME Hospitals, Inc. d/b/a Delray Community Hospital ("Delray") to add 24 acute care beds. Delray is located in AHCA District 9, Subdistrict 5, for southern Palm Beach County, as is the Petitioner, Bethesda Memorial Hospital, Inc. ("Bethesda"). Bethesda challenged AHCA's preliminary approval of Delray's CON and, in Division of Administrative Hearings ("DOAH") Case No. 95-2649RX, also challenged the validity of the need methodology in Rule 59C-1.038, the acute care bed need rule. The cases were consolidated for hearing. By Final Order of August 17, 1995, paragraphs (5), (6) and (7)(a)-(c) of the acute care bed need rule were held invalid. Although the cases were consolidated for hearing, the parties stipulated that the witnesses and exhibits listed in this Recommended Order constitute the record in this case.

AHCA presented the testimony of Elizabeth Dudek, expert in health care planning and certificate of need policy and procedure. There were no AHCA exhibits.

Delray presented the testimony of Laura Cillo, expert in hospital administration; Jean Iapichino, R.N., expert in nursing and nursing administration; Julie Hilsenbeck, R.N., expert in nursing and nursing administration; Ivan Puente, M.D., expert in trauma care and surgery; Roy Katzin, M.D., expert in neurology; Santosh K. Mathen, M.D., expert in emergency medicine; Keith A. Kasper, expert in health care finance; and Daniel J. Sullivan, expert in health care planning, health care finance, and financial feasibility of health care projects. Delray's exhibits 1-19 and 21 were received in evidence. Delray's exhibit 20 was not received in evidence.

Bethesda presented the testimony of Armand Balsano, expert in health care planning and financial feasibility; Virgil C. Norris, M.D., expert in surgery; Jeri-Ann Saltamacchia, R.N., expert in nursing and emergency department nurse management; Harold J. Lynch, Jr., M.D., expert in internal medicine and pulmonology; and Gale Marsh, R.N., expert in critical care nursing and critical care unit management. Bethesda's exhibits 1-6 were received in evidence.

The transcript of the final hearing was received on July 10, 1995. After a motion to extend post-hearing deadlines was granted, proposed findings of fact and conclusions of law were filed on August 21, 1995.

FINDINGS OF FACT

1. The Agency For Health Care Administration ("AHCA") administers the state certificate of need ("CON") program for health care services and facilities. In August 1994, AHCA published a numeric need of zero for additional acute care beds in District 9, Subdistrict 5, for southern Palm Beach County.

2. In September 1994, NME Hospitals, Inc. d/b/a Delay Community Hospital, Inc. ("Delray") applied for a certificate of need ("CON") to add 24 acute care beds in District 9, Subdistrict 5, for a total construction cost of $4,608,260. AHCA published its intent to approve the application and to issue CON No. 7872 to Delray, on January 20, 1995, in Volume 21, No. 3 of the Florida Administrative Weekly.

3. By timely filing a petition, Bethesda Memorial Hospital, Inc. ("Bethesda"), which is located in the same acute care subdistrict, challenged AHCA's preliminary decision. Bethesda also filed a petition challenging Rule 59C-1.038, Florida Administrative Code, the acute care bed need rule, which resulted in a determination that the need methodology in the rule is invalid. Bethesda Memorial Hospital, Inc. v. AHCA and NME Hospital, Inc., DOAH Case No. 95-2649RX (F.O. 8/16/95).

4. Delray and Bethesda are in a subdistrict which includes five other hospitals, Wellington Regional Medical Center ("Wellingon"), West Boca Medical Center ("West Boca"), Palm Beach Regional Medical Center ("Palm Beach Regional"), J. F. Kennedy Medical Center ("JFK"), and Boca Raton Community Hospital ("BRCH"). The hospitals range in size from 104 to approximately 400 beds. Wellington, West Boca, and Palm Beach Regional have fewer, and Bethesda, JFK and BRCH have more than Delray's 211 beds.

5. Bethesda, located in Boynton Beach, is accredited by the Joint Commission for the Accreditation of Hospital Organizations ("JCAHO") for the maximum time available, 3 years. Bethesda has 330 beds, and offers obstetrics, pediatrics, and emergency room services. An average of 10 patients a month are transferred, after their condition is stabilized, from the emergency room at Bethesda to other hospitals, and most are participants in the Humana health maintenance organization ("HMO"), which requires their transfer to an Humana-affiliated hospital. Approximately one patient a month is transferred for open heart surgery or angioplasty after stabilization with thrombolitic therapy at Bethesda. Bethesda has a 12-bed critical care unit, a 12-bed surgical intensive care unit, and a telemetry or progressive care unit. From October to April, Bethesda also opens a 10-bed medical intensive care unit. Even during this "season," when south Florida experiences an influx of temporary winter residents, Bethesda's critical care beds are very rarely full. Only one time during the 1994-1995 season was a patient held overnight in the emergency room waiting for a bed at Bethesda. Only diagnostic cardiac caths are performed at Bethesda due to the absence of back-up open heart surgery.

6. Delray is located on a medical campus with Fair Oaks Hospital, a 102 bed psychiatric facility, and Hillhaven Convalescent Center, which has 108 beds. Delray is physically connected to Pinecrest Rehabilitation Hospital, which has 90 beds. The campus also includes a medical mall, with outpatient services, a home health agency, and medical office buildings. Delray has a medical staff of 430 physicians.

7. Delray is a for-profit hospital owned and operated by NME Hospitals, Inc., a wholly owned subsidiary of National Medical Enterprises, which after merging with American Medical International, does business as Tenet Health Care Corporation ("Tenet"). Tenet owns, operates, or manages 103 facilities, including Fair Oaks and Pinecrest Rehabilitation Hospital. Delray owns Hillhaven Convalescent Center, but it is managed by the Hillhaven nursing home management company. NME Hospitals, Inc., also owns West Boca Medical Center, which is approximately 10 to 12 miles from Delray. South Florida Tenet Health System is an alliance of the Tenet facilities, which has successfully negotiated managed care contracts offering the continuum of care of various levels of providers within one company.

8. AHCA published a numeric need of zero for additional acute care beds in the southern Palm Beach County subdistrict, for July 1999, the applicable planning horizon. Delray's application asserts that special circumstances exist

for the approval of its application despite the absence of numeric need. AHCA accepted and reviewed Delray's application pursuant to the following section of the acute care bed need rule:

> (e) Approval Under Special Circumstances. Regardless of the subdistrict's average annual occupancy rate, need for additional acute care beds at an existing hospital is demonstrated if a net need for beds is shown based on the formula described in paragraphs (5)(b), (7)(a), (b), (c), and (8)(a), (b), (c), and provided that the hospital's average occupancy rate for all licensed acute care beds is at or exceeds 75 percent. The determination of the average occupancy rate shall be made based on the average 12 months occupancy rate made available by the local health council two months prior to the begining of the respective acute care hospital batching cycle.

9. The need methodology referred to in the special circumstances rule indicated a net need for 1442 additional beds in District 9. All parties to the proceeding agree that the net need number is unrealistic, irrational, and/or wrong. That methodology was invalidated in the previously consolidated rule challenge case. Delray also met the requirement of exceeding 75 percent occupancy, with 75.63 percent from January through December 1993. In 1994, Delray's occupancy rate increased to 83 percent.

10. In 1993, occupancy rates were 55.6 percent in District 9 and 52.5 percent in subdistrict 5. At individual hospitals, other than Delray, occupancy rates ranged from lows of 25.5 percent at Wellington and 35 percent at Palm Beach Regional to highs of 58 percent at BRCH and JFK. A study of four year trends shows declining acute care occupancy at every subdistrict hospital except Delray.

11. Delray points to occupancy levels in intensive care units as another special circumstance for adding new beds. Currently, Delray has 8 beds in a trauma intensive care unit ("TICU"), 8 in a surgical intensive care unit ("SICU"), 7 in a critical or coronary care unit ("CCU"), 7 in a medical intensive care unit ("MICU"), and 67 beds in a telemetry or progressive care unit ("PCU"). For the fiscal year ending May 31, 1994, occupancy rates were 80 percent in the PCU, 91 percent in CCU, and 128 percent in SICU. If the CON is approved, Delray plans to allocate the 24 additional beds to increase the PCU by 10, CCU by 7, and the SICU by 7 beds. Expert testimony established 75 percent to 80 percent as a range of reasonable occupancy levels for intensive care units.

12. A PCU, telemetry, or step down unit serves as a transition for patients leaving ICUs who require continued heart rate monitoring. PCU staffing ratios are typically 1 nurse to every 4 patients. CCU is used for patients who have had heart attacks or other serious cardiac problems and continue to need closer personal monitoring. SICU is used primarily for post-surgery open heart patients. The TICU is used for patients with neurological injuries and those in need of neurosurgery. When the ICUs are full, overflow patients are placed in holding areas of the ICU, the emergency room ("ER"), telemetry unit, or in a medical holding unit behind the emergency room. During the season, from November to April, from 20 to 55 patients are in holding areas, most of whom

would otherwise be in an ICU or PCU bed. Critical care nurses are moved to the holding areas to care for critical patients. Additional staffing requirements are met, in part, by using contract nurses from an agency owned by Tenet, called Ready Staff. Other temporary or traveling nurses go through a three day orientation and are paired with regular staff mentors. Traveling nurses have three to six month contracts to work at various hospitals throughout the county, as needed. Intensive care nurses are cross-trained to work in any of the ICUs, but the same nurses usually are assigned to open heart and trauma patients.

13. Since May 1991, Delray has been the state-designated level II trauma center for southern Palm Beach County, as is St. Mary's Hospital for the northern areas of the County. Trauma patients are transported by ambulance or helicopter, and treated in two designated trauma rooms in the emergency department. The state designation requires Delray to have one of its eight trauma surgeons, trauma nurses, anesthesiologists, and certain other ancillary services available in the hospital at all times. Delray also must have a bed available in its TICU.

CON Review Criteria

14. By supplemental prehearing stipulation, the parties agreed that Delray's CON application includes the information and documents required in Section 408.037, Florida Statutes. The parties also stipulated that the project is financially feasible in the short term, and that proposed construction costs and methods, and equipment costs are reasonable. Based on prehearing stipulations, the statutory review criteria in dispute are as follows:

> 408.035(1)(a) - need in relation to district and state health plans;
>
> 408.035(1)(b) and (1)(d) - availability, accessibility, efficiency, and adequacy of other hospitals;
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> 408.035(1)(b) and (1)(c) - quality of care at other hospitals and the applicant's ability to provide and record of providing quality of care;
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> 408.035(1)(h) - availability of critical care nurses; and
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> 408.035(1)(i) - long term financial feasibility.

State and District Health Plans

15. The 1993 Florida State Health Plan has a preference for approving additional acute care beds in subdistricts with at least 75 percent occupancy, and at facilities equal to or in excess of 85 percent occupancy. Subdistrict 5 and Delray do not meet the preference. See, Finding of Facts 9 and 10.

16. The state health plan also includes a preference for hospitals which are disproportionate share Medicaid providers. Delray does not meet the preference, and notes that 70 percent of its patients are over 65 years old and entitled to Medicare reimbursement. In fact, there are no disproportionate share providers in the subdistrict.

17. Delray meets the state plan preference for proposing a project which will not adversely affect the financial viability of an existing, disproportionate share provider.

18. The state health plan also has four preferences related to emergency services, for accepting indigent patients in ER, for a trauma center, for a full range of ER services, and for not having been fined for ER services violations. Delray meets all four preferences related to emergency services.

19. The 1990 District 9 Health Plan, with a 1993 CON Allocation Factors Report, favors applicants who serve Medicaid/Indigent, handicapped, and underserved population groups. In 1992 and 1993, approximately 2.5 percent of the patients at Delray were in the Medicaid program. Delray also provided 3 percent indigent and charity care for 1993. The hospital's 1992 financial reports do not indicate that it provided any indigent or charity care. In 1993-1994, Delray had the lowest percentage of Medicaid and charity patients at a state designated level II trauma center. AHCA proposes to condition approval of CON 7872 on Delray's providing 2.4 percent of total annual patient days to Medicaid and 1 percent of total annual patient days to charity care, as projected by Delray in Table 7 of the application.

20. Under the district health plan, priority is given for applicants who document cost containment. One example of cost containment, according to the plan, is sharing services with other area hospitals to enhance efficient resource utilization and avoid duplication. Delray describes its patient-focused care model as an example of cost containment. In response to rising labor cost, the underutilization of certain required categories of employees, and the large number of staff interacting with each patient, Delray created the model which emphasizes cross-training of staff to work in teams led by a registered nurse. Delray has not proposed sharing services with other hospitals, and has not documented cost containment as that is described in the district health plan.

Availability, Accessibility, Efficiency and Adequacy of Other Hospitals

21. Additional acute care beds at Delray will not meet any demonstrated numeric, geographic, or financial need. Acute care beds are available in adequate numbers in the subdistrict. Roughly half, or 800, of the subdistrict's 1700 beds were empty most days in 1993 and 1994.

22. Bethesda's expert in health care planning and financial feasibility testified that some available, more appropriate alternatives to the approval of additional beds at Delray are the transfer of patients to other subdistrict hospitals, including Tenet's West Boca, the transfer of unused bed capacity from one area of the hospital to another, or the transfer of unused bed capacity from West Boca to Delray. Bethesda also contends that Delray could find alternatives to placing outpatient surgery and outpatient cardiac cath patients in inpatient beds from four to twenty-three hours for observation and care. In support of Delray, AHCA's expert testified that institution-specific demand, in Delray's case, has reached the level of community need, because other subdistrict hospitals are not adequate or available to treat the type of patients treated at Delray.

23. All of Delray's patients come from areas of the county which overlap the service areas of other hospitals, which shows the absence of any geographic access barriers. A diagnostic related group, or DRG, analysis shows that most

of the categories of diagnosed illnesses or injuries treated at Delray are also treated at other subdistrict hospitals. The DRGs exclusively treated at Delray are related to trauma. Others treated in the subdistrict only at Delray and JFK are related to angioplasty and open heart surgery.

24. Of the state level II trauma centers, Delray reported the highest percentage, 96.5 percent, of discharges of all patients were urgent or emergent cases. By comparison, the lowest were 65.6 percent at St. Joseph's Hospital in Tampa and 66 percent at West Florida Regional Medical Center, and the next highest was 94.2 percent at Bayfront Medical Center. Bethesda's expert suggested that the number was too high and could result from miscoding. Approximately 70 to 90 trauma patients are treated each month at Delray and approximately 50 percent of those are admitted to the hospital. One Bethesda witness, a doctor on the staff at both Bethesda and Delray, testified that he was called in once when Delray refused to go on "by-pass status," to send an incoming trauma patient to St. Mary's, knowing the patient was likely to need a CT scan. At the time, Delray's main scanner inside the hospital was inoperable or undergoing repairs. The patient who arrived by helicopter was taken by ambulance to another scanner on the campus, approximately 1000 yards away from the hospital. The same doctor also complained that ER patients who are upgraded to trauma status cannot be downgraded by trauma surgeons. There was no evidence how often the inside CT scan is unavailable and, consequently, no showing that altering this practice would result in an appreciable decline in the demand for trauma services at Delray. Similarly, there was no evidence of any impact on hospital admissions resulting from upgrading emergency patients to trauma patients.

25. Trauma victims seldom require open heart surgery. Therefore, a different category of patients served only in the subdistrict at JFK and Delray is open heart surgery patients. Because of its location in an area with a large population over age 65 and due to the services it provides, one Delray witness described Delay, as a "cardiac" hospital. Delray has no pediatric or obstetric services. The percentage of residents over 65 in Delray's service area is about 35 percent, in contrast to a statewide level approaching 20 percent.

26. Delray began an open heart surgery program in August, 1986. There are now approximately 50 cardiologists on staff, 19 performing cardiac catheterizations ("caths") and angioplasties, and three performing open heart surgeries. In fiscal year 1993, approximately 1900 cardiac caths, and 450 open heart surgeries were performed at Delray. In fiscal year 1994, that increased to approximately 2100 patients cathed and 540 open heart surgeries. Through April 1995, or 11 months into the fiscal year, there were approximately 2300 caths and 526 open heart surgeries. The cath labs are available twenty-four hours a day, seven days a week, within forty-five minutes notice. By comparison, the cath lab at Bethesda operates on weekdays until 3:30 p.m. Ten to twelve physicians use Delray's two cardiac cath labs and a third overflow lab, if needed. The cath labs at Delray and Bethesda are considered "open" because any qualified staff physician is eligible to receive privileges to use the lab. A backlog occurs in the Delray cath lab when critical care beds are not available for patients following caths. Delray has three open heart surgery operating rooms and three open heart surgeons, with the capacity to perform 1000 open heart surgeries a year.

27. Within the subdistrict, approximately 11 miles from Delray, JFK also provides cardiac cath, angioplasty, and open heart surgery services. JFK has 369 beds and is equipped with two cardiac cath labs, each with the capacity to accommodate 2000 procedures a year. In fiscal year 1994, approximately 3200

caths were performed at JFK. The cath lab is "closed," meaning JFK has entered into an exclusive contract for services with one group of invasive cardiologists. JFK's medical staff has relatively little overlap, approximately 10 to 15 percent, with the medical staff at Delray. Across all patients and all diagnoses, there is also relatively little geographic overlap. JFK, by and large, serves the central area and Delray serves the southern area of Palm Beach County. The average census in thirty critical care beds at JFK was 16.5 patients in 1994, and 18.4 in the first six months of 1995. A high range of 70 percent to 80 percent occupancy in JFK's critical care beds is reached during the peak season. Although JFK's thirty critical care beds are not officially divided into different types of intensive care services, a de facto designation has developed. Depending on the patient mix, the same 16 beds are generally used for cardiac critical care. The average daily census for cardiac critical care was 13.4 in March 1994 and 23.4 in February 1995. Overall, there is no excess capacity in the district in critical care beds during the height of the season. The average occupancy of all critical care beds in southern Palm Beach County was 104 percent in February 1992, 98 percent in February 1993, and 93.5 percent in February 1994.

28. Open heart surgery and angioplasty are more frequently than not scheduled up to a week ahead of time. Most cardiac patients can be admitted to any emergency room and stabilized with thrombolytic therapy before transfer to another hospital for an angioplasty or open heart surgery, without compromising their conditions. However, at Delray, cardiac patients are more likely to be emergent or urgent cases, remaining in the hospital for stabilization, scheduled for surgery within 24 hours, and remaining in SICU an average of forty-eight hours following surgery. The older patients are more difficult to transfer because they tend to have more consulting specialists on the staff of the hospital in the service area where they reside. Transferring open heart surgery patients from Delray to JFK is not beneficial as a health planning objective during the season, when JFK operates at reasonable levels of 70 percent to 80 percent occupancy in critical care beds and exceeds the capacity of its de facto cardiac critical care beds.

29. Delray's emergency department can accommodate 23 patients at one time. Over the past three years, ER visits have increased by approximately 1,000 each year. Approximately 20 percent to 25 percent of patients treated in its emergency room, excluding trauma patients, are admitted to Delray. During the winter season, there are also more emergency room patients who do not have local physicians, most complaining of cardiac and respiratory problems. By federal law, certain priority categories of emergency patients must be taken to the nearest hospital. Federal law also prohibits patient transfers to a different hospital unless a patient's medical condition is stable, the patient consents, and the other hospital has an available bed and a staff doctor willing to take the patient. Patient condition and consent are major factors preventing transfers of elderly residents of the Delray service area to other hospitals.

30. Delray also reasonably expects an increase in patients due to an increase in its market share, managed care contracts, and population in its service area. Managed care contracts, usually for 3 year terms, are not alone a reliable basis for making long term community health planning decisions. Combining trends in growth, population aging, declining lengths of stays in hospitals, market share and the greater consumption of inpatient services by people over 65, however, Delray reasonably expects an incremental increase of 1667 discharges by 1999. At 80 percent occupancy, the incremental patients attributable to population growth alone, according to Delray's expert, justifies an additional 34 beds.

31. For a substantial part of 1994, ICU, CCU and medical/surgical beds at Delray exceeded reasonable occupancy standards. In the first four months of 1995, medical/surgical occupancy levels ranged from 96.7 percent to 119.4 percent. Given those levels and the projected growth, transfer of beds from medical/surgical units is not a reasonable option for increasing the supply of critical care beds. Delray is small when compared to all other high volume open heart surgery and level II trauma hospitals in Florida.

32. Another option suggested by Bethesda's expert was the transfer of beds from West Boca to Delray. Because the beds have already been built, a transfer would not reduce capital or fixed costs at West Boca. The only effect that was apparent from the evidence in this case would be a statistical increase in subdistrict utilization. In addition, with 171 beds, West Boca is relatively small and in a growing area of Palm Beach County.

33. Bethesda's contention that Delray could stop using inpatient beds for the four to twenty-three hour outpatients was not supported by the evidence. There was no showing that the physical plant or space exists for the construction of observation beds near an ambulatory surgery center. Given the testimony that all hospitals use inpatient beds for certain outpatients, and that Delray averages five to seven outpatients in inpatient medical/surgical beds at any time, there is no evidence of a practical alternative with any significant impact on the overcrowding at Delray. Bethesda also challenged the need for critical care for fractures, cellulitis, and fever of unknown origin, which were among the diagnoses listed for patients in the ER hold. However, Bethesda's expert also acknowledged that some patients in ER hold at Delray were waiting for medical/surgical beds not only ICU beds. Patients are placed in holding areas whenever assignment to an appropriate bed is not possible within thirty minutes of the issuance of orders to admit the patient.

34. Delray proved that it is unique in the subdistrict in treating trauma patients and cardiac patients in a service area with minimal geographic and medical staff overlap with that of JFK. The transfer of such patients to other hospitals in the subdistrict is often not practical or possible. Delray also demonstrated that other subdistrict hospitals are not available alternative intensive care providers when their ICUs are also full or over optimal levels of occupancy, during the season. In addition, the demographic characteristics of Delay's service area support projected increases in inpatient days due to increased market share, population aging and growth. All of these factors indicate that Delray cannot, as Bethesda suggests, control its own growth, transfer, or redirect patients.

Quality of Care and Availability of Critical Case Nurses

35. Delray is JCAHO accredited. There is no evidence that quality of care affects hospital utilization in southern Palm Beach County. Open heart surgery mortality rates from 1990 to 1994 were 1.9 percent at JFK and 3 percent at Delray, but the data is not adjusted to take into consideration "case-mix," meaning the severity of illnesses, and is, therefore, meaningless as a comparison. A 1994 Medicare case mix index report shows Delray treating the sickest patients followed by JFK, then Bethesda. The sicker, older patients, exert more pressure on ICUs.

36. Because ICU nursing ratios are one-nurse-to-one-patient or, more typically, one-to-two and PCU ratios are one-to-four, PCUs provide a step down from ICUs. PCU beds are used for patients who no longer need ICU care, but

require more intense monitoring than that provided on the medical/surgical floors with nurse/patient ratios of one-to-twelve or one-to-twenty. In PCU or telemetry beds, radio signals transmit data to heart monitors. However, if PCU beds are not available, patients are left in the ICUs longer than necessary, aggravating the backlog cause by crowded ICUs.

37. Critical care is a resource-intensive service, and Bethesda argues that Delray cannot increase the service because of the shortage of critical care nurses in Palm Beach County. However, the testimony presented by Bethesda is not consistent. Bethesda's expert in critical care nursing and critical care unit management testified that vacancies are difficult to fill, that there is a shortage of critical care nurses, but that Bethesda does not experience a shortage of critical care staff. There is no explanation why Bethesda has no shortage, but Delray would if its CON is approved. Delray's director of neuroscience and critical care testified that she maintains a file of available critical care nurses and can recruit the additional staff needed due to Delray's competitive salaries and benefits.

Long Term Financial Feasibility

38. There are no revenues or expenses during construction of the 24 beds, just construction costs. After the beds are in service, Delray projects net income of $1,951,164 in 1997 and $2,003,769 in 1998.

39. In projecting revenues and expenses for the beds, Delray used its historical percentages of patients in each unit receiving a particular type of care and the historical cost of that care, and assumed that the same breakdown in the 24 new beds. Using the historical financial experience, Delray constructed a pro forma for the 24 beds, with an expected average daily census of 21.6 patients.

40. If the 24 new beds are used only for existing holding area patients then, as Bethesda contends, Delray's pro forma should show a shift of revenues and expenses to the new beds, and the same amounts deducted from the remainder of the hospital. Delray already charges holding area patients based on the intensity of nursing care provided, even though the patients are not physically located in an ICU. The ER hold patients accounted for 2,210 patient days in 1994, which are reallocated to ICU beds in the pro forma.

41. However, Delray also projected an incremental increase of 7,865 patient days which, contrary to Bethesda's claim, does not include or double-count the ER hold patient days. Of these, 54 percent of incremental patient days are projected to be in the ICUs or PCU. The additional patients will, therefore, spend 46 percent of total patient days in medical/surgical beds. Routine revenue estimates of $492 a day in year one were criticized as too low for the projected 54 percent ICU/46 percent medical/surgical mix. However, $492 a day is a reasonable estimate of incremental routine revenues for the hospital as a whole. In 1994, patients at Delray spent 44 percent of total days in medical/surgical beds as compared to the projection of 46 percent for new patients. There is no material variation from 44 percent to 46 percent, therefore $492 a day is a reasonable projected incremental routine revenue. Delray has demonstrated, in an incremental analysis, the financial feasibility of adding 24 critical care beds for existing and additional patients.

42. Delray has also considered the financial impact of additional patients in all categories of beds. Although criticized by Bethesda for this approach, Delray explained that a critical care bed generates revenues from a

medical/surgical bed when patient's condition is downgraded. The financial analysis is reasonable, particularly since Medicare pays a flat rate by DRG regardless of how a patient's total days are divided between ICUs and medical/surgical beds.

43. Bethesda questioned whether the use of new beds for new patients will eliminate the use of holding areas. The movement of patients in and out of ICUs will be enhanced by having more ICU and PCU beds, even if the additional beds do not eliminate entirely the use of holding areas during the peak season. Projected average occupancies are expected to reach 98 percent in March 1997 and 1998.

44. Delray also demonstrated that the share of its projected increased admissions which would have otherwise gone to Bethesda is approximately 150 patients, representing a net decline in revenue to Bethesda of approximately $257,000, in comparison to Bethesda's net income of $9 million in 1994. Bethesda also will no longer receive a county tax subsidy of $1 million in income and $3.5 million in restricted funds, after 1994.

CONCLUSIONS OF LAW

45. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this case, pursuant to Subsection 120.57(1) and 408.039(5), Florida Statutes.

46. NME Hospitals, Inc., d/b/a Delray Community Hospital, as the applicant, has the burden of proving, its entitlement to certificate of need, based on a balanced consideration of the criteria. Boca Raton Artificial Kidney Center, Inc. v. Department of Health and Rehabilitative Services, 475 So.2d 260 (Fla. 1st DCA 1985); Florida Department of Transportation v. J.W.C. Company, Inc., 396 So.2d 778 (Fla. 1st DCA 1981).

47. Although its financial solvency is not threatened, Bethesda has standing to challenge the issuance of a CON to Delray, as did Palm Beach Gardens in St. Mary's Hospital, Inc., et. al v. AHCA et. al., DOAH 93-0956 and 93-0957 (F.O. 1/13/95).

48. Bethesda argues that the approval of Delray's CON will impermissibly respond to an institution-specific need, not a community need, as required by Section 408.302(2), Florida Statutes. Bethesda relies on St. Mary's hospital, Inc., et al. v. Agency For Health Care, supra. In St. Mary's, the applicant constructed, equipped and operated an outpatient cardiac catherization laboratory and applied for CON authorizing it to perform inpatient cardiac catheterizations. The Recommended Order in St. Mary's was based on the applicant's failure to demonstrate need and to support projected utilization volumes, not solely on institution-created demand.

49. Bethesda also cites Naples Community Hospital v. AHCA, DOAH Case No. 92-1510 (F.O. 6/6/93) for the proposition that peak seasonal demand for acute care beds is not a "not normal" circumstance unless "a credible threat of a negative impact to patient outcomes exists." However, the average occupancy level of Naples Community Hospital was less than the 75 percent threshold of Rule 59C-1.038(7)(e), and AHCA clarified its adoption of the Recommended Order to "not suggest that such circumstances are the only way "not normal" circumstances can be established." (F.O. at page 4).

50. Consideration of the Delray application in relation to the state and local health plans is required by Subsection 408.035(1)(a), Florida Statutes.

51. Delray, on balance, meets the preferences in the state health plan. Although not meeting occupancy level and Medicaid requirements, Delray meets the preferences for emergency and trauma services, and for proposing a project which will not adversely affect another hospital which is a disproportionate share provider of the Medicaid reimbursed services.

52. The Delray application is not in compliance with the local health plan, having not documented cost containment as envisioned by the plan, and due to the low levels of Medicaid and charity care, the lowest of any level II trauma center in the state.

53. Delray established the need for the additional 24 beds, based on its high average annual occupancy in medical/surgical, ICU, and PCU beds. Likewise, during the season, beds at other hospitals are either not accessible, appropriate, or adequate for the types of patients at Delray, in compliance with the need criteria of Subsection 408.035(1)(b) and (d).

54. Delray demonstrated that the need for the additional beds at Delray is a community need based on the DRG analysis of the patients who are not served at other subdistrict hospitals, trauma patients, and those who require angioplasty and open heart surgery services, but are not in JFK's primary service area. Delray also demonstrated community need by showing that it is illegal, impractical and/or impossible to transfer many patients who are admitted from its emergency room.

55. In Humana of Florida, Inc. d/b/a Humana Hospital Pasco v. AHCA, DOAH Case No. 92-1497, 17 FALR 2300 (F.O. 6/3/93), AHCA approved the addition of 24 acute care beds at East Pasco Hospital, which exceeded 100 percent occupancy in the peak winter season. East Pasco's case was less compelling than is Delray's. The projected average daily census was 5 patients in 24 beds in year 2 at East Pasco, in contrast to 21.6 patients in 24 beds at Delray. In addition, East Pasco was not a trauma center, and offered the same medical services as the only other hospital in the subdistrict, with which it shared "virtually identical" medical staffs and primary service areas. (R.O. at page 3; F.O. at page 1).

56. Delray meets the quality of care criteria of Subsection 408.035(1)(c), and can recruit and hire the necessary staff, as required by Subsection 408.035(1)(h).

57. Delray does not seek approval of the project as a joint or shared program, to meet needs in adjoining areas, or as a research or training program, under Subsections 408035(1)(e), (f) and (g).

58. The parties stipulated to short-term financial feasibility and Delray demonstrated the long-term financial feasibility of its project, as required by Subsection 408.035(1)(i).

59. The addition of 24 acute care beds, as proposed by Delray, does not respond to any special needs or circumstances of large numbers of people outside the service district, for of any health maintenance organizations, as AHCA interprets Subsections 408.035(1)(j) and (k).

60. There was no evidence that the project will impact costs or competition for acute care beds, as described in Subsection 408.035(1)(l). The

parties stipulated that costs and methods of construction were reasonable, pursuant to Subsection 408.035(1)(m).

61. Considering, under Subsection 408.035(1)(n), past and proposed service to Medicaid and indigent patients, Delray's past levels and proposed commitment for the new beds are consistent with the subdistrict.

62. Delray meets the criterion of Subsection 408.035(1)(o), for promoting a continuum of care in a multi-level health care system.

63. On balance, the addition of 24 acute care beds at Delray is justified by "not normal" circumstances, particularly the absence of another level II trauma center and the lack of medical staff and geographic service area overlap with JFK, which severely limits the ability to redirect Delray's cardiac patients to JFK.

RECOMMENDATION

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

RECOMMENDED that a Final Order be entered issuing Certificate of Need 7872, approving the addition of 24 acute care beds, to NME Hospital, Inc., d/b/a Delray Community Hospital, conditioned on the provision 2.4 percent of total annual patient days to Medicaid and 1 percent of total annual patient days to charity care.

DONE AND ENTERED this 7th day of November, 1995, in Tallahassee, Leon County, 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 7th day of November, 1995.

APPENDIX TO RECOMMENDED ORDER, CASE NO. 95-0730

To comply with the requirements of Section 120.59(2), Florida Statutes (1993), the following rulings are made on the parties' proposed findings of fact:

Petitioner, Bethesda Memorial, Proposed Findings of Fact.

1. Accepted in Findings of Fact 14.
2. Accepted in or subordinate to Findings of Fact 2, 7, and 10.
3. Accepted in or subordinate to Findings of Fact 23 and 27.
4. Accepted in or subordinate to Findings of Fact 21 and 23.
5. Accepted in Findings of Fact 22.

6. Accepted in or subordinate to Findings of Fact 21.
7. Accepted in Findings of Fact 23.
8,9. Accepted in Findings of Fact 19 and 20.
10. Accepted except first sentence in Findings of Fact 15.
11-12. Accepted in Findings of Fact 16.
13. Accepted in Findings of Fact 18.
14. Rejected in Findings of Fact 15-18.
15-17. Accepted in or subordinate to Findings of Fact 21 and 22.
18. Accepted in Findings of Fact 35.
19. Rejected first sentence in Findings of Fact 30.
20. Accepted in part and rejected in part in Findings of Fact 23-29.
21. Accepted in or subordinate to Findings of Fact 14.
22. Subordinate to Findings of Fact 14 and accepted in Findings of Fact 21.
23-25. Accepted in or subordinate to Findings of Fact 4.
26. Rejected in Findings of Fact 27.
27-28. Accepted in Findings of Fact 30.
29. Accepted in Findings of Fact 21.
30. Rejected first sentence in Findings of Fact 38-43.
31-32. Rejected in or subordinate to Finding of Fact 43.
33. Accepted in Findings of Fact 40.
34-35. Accepted in or subordinate to Findings of Fact 39-41.
36. Accepted in Findings of Fact 37.
37(1). Accepted in Findings of Fact 40 and 41.
37(2). Accepted in Findings of Fact 11.
37(3). Accepted in Findings of Fact 39 and 43.
38-39. Accepted in part and rejected in part in Findings of Fact 40 and 43.
40-48. Rejected in part in Findings of Fact 40 and 41.
49-51. Rejected in Findings of Fact 41.
52. Subordinate to Findings of Fact 41.
53. Rejected in Findings of Fact 38-42.
54(A). Rejected in Findings of Fact 33.
54(B). Accepted in or subordinate to Findings of Fact 33.
54(C). Rejected
54(D-E). Subordinate to Findings of Fact 34.
54(F). Accepted in Findings of Fact 19.
54(G). Subordinate to Findings of Fact 38.
54(H). Accepted in Findings of Fact 22.
54(I). Subordinate to Findings of Fact 34.
54(J). Subordinate to Findings of Fact 30.
54(K). Subordinate to Findings of Fact 28.
54(L). Rejected as speculative in Findings of Fact 35.
54(M). Subordinate to Findings of Fact 7 and 34.
54(N). Conclusions rejected. See Findings of Fact 16.
54(O-P). Conclusions rejected. See Findings of Fact 24.
54(Q). Accepted in Findings of Fact 21.
54(R). Conclusions rejected. See Findings of Fact 24.
55. Accepted in Findings of Fact 12.
56. Accepted in Findings of Fact 21 and 23.
57. Accepted in preliminary statement.
58. Accepted in Findings of Fact 12.
59. Accepted in relevant part in Findings of Fact 29.
60. Accepted in Findings of Fact 35.
61. Accepted in or subordinate to Findings of Fact 26.
62-63. Accepted in part in Findings of Fact 27-29.
64. Accepted in Findings of Fact 23, 27 and 28.

65. Subordinate to Findings of Fact 26.
66. Subordinate to Findings of Fact 30
67. Subordinate to Findings of Fact 26.
68. Subordinate to Findings of Fact 30.
69. Subordinate to Findings of Fact 26.
70. Subordinate to Findings of Fact 27.
71. Subordinate to Findings of Fact 27.
72. Subordinate to Findings of Fact 26 and 27.
73. Accepted in part in Findings of Fact 28.
74. Accepted in Findings of Fact 23.
75. Accepted in or subordinate to Findings of Fact 6.
76. Accepted in Findings of Fact 26.
77. Accepted in Findings of Fact 35-37.
78. Accepted in Findings of Fact 27.
79-81. Accepted in or subordinate to Findings of Fact 27 and 28.
82-85. Accepted in or subordinate to Findings of Fact 28.
86. Accepted in Findings of Fact 10.
87. Accepted in or subordinate to Findings of Fact 27.
88. Subordinate to Findings of Fact 28 and rejected in Findings of Fact 35.
89. Rejected in general in Findings of Fact 27 and 28.
90. Subordinate to Findings of Fact 27.
91. Subordinate to Findings of Fact 28.
92. Rejected in Findings of Fact 35.
93. Accepted in Findings of Fact 30.
94-98. Accepted in part or subordinate to Findings of Fact 28 and 29.
99-100. Rejected in or subordinate to Finding of Fact 28 and 29.
101. Subordinate to Findings of Fact 35.
102-104. Subordinate to Findings of Fact 27, 28 and 35.
105. Accepted in Findings of Fact 28.
106-107. Subordinate to Findings of Fact 35.
108-111. Accepted in or subordinate to Findings of Fact 27.
112. Subordinate to Findings of Fact 26.
113. Subordinate to Findings of Fact 27.
114. Accepted in Findings of Fact 35.
115. Accepted in Findings of Fact 27.
116. Subordinate to Findings of Fact 16.
117-122. Accepted in Findings of Fact 5 and 35.
123. Rejected in Findings of Fact 37.
124. Accepted in part and rejected in part in Findings of Fact 44.

Respondent, AHCA, Proposed Findings of Fact.

1. Accepted in or subordinate to preliminary statement.
2. Accepted in or subordinate to Findings of Fact 1.
3. Accepted in Findings of Fact 4.
4. Accepted in Findings of Fact 13 and 25.
5-6. Accepted in or subordinate to Findings of Fact 1 and 8-10.
7. Accepted in Findings of Fact 4 and 26.
8. Accepted in or subordinate to Findings of Fact 24 and 31.
9. Accepted in or subordinate to Findings of Fact 35.
10. Subordinate to Findings of Fact 22.
11. Accepted in Findings of Fact 21.
12. Accepted in Findings of Fact 22.
13. Accepted in part and rejected in part in Findings of Fact 8, 9 and 34.

Respondent, NME, Proposed Findings of Fact.

1. Accepted in Findings of Fact 2.
2. Accepted in Findings of Fact 11.
3. Accepted in Findings of Fact 4 and 6.
4. Accepted in or subordinate to Findings of Fact 26.
5. Accepted in Findings of Fact 6.
6-10. Accepted in or subordinate to Findings of Fact 24-26.
11. Accepted in Findings of Fact 35.
12. Subordinate to Findings of Fact 16.
13-14. Accepted in or subordinate to Findings of Fact 8-13 and 23-34.
15. Accepted in Findings of Fact 9 and 10.
16. Accepted in Findings of Fact 10.
17. Accepted in Findings of Fact 5, 12 and 34.
18. Accepted in Findings of Fact 9 and 10.
19. Accepted in Findings of Fact 30.
20. Subordinate to Findings of Fact 9.
21. Accepted in or subordinate to Findings of Fact 13, 23 and 35.
22. Accepted in or subordinate to Findings of Fact 11-12 and 28.
23. Accepted in Findings of Fact 11.
24. Accepted in or subordinate to Findings of Fact 11.
25. Accepted in Findings of Fact 14 and 34.
26. Accepted in or subordinate to Findings of Fact 25.
27. Rejected.
28. Accepted in Findings of Fact 35.
29. Accepted in Findings of Fact 13 and 31.
30. Accepted in Findings of Fact 24.
31. Accepted in Findings of Fact 13.
32. Accepted in Findings of Fact 36.
33. Subordinate to Findings of Fact 12 and 13.
34. Accepted in Findings of Fact 23 and 29.
35. Accepted in Findings of Fact 29.
36-43. Accepted in or subordinate to Findings of Fact 11 and 12.
44-50. Accepted in or subordinate to Findings of Fact 22 and 23-29.
51. Subordinate to Findings of Fact 6.
52. Accepted in or subordinate to Findings of Fact 34.
53. Accepted in or subordinate to Findings of Fact 28.
54. Accepted except last sentence in Findings of Fact 24.
55-56. Accepted in or subordinate to Findings of Fact 22 and 33.
57. Accepted in or subordinate to Findings of Fact 27 and 28.
58. Accepted in Findings of Fact 22.
59. Accepted in Findings of Fact 24.
60. Accepted in Findings of Fact 26.
61. Accepted in or subordinate to Findings of Fact 35.
62. Accepted in Findings of Fact 23.
63-65. Accepted in or subordinate to Findings of Fact 30.
66-67. Accepted in or subordinate to Findings of Fact 31.
68-72. Accepted in or subordinate to Findings of Fact 7 and 30.
73-76. Accepted in or subordinate to Findings of Fact 8 and 9.
77. Accepted in Findings of Fact 34.
78. Accepted, except last phrase in Findings of Fact 15-20.
79. Accepted in or subordinate to Findings of Fact 21-22.
80. Accepted in or subordinate to Findings of Fact 22.
81. Accepted in or subordinate to Findings of Fact 22-34.
82. Subordinate to Findings of Fact 22.
83-86. Accepted in Findings of Fact 12 and 35-37.
87-89. Accepted in Findings of Fact 35-37.

90. Accepted in Findings of Fact 30.
91. Accepted in Findings of Fact 38 and 39.
92. Accepted in Findings of Fact 38.
93. Accepted in Findings of Fact 41.
94. Subordinate to Findings of Fact 38.
95-99. Accepted in or subordinate to Findings of Fact 38-42.
100. Accepted, except first sentence, in or subordinate to Findings of Fact 44.
101. Subordinate to Findings of Fact 22.
102-104. Accepted in or subordinate to Findings of Fact 16 and 19.
105-106. Accepted in or subordinate to Findings of Fact 7.
107-108. Issue not reached. See Findings of Fact 14.
109-114. Accepted in or subordinate to Findings of Fact 44.

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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 ten 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.