STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

GOOD SAMARITAN HOSPITAL, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 99-0712
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION and COLUMBIA/JFK MEDICAL CENTER LIMITED PARTNERSHIP, d/b/a JFK MEDICAL CENTER,	)	
	)	
Respondents.	)	
_____	)	
ST. MARY'S HOSPITAL, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 99-0713
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION and COLUMBIA/JFK MEDICAL CENTER LIMITED PARTNERSHIP, d/b/a JFK MEDICAL CENTER,	)	
	)	
Respondents.	)	
_____	)	
WELLINGTON REGIONAL MEDICAL CENTER, INC., d/b/a WELLINGTON REGIONAL MEDICAL CENTER,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 99-0714
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION and COLUMBIA/JFK MEDICAL CENTER LIMITED PARTNERSHIP, d/b/a JFK MEDICAL CENTER,	)	
	)	
Respondents.	)	
_____	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on June 30, 1999 through July 2, 1999, and July 7 and 8, 1999, at the Division of Administrative Hearings, the DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida, before Eleanor M. Hunter, a duly-designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioners: Good Samaritan Hospital, Inc. and St. Mary's Hospital, Inc.:

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STATEMENT OF THE ISSUE

Whether Certificate of Need Application Number 9099, filed by Columbia/JFK Medical Center, L.P., d/b/a JFK Medical Center,

to convert 20 skilled nursing beds to 20 acute care beds, meets the criteria for approval.

PRELIMINARY STATEMENT

Columbia/JFK Medical Center, L.P., d/b/a JFK Medical Center (JFK) is the applicant for Certificate of Need (CON) Number 9099. If approved, JFK will convert 20 skilled nursing beds to 20 acute care beds. JFK is located in Agency for Health Care Administration (AHCA) District 9, Subdistrict 5, in Palm Beach County, Florida.

AHCA preliminarily approved JFK's application, which Good Samaritan Hospital, Inc. (Good Samaritan); St. Mary's Hospital, Inc. (St. Mary's); and Wellington Regional Medical Center, Inc. (Wellington) opposed by filing petitions in this proceeding. During the final hearing, Wellington submitted a notice voluntarily dismissing its petition in DOAH Case No. 99-0714.

JFK presented the testimony of Randall Wolff, M.D., an expert in emergency medicine and internal medicine; Gary M. Mervak, an expert in health care financial administration; Gretchen Szafaryn, R.N., an expert in emergency department administration and emergency nursing; Mary Bishop, R.N., an expert in nursing and administration of clinical programs; Kathleen Dassler, R.N., an expert in nursing administration; Madelyn Passarella, an expert in physician services and recruitment; Darryl Weiner, an expert in health care finance and health care project financial feasibility; and Michael L.

Schwartz, an expert in health care planning and hospital administration. By depositions, JFK also presented the testimony of Linda Anderson; Phillip Robinson; Jose Arrascue, M.D.; Michael Ray, M.D.; Robert Collins, M.D.; Jack Zeltzer, M.D.; Daniel Spurlock, M.D.; and Larry Bush, M.D. Including the depositions, JFK's Exhibits numbered 1 through 6, 8 through 12, 14, and 16 through 26 were received in evidence.

The Petitioners, Good Samaritan and St. Mary's, presented the testimony of Jay Cushman, an expert in health planning, and Frank Nask, an expert in hospital financial operations. Petitioner's Exhibits numbered 1 through 12 were received in evidence.

AHCA presented the deposition testimony of Elfie Stamm, an expert in health planning. The deposition was marked and received into evidence as AHCA's Exhibit numbered 1.

The nine-volume Transcript of the final hearing was filed on August 29, 1999. Following a Joint Motion for Extension of Time, proposed recommended orders were filed on September 14, 1999.

FINDINGS OF FACT

1. Columbia/JFK Medical Center, L.P., d/b/a JFK Medical Center (JFK) is the applicant for Certificate of Need (CON) Number 9099 to convert a 20-bed hospital-based skilled nursing unit (SNU) to 20 general acute care or medical/surgical beds. The construction cost is approximately $117,000, of the total project cost of $151,668. JFK is an affiliate of Columbia

Hospital System (Columbia), the largest for-profit hospital chain in the United States.

2. The Agency for Health Care Administration (AHCA) is the state agency which administers the CON program for health care services and facilities in Florida.

3. JFK is a 343-bed hospital located in Atlantis, Florida, in Palm Beach County, AHCA District 9, Subdistrict 5. Pursuant to a previously approved CON, an additional 24 acute care beds are under construction at JFK, along with 12 CON-exempt observation beds, at a cost of approximately $4 million. In August 1998, JFK was allowed to convert 10 substance abuse beds to 10 acute care beds.

4. Other acute care hospitals in District 9 include the Petitioners: St. Mary's Hospital, Inc. (St. Mary's), and Good Samaritan Hospital, Inc. (Good Samaritan), which are located in northern Palm Beach County, AHCA District 9, Subdistrict 4, approximately 11 and 9 miles, respectively, from JFK.

5. The remaining hospitals in District 9, Subdistrict 5, in southern Palm Beach County, and their approximate distances from JFK are as follows: Wellington (8 miles), Bethesda (7 miles), West Boca (18 miles), Delray (12 miles), and Boca Raton Community (17 miles). JFK and Delray are both "cardiac" hospitals offering open heart surgery services, with active emergency rooms, and more elderly patients in their respective service areas.

6. The parties stipulated to the following facts:

1. JFK's CON application was submitted in the Agency for Health Care Administration ("AHCA") second hospital batching cycle in 1998, and was the only acute care bed application submitted from acute care bed District 9, Subdistrict 5. AHCA noticed its decision to approve JFK's CON 9099 by publication in Volume 25, Number 1, Florida Administrative Weekly, dated January 8, 1999.

2. Good Samaritan and St. Mary's each timely filed a Petition for Formal Administrative Proceeding challenging approval of JFK's CON application. By Order dated March 17, 1999, the cases arising from those petitions were consolidated for the purposes of all future proceedings.

3. JFK has the ability to provide quality care and has a record of providing quality of care. §408.035(1)((c), Fla. Stat.

4. JFK's CON application, at Schedule 6 and otherwise, projects all necessary staff positions and adequate numbers of staff, and projects sufficient salary and related compensation. See, §408.035(1)(h).

5. JFK has available the resources, including health personnel, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation. See, §408.035(1)(h), Fla. Stat.

6. JFK's CON application proposal is financially feasible in the immediate term. §408.035(1)(i), Fla. Stat.

7. JFK's CON application proposal is financially feasible in the long term, except, Good Samaritan and St. Mary's contend as it relates to projected utilization. §408.035(1)(i), Fla. Stat.

8. Schedules 9 and 10 and the architectural schematics in JFK's application are complete and satisfy all applicable CON application

requirements. Schedule 1 in the application is complete, reasonable, and not at issue. JFK's proposed construction/renovation design, costs, and methods of construction/renovation are reasonable and satisfy all applicable requirements. See, §408.035(1)(m), Fla. Stat.

9. JFK's CON application satisfies all minimum application content requirements in Section 408.037(1), Florida Statutes; except that Good Samaritan and St. Mary's contend that subsection (1)(a), is not satisfied.

10. JFK certified that it will license and operate the facility if its CON proposal is approved. See, §408.037(2), Fla. Stat.

11. JFK's Letter of Intent was timely filed and legally sufficient. See, §408.039(2)(a) and (c), Fla. Stat.

12. Good Samaritan does not provide cardiac catheterization services, angioplasty, or open heart surgery.

13. St. Mary's does not provide elective angioplasty or open heart surgery services.

14. JFK is one of the hospitals to which Good Samaritan and St. Mary's transfer patients in need of inpatient cardiac catheterization services, angioplasty, and open heart surgery.

15. Neither Good Samaritan nor St. Mary's have any present plans to apply for CON approval to add skilled nursing beds or acute care beds.

7. The parties also stipulated that Subsections 408.035(1)(e), (f), (g), (h) - as related to training health professionals, (j), (k), and (2), Florida Statutes, are not at issue or not applicable to this proposal.

8. For the batching cycle in which JFK applied for CON Number 9099, AHCA published a fixed need of zero for District 9, acute care subdistrict 5.

9. In the absence of a numeric need for additional acute care beds in the subdistrict, JFK relied on not normal circumstances to support the need for its proposal, including the following: delays in admitting patients arriving through the emergency room to inpatient beds, delays in moving patients from surgery to recovery to acute care beds, and seasonal variations in occupancy exceeding optimal levels and, at times, exceeding 100%.

10. Good Samaritan and St. Mary's oppose JFK's CON application. In general, these Petitioners claimed that other problems cause overcrowding in the emergency room at JFK, that the type of beds proposed will not be appropriate for the needs of most patients, that "seasonality" is not unique to or as extreme at JFK, and that a hospital-specific occupancy level below that set by rule cannot constitute a special or not normal circumstance. If JFK achieves the projected utilization, experts for Good Samaritan and St. Mary's also projected adverse financial consequences for those hospitals.

Rule 59C-1.038(5) - special circumstances

11. During the hearing, the parties stipulated that the numeric need for new acute care beds in the subdistrict is zero.

The rule for determining numeric need also includes the following provision:

> (5) 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 the hospital's average occupancy rate based on inpatient utilization of all licensed acute care beds is at or exceeds 80 percent. The determination of the average occupancy rate shall be made based on the average 12 months occupancy rate for the reporting period specified in section (4). Proposals for additional beds submitted by facilities qualifying under this subsection shall be reviewed in context with the applicable review criteria in section 408.035, F.S.

12. The applicable time period for the special circumstances provision is calendar year 1997. JFK's reported acute care occupancy was 76.29% in 1997, and 79.7% in 1998, not 80%, as required by the rule.

13. JFK and AHCA take the position that other special circumstances may, nevertheless, be and have been the basis for the approval of additional acute care beds. JFK also maintained that the reported average occupancy levels understated the demand for and actual use of its inpatient beds.

14. Due to seasonal fluctuations caused by the influx of winter residents, JFK reached or exceeded 100% occupancy on 5 or 6 days, exceeded 80% occupancy on 20 days, and averaged 90.9% occupancy, in January 1999. In February 1999, the average was 96.5%, but was over 100% on 8 days, and over 90% on 25 days. In March 1999, the average occupancy was 90.1%, but exceeded 100% on

one day, and 90% on 17 days. In recent years, the "season" also has extended into more months, from approximately Thanksgiving to Easter or Passover. It also includes flu season which disproportionately affects the health of the elderly. JFK also demonstrated that occupancy varies based on the day of the week, generally highest on Mondays, Tuesdays, and Wednesdays and lowest on weekends.

15. JFK's acute care beds were also occupied by patients who were not classified as 24-hour medical/surgical inpatients. Others included observation and 23-hour patients, covered by Medicare or health maintenance organizations (HMOs). Some of those patients were classified initially as outpatients to lower reimbursement rates, but routinely subsequently reclassified and admitted as inpatients. In fact, during the applicable time period for determining occupancy, Medicare allowed patients to be classified as outpatients for up to 72-hour hospital stays. Subsequently, Medicare reduced the allowable hospital stay to 48 hours for all "outpatients," according to AHCA's expert witness. When not classified as inpatients, patients are not counted in average occupancy rates which are based solely on the admitted inpatient census, counted each midnight. For example, in February 1999, the average daily census for 23-hour patients was 10.8 patients, which, when combined with 24-hour patients, results in an average occupancy of 99.7% for the month. Due to the Medicare classification system, some but not all of the so-

called 23-hour patients affect the accuracy of the inpatient utilization data. According to AHCA's expert witness, however, numeric need cannot be determined because of JFK's failure to quantify the number of Medicare patients who actually affected the acute care bed utilization.

16. The 23-hour or observation patients may use, but do not require CON-approved and licensed acute care beds. Instead, those patients may be held in either non-CON, non-licensed "observation" beds or in licensed acute care beds. As AHCA determined, to the extent that 23-hour patients in reality stayed longer, and adversely affected JFK's ability to accommodate acute care patients, their presence can be considered to determine if special circumstances exist. Combining 24-hour and 23-hour patients, JFK experienced an occupancy rate of 80% in 1996, and 85.7% in 1997. While some of the 23-hour patients were, in fact, outpatients who should not be considered and others stayed from 24 hours up to 3 days and should be considered, JFK's proportion of Medicare services is important to determining whether special circumstances based on acute care utilization exist. With 74% of all JFK patients in the Medicare category, but without having exact numbers, it is more reasonable than not to conclude that the occupancy level is between the range of 76.29% for acute care only and 85.7% for acute care and 23-hour patients. A reasonable inference is that JFK achieved at least 80% occupancy of patients who were in reality inpatients in its acute care beds in 1997.

The expert health planner for the Petitioners conceded that bed availability declines, capacity is a constraint, and high occupancy becomes a barrier to service at some level between 80 and 83% occupancy. In a prior CON filed on behalf of Good Samaritan for a 4-bed addition to an 11-bed neonatal intensive care unit (NICU), the same expert asserted that 76% occupancy was a reasonable utilization standard. That occupancy level was based on the desire to maintain 95% bed availability. An exact comparison of the occupancy levels in this and the NICU case, however, is impossible due to the small size of the NICU unit and the fact that the applicant met the occupancy level in that rule for special circumstances.

17. The statistical data on the number patients actually using acute care beds at JFK in excess of 24-hours despite their classification, supports its claim of overcrowding.

Emergency Room Conditions

18. JFK described overcrowding in its emergency department as another special circumstance creating a need for additional acute care beds.

19. The emergency room at JFK has 37 bays each with a bed and another 15 to 17 spaces used for stretchers. Eighteen parking spaces are reserved for ambulances in front of the emergency department.

20. It is not uncommon for a patient to wait in the JFK emergency room up to 24 hours after being admitted to the

hospital, before being moved to an acute care bed. In February 1999, after having converted 10 substance abuse beds to acute care beds in October 1998, JFK still provided 234 patient days of acute care in the emergency department. The waiting time for patients to receive a bed after being admitted through the emergency department ranged from 10 hours to 5 days in the winter, and from an average of 6 hours up to 24 hours in the summer. While JFK claims that the quality of care is not adversely affected, it does note that patient privacy and comfort are compromised due to the noise, lights, activity, and lack of space for visitors in the emergency room.

21. JFK's patients tend to be older and sicker than the average. As a result, more patients arriving at its emergency room are admitted to the hospital. In the winter of 1998, JFK was holding up to 35 acute care inpatients at a time in the emergency room. Nationally, from 15% to 20% of emergency room patients are admitted to hospitals. By contrast, almost twice that number, or one-third of JFK's emergency room patients become admitted inpatients.

22. Emergency room admissions are also a substantial number of total admissions at JFK. In calendar year 1998, slightly more than 65% of all inpatient admissions to JFK arrived through the emergency room, most by ambulance. Ambulance arrivals at any particular hospital are often dictated by the patient's condition, with unstable patients directed to the nearest

hospital. Once patients are stabilized in the emergency room at JFK, those requiring obstetric, pediatric, or psychiatric admissions are transferred from JFK which does not provide those inpatient services. Emergency room patients in need of acute care services provided at JFK, like the neonates at issue in the prior Good Samaritan application, are unlikely candidates for transfer

23. The emergency room at JFK receives up to 50,000 patient visits a year, up from approximately 32,000 annual visits five years ago. JFK operates one of the largest and busiest emergency departments in Palm Beach County. Due to overcrowding in the emergency department at Delray Hospital, in southern Palm Beach County, patients have been diverted to other facilities, including JFK.

24. In terms of square footage, JFK's emergency room does not meet the standards to accommodate the 52 to 54 bays and stretchers and related activities. JFK lacks adequate space for support services which should also be available in the emergency department. The Petitioners asserted that enlarging the emergency room will alleviate its problems. JFK demonstrated, however, that regardless of the physical size of the emergency room, optimal patient care requires more capacity to transfer patients faster to acute care beds outside the emergency department.

Conditions in Other Departments

25. Of 343 operational beds at JFK at the time of the final hearing, 290 were monitored or telemetry acute care beds, 30 were critical care beds, and 23 were non-monitored, non-critical care beds. Most of the monitored beds are in rooms equipped with antennae to transmit data from electrodes and monitors when attached to patients. When monitoring is not necessary, the same beds are used by regular acute care patients.

26. The large number of monitored beds located throughout the hospital in various units reflects JFK's largely elderly population and specialization in cardiology. In 1998, 820 inpatient cardiac catheterizations (caths) were performed at JFK. Petitioners Good Samaritan and St. Mary's transferred 90 and 28 of those cath patients, respectively to JFK. In the first five months of 1999, 449 caths were performed, including procedures on 35 patients transferred from Good Samaritan and 16 from St. Mary's. Cath lab patients are held in the lab longer after their procedures when beds are not available in cardiac or the post-anesthesia care units. The Petitioners suggested that cath lab patients could be placed in a 12-bed holding area added to the lab in July 1999; however, that space was expected to be filled by patients being prepared for caths. Open heart surgery is available in Palm Beach County at three hospitals, Delray, JFK and Palm Beach Gardens. Patients admitted to JFK for other

primary diagnoses often require cardiac monitoring even though they are not in a cardiac unit.

27. The additional 24 beds which were under construction at the time of the final hearing will also be monitored beds. The 20 beds at issue in this proceeding will not be monitored. The Petitioners questioned whether non-monitored beds will alleviate overcrowding at JFK where so many patients require monitoring.

28. JFK physicians in various specialties testified concerning conditions in other areas of the hospital. A nephrologist, who consults primarily in intensive care units, described the backlog and delay in moving patients from intensive care into acute care beds. A cardiologist noted that patients are taking telemetry beds they do not need because there is no other place to put them. A general and vascular surgeon described the overcrowding as a problem with the ability to move patients from more to less intensive care when appropriate. Elective surgeries have been delayed to be sure that patients will have beds following surgery. The evidence presented by JFK supports the conclusion that the additional acute care beds will assist in alleviating overcrowding in other hospital units, including backlogs in the existing monitored beds.

29. JFK has established as factual bases for special circumstances that its high occupancy exceeds the optimal much of the year, aggravated by seasonal fluctuations; that it has relatively large emergency room admissions over which it has no

control; and that its intensive care and monitored beds are not available when needed.

Number of Beds Needed

30. With the conversion, in 1998, of 10 substance abuse beds to acute care beds and the 1999 construction of 24 of 40 additional beds requested by JFK, the number of licensed and approved beds at JFK increased to 367. In addition, with CON-exemption, JFK has added observation beds. As a result of AHCA's partial approval of the previous JFK request for new construction and due to unfavorable changes in Medicare reimbursement policies for hospital-based SNUs, JFK now seeks this 20-bed conversion. JFK ceased operating the SNU in October 1998, after Medicare reimbursement changed to a system based on resource utilization groups (RUGs). JFK was unable to operate the SNU without financial losses, that is, unable to cover its patient care costs under the RUGs system. The proposal to convert the beds back to acute care, as they were previously licensed will allow JFK to reconnect existing oxygen lines in the walls and to use the beds for acute care patients. Although Good Samaritan and St. Mary's suggested that JFK can profitably operate a SNU, there was no evidence presented other than its previous occupancy levels which were very high, and the fact that Columbia is not closing all of its SNUs. The Petitioners also question JFK's ability to use its SNU beds for acute care and/or observation patients. AHCA, however, took the position that acute care licensure is required

for beds in which acute care patients are routinely treated. Otherwise, the agency would not have accurate data on utilization, bed inventory, and the projected need.

31. In order to demonstrate the number of beds needed, JFK's expert used historical increases in admissions. Some admissions data was skewed because the parent corporation, Columbia, closed Palm Beach Regional in 1996, and consolidated its activities at JFK. Excluding from consideration the increase of 3,707 admissions from 1995 to 1996, JFK's expert considered approximately 800 as reasonable to assume as an average annual increase. That represents roughly the mid-point between the 1996 to 1997 increase of 605, and the 1997 to 1998 increase of 1,076 admissions. A projected increase of 800 admissions for an average 5-day length of stay would result in an increase of 4,000 patient days a year which, at 80% occupancy, justifies an increase of 14 beds a year. Considering the closing of Palm Beach Regional, the number of beds in the subdistrict will have been reduced by 170.

32. At the hearing, JFK's expert also relied on 3.3% annual patient day increase to project the number of beds needed, having experienced an increase of 5.8% from 1997 to 1998. Using this methodology, JFK projected a need for 20 additional acute care beds by 2002, and over 40 more by 2004. That methodology assumed patient growth in the excess of population growth and, necessarily, an increase in market share. JFK's market share

increased in its primary service area from approximately 19% in 1993 to 27% in 1997. But the market share also slightly declined from 1997 to 1998.

33. AHCA's methodology for determining the number of beds needed was based on the entire population of Palm Beach County, not just the more elderly southern area. It also assumed that JFK's market share would remain constant. Using this more conservative approach than JFK, AHCA projected a need for 383 acute care beds, or 16 beds added to the current total of 367 licensed and approved beds, at an optimal 75% occupancy by the year 2004. AHCA relied on a projection of 104,959 total patient days in 2004. Using the same methodology, JFK's expert determined that total projected patient days for 1998 would have been 94,225, but the actual total was 98,126 patient days.

34. AHCA's methodology underestimates the number of beds needed, but does confirm that more than 16 additional beds will be needed by 2004. AHCA's reliance on 75% as an optimal future occupancy level as compared to the hospital-specific historical level of 80% was criticized, as was the use of the year 2004 as a planning horizon. The rule requires 80% occupancy for a prior reporting period and does not establish any planning horizon.

35. Good Samaritan and St. Mary's used 80% occupancy in their analysis of bed need. At 80% occupancy, Petitioners projected an average daily census of 265 patients in 331 beds in 2001, or 268 patients in 334 beds in 2002, and 270 patients in

358 beds in 2003, as compared to 367 existing and approved beds. The Petitioners' projection is an underestimate of bed-need based on the actual average daily census of 269 patients in 1998. The Petitioners' methodology erroneously projects a need for fewer licensed beds than JFK has currently, despite the special circumstances evincing overcrowding. At 80% occupancy, based on the special circumstances rule, a hospital exceeds the optimal level and needs more beds. But, according to the Petitioners, 80% is a future occupancy target for the appropriate planning horizon of 2002. As AHCA's expert noted, it is illogical to use 80% as both optimal and as an indication of the need for additional beds. Similarly, it is not reasonable to use a planning horizon which coincides with the time when more beds will be needed. Therefore, the use of 75% for the five-year planning horizon of 2004 is a reasonable optimal target, as contrasted to the need for additional beds when 80% occupancy is reached at some future time beyond the planning horizon.

36. AHCA's underestimate of need at 16 more beds by 2004, and JFK's overestimate of need at 40 more beds by 2004, support the conclusion that the requested addition of 20 beds in this application is in a reasonably conservative range.

Rule 59C-1.038(6)(a) and Subsection 408.035(l)(n) - service and commitment to medically indigent; and Rule 59C-1.038(6)(b) - conversion of beds

37. Rule 59C-1.038(6), Florida Administrative Code, also includes the following criteria:

> (a) Priority consideration for initiation of new acute care services of capital expenditures shall be given to applicants with documented history of providing services to medically indigent patients or a commitment to do so.
>
> (b) When there are competing applications within a subdistrict, priority consideration shall be given to the applications which meet the need for additional acute care beds in a particular service through the conversion of existing underutilized beds.

38. Subsection (a) of the Rule, overlaps with District 9 health plan allocation factor one, which must be considered pursuant to Subsection 408.035(1)(a), and with the explicit criterion of Subsection 408.035(1)(n), Florida Statutes. All three require a commitment to and record of service to Medicaid, indigent and/or handicapped patients.

39. JFK agreed to have its CON conditioned on 5% of the care given in the 20 new beds to Medicaid and charity patients. The commitment for the 24 beds under construction is 3% for Medicaid and charity patients.

40. If charity patients are defined as those with family incomes equal to or below 150% of federal poverty guidelines, JFK provided $2.9 million in charity care in calendar year 1998, and $720,000 as of April for 1999. JFK provided an additional 3% to 5% in Medicaid care. The Medicaid total includes Palm Beach County Health Care District patients, who are also called welfare patients. The charity care provided by JFK is equivalent to approximately 1% of its gross revenue. JFK explained its

relatively low Medicaid care as a function of its relatively limited services for people covered by Medicaid, particularly, the young who utilize obstetrics and pediatrics. JFK pointed to the differing demographics in Palm Beach County with more elderly, who have Medicare coverage, located in its primary service area. Excluding pediatric and obstetric care, Medicaid covered 6.7% of patients in southern Palm Beach County as compared to 16.3% in northern Palm Beach County. Of the Medicaid patients, 2.9% in the southern area as compared to 6% in the northern area are adults. On this basis, JFK established the adequacy of its historical Medicaid and indigent care, and of its proposed commitment.

41. Subsection (6)(b) of Rule 59C-1.038 is inapplicable when, as in this case, there are not competing applications to compare.

Subsection 408.035(1)(a) - other local health plan factors and Subsection 408.035(1)(o) - continuum of care

42. District 9 allocation factor 2, favoring cost containment practices, is enhanced by the proposed conversion rather than the new construction of beds. Within the Columbia group of hospitals, there is an effort to avoid unnecessary duplications of services. JFK caters to an elderly population and to providing cardiology, neurology, and oncology services. Columbia's Palms West provides pediatric and obstetric care. Another Columbia facility in Palm Beach County, Columbia Hospital, specializes in inpatient psychiatric services. The

elimination of the hospital-based SNU at JFK does eliminate one level of care in the system, contrary to the criteria.

43. District 9 health plan allocation factor 3 requires favorable consideration of plans, like JFK's, to convert unused or underutilized beds. In this case, the JFK SNU was highly utilized but unprofitable. There is no evidence that alternative placements in free-standing nursing homes are inappropriate or unavailable. Minor inefficiencies result from the time lag for transfers during which skilled nursing patients remain in acute care beds. To some extent, the inefficiencies were already occurring while JFK operated the SNU due to its high average census of 18 or 19 patients in a total of 20 SNU beds. Those inefficiencies are outweighed by the low cost conversion of 20 beds for $117,000, particularly as compared to its prior 24-bed construction for $4 million.

44. In general, the applicable local health plan allocation factors support the approval of the JFK application.

Rule 59C-1.030 - needs access for low income, minorities, handicapped, elderly, Medicaid, Medicare, indigent or other medically underserved

45. In general, the proposal is intended to increase access to JFK's services by decreasing waiting times for admissions. The services are used by a large number of elderly patients, who are primarily covered by Medicare. JFK demonstrated that the population in its service area also tends to be wealthier than the population in northern Palm Beach County. Medicaid and

indigent access to care at JFK is consistent and reasonable given the demographic data presented. Access for elderly Medicare patients will be enhanced by the proposal.

Subsection 408.035(1)(b) - accessibility, availability, appropriateness, and adequacy of like and existing services

46. Good Samaritan and St. Mary's argue that hospitals below 75% occupancy are available alternatives to JFK's patients. Yet, those facilities are not viable alternatives for unstable patients admitted through the emergency room. Neither is it appropriate to transfer patients who need services provided at JFK. JFK does not allege that any problems exist at other facilities, but only that it is affected by special circumstances. From January to June 1998, the closest hospitals to JFK experienced wide-ranging occupancy levels from 92% at Delray, the hospital with services most comparable to those at JFK, to 57% at Bethesda, and 47% at Wellington. The wide range in occupancy rate is further indication of uniqueness of the need for patients to access services available only at Delray and JFK.

Subsection 408.035(1)(d) - outpatient care or other alternatives

47. Admitted inpatients have no alternatives to their need for acute care beds.

Subsection 408.035(1)(h) - alternative use of resources and accessibility for residents

48. The continued use of the 20 beds as a SNU was suggested as an alternative. As noted, however, that proved to be

financially unprofitable at JFK, in comparison to the low cost conversion to acute care beds.

49. AHCA reasonably rejected the idea that of the beds being designated "observation" beds when used for acute care patients. In addition, in 1996, JFK estimated the cost of moving patients from bed to bed in the hospital due to the shortage of appropriate beds, when needed, at up to $1 million.

50. This project is intended to meet a facility-specific need based on the demand for services at JFK from patients who cannot reasonably initially be sent or subsequently transferred to other hospitals. As such, JFK's additional beds do not meet the criterion for accessibility for all residents of the district.

Subsection 408.035(1)(i) - utilization and long-term financial feasibility

51. Good Samaritan and St. Mary's contend that JFK's proposal includes unrealistically high utilization projections for the additional 20 beds. Using 98,000 patient days in 1998, which excludes any days attributable to skilled nursing beds, total utilization projected in the second year is 78.4%. For the additional 20 beds, projected utilization is 77.4%.

52. The expert for Good Samaritan and St. Mary's disagreed with the allocation of patient days between the existing and additional beds. If 80% utilization is assigned to existing 367 beds, as he suggested, then the average annual occupancy of the 20 new beds would be only 50%. The financial break-even point

for the project, however, is 50 to 75 patient days, or 10 to 15 patients with average lengths of stay of 5 days. Therefore, even with the lower projected occupancy of 50%, or an average of 10 beds at any time, the project is financially feasible in the long-term.

53. In reality, a separate allocation of patient days to the 20 new beds is somewhat arbitrary. It is also less important than total projected utilization, since the 20 beds do not represent a separate unit in which specialized services will be provided. The additional beds will become a part of the total medical/surgical inventory. By demonstrating that there will be sufficient total occupancy to exceed the financial break-even point in the newly converted beds regardless of the allocation of patient days to any particular bed, JFK demonstrated the long-term financial feasibility of the proposal for CON 9099.

Subsection 408.035(1)(l) - impact on costs; effects of competition

54. If the JFK proposal is approved, Good Samaritan anticipates a loss of 255 patients, or 1,392 patient days, which is equivalent to a financial loss of over $1.5 million. St. Mary's anticipates losses of 158 patients or 973 patient days, and in excess of $1 million. Both hospitals were experiencing overall operating losses in 1999. But, the estimates of financial losses for both hospitals did not take into consideration all of the expense reductions associated with serving fewer patients.

55. Excluding pediatrics and obstetrics, which are not available at JFK, JFK's overlapping service areas with Good Samaritan and St. Mary's are minimal. Good Samaritan's market share in JFK's primary service area is 4.8%, and St. Mary's is 9.3%. Pediatrics and obstetrics contribute 30.7% of total patients at Good Samaritan, and 49.5% at St. Mary's.

56. Physician overlap among the hospitals is also limited. Although 357 doctors admitted patients to JFK and 464 to St. Mary's in the first two quarters of 1998, the number of overlapping doctors was 28. With a total of 379 admitting doctors at Good Samaritan for the same period of time, only 21 were included in JFK's 357 admitting physicians. In general, doctors in the northern Palm Beach County acute care subdistrict seldom admit patients to hospitals in the southern subdistrict, and vice versa.

57. The absence of overlapping medical staff also reflected the differences in the services. Most of the top twenty doctors who admitted patients to Good Samaritan and St. Mary's were obstetricians and pediatricians. When obstetricians and pediatricians are excluded, the number of overlapping doctors for JFK and Good Samaritan is reduced to 15, and for JFK and St. Mary's to 22.

58. In addition to providing different services, to different areas of the County, doctors who practice primarily in one or the other subdistrict served patients in different payor

classification mixes. In 1997, JFK's patients were 74% Medicare, consistent with the fact that a larger percentage of elderly patients live in JFK's service area. By contrast, Medicare patients were approximately 48% of the total at Good Samaritan, and 32% of the total at St. Mary's.

59. Historically, the addition of acute care beds at JFK has not affected other hospitals in the district or even the same acute care subdistrict. After the conversion of 10 substance abuse beds in the fall of 1998, the acute care patient days at every hospital in the same subdistrict increased in early 1999 over comparable periods of time in 1998.

60. The assumption that additional beds at JFK will take patients from other hospitals includes the assumption that JFK will draw a larger share of an incremental increase of patients. The assumption is, in other words, that all patients will be new to JFK. The expert health planner for Good Samaritan and St. Mary's conceded that facility-specific overcrowding can justify projections that the additional beds will accommodate the existing census plus growth attributable to increasing population, and will not generate new patients. The expert assumed, nevertheless that from 1478 to 1486 new patients (depending on whether the length of stay is rounded off) would be associated with JFK's project. From that total, the proportional losses allocated were 255 patients from Good Samaritan and 158 patients from St. Mary's.

61. Another underlying assumption increase is that all of the new patients would go to other hospitals if JFK does not add 20 acute care beds. That assumption suggests that all of the patients could receive the services they need at the other facilities, which is not supported by the facts or current utilization data.

62. More likely, with the addition of beds due to overcrowding, some patients will come from the existing hospital census at JFK. It is not reasonable to assume that JFK will have all new patients, nor that all patients could be treated at other hospitals in the absence of JFK's expansion. The proportion of emergency room admissions at JFK is reasonably expected to continue. Patients who arrive at JFK requiring open heart surgery, angioplasties or invasive cardiac caths are reasonably expected to continue to receive those services at JFK, including patients who are transferred to JFK from Good Samaritan and St. Mary's.

63. Based on the failure to support the assumptions, and the differences in service areas, medical staff, specialties, and patient demographics, Good Samaritan and St. Mary's have not shown any adverse impact from the JFK proposal.

64. On balance, considering the statutory and rule criteria for reviewing CON applications, JFK established, as a matter of fact, that it meets the special circumstance criteria related to emergency room admissions, pre- and post-surgical and intensive

care backlogs, and average annual occupancy projections in excess of optimal levels.

CONCLUSIONS OF LAW

65. The Division of Administrative Hearings has jurisdiction in this proceeding pursuant to Sections 120.569 and 120.57(1), Florida Statutes, and Section 408.039(5), Florida Statutes.

66. As the applicant, JFK has the burden of demonstrating its entitlement to a CON, based on a balanced consideration of the criteria. Boca Raton Artificial Kidney Center v. Department of Health and Rehabilitative Services, 475 So. 2d 260 (Fla. 1st DCA 1985); Florida Department of Transportation v. J. W. C., Co., 396 So. 2d 778 (Fla. 1st DCA 1981).

67. The special circumstances provision of the acute care rule applies, in the absence of numeric need, as follows:

> (5) 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 the hospital's average occupancy rate based on inpatient utilization of all licensed acute care beds is at or exceeds 80 percent. The determination of the average occupancy rate shall be made based on the average 12 months occupancy rate for the reporting period specified in section (4). Proposals for additional beds submitted by facilities qualifying under this subsection shall be reviewed in context with the applicable review criteria in section 408.035, F.S.

Rule 59C-1.038(5), Florida Administrative Code

68. Special circumstances, recognized by AHCA, have included seasonal high occupancy levels and unusually large emergency room admissions. Humana of Florida, Inc. v. AHCA and Adventist Health System/Sunbelt, Inc., d/b/a East Pasco Medical Center, 17 FALR 2538, DOAH Case No. 92-1497 (F.O. 6/3/93).

69. The experience in the emergency room and other specialized units at JFK distinguishes the facts from those cases in which seasonal occupancy alone was rejected as a special circumstance for approval of a CON. Some of those decisions include the explanation that seasonal occupancy fluctuations are common at Florida hospitals and is included in a calculation of average annual occupancy. Naples Community Hospital v. AHCA and Southwest Florida Regional Medical Center, 15 FALR 2615, DOAH Case No. 92-1510 (F.O. 6/6/93); Leesburg Regional Medical Center v. Department of Health Rehabilitative Services and Lake Community Hospital, DOAH Case No. 83-156 (R.O. 12/15/83).

70. As Good Samaritan and St. Mary's correctly indicated, however, the applicant in the East Pasco case met the facility-specific occupancy level of the acute care rule, which was 75%, at that time. In fact, while acknowledging seasonal occupancy exceeding 100%, and 55% (twice the national average) of inpatient admissions from the emergency department, AHCA's conclusions of law include the following statement:

> "A threshold requirement under (7)(e) is that the applicant-hospital must have an average annual occupancy exceeding seventy-five percent (75%)."

17 FALR at 2547.

71. AHCA goes on to note that "East Pasco's occupancy of 78.7% allowed it to seek approval under (7)(e)." That language in East Pasco, supports a conclusion that the failure to achieve the facility-specific occupancy level in the rule bars further consideration of special circumstances.

72. Similarly, in Bethesda Memorial Hospital, Inc. v. NME Hospital, Inc., d/b/a Delray Community Hospital and AHCA, 18 FALR 2330 (1996), DOAH Case No. 95-0730 (F.O. 12/18/95), Delray received a CON to add 24 acute care beds. Among the special circumstances at Delray were occupancy rates ranging from 80 to 128% in its intensive care units, while 75 to 80% was considered reasonable. Delray was also a trauma center with an active emergency room, and a "cardiac" hospital in a service area of more elderly people. Unlike JFK in the present case, Delray, like East Pasco, exceeded the special circumstances hospital-specific occupancy. Delray reported 75.63% to average annual occupancy at the same time the rule set the requirement at 75%.

73. JFK and AHCA rely on the decision in Sarasota County Public Hospital Board v. Department of Health Rehabilitative Services, 11 FALR 6248, DOAH Case Nos. 89-1412 and 89-1413 (F.O. 11/17/89) to argue for a consideration of "reality in the CON process," meaning, in this case, whether the proposal meets the requirements based on a consideration of the actual acute care occupancy rate. In South Broward Hospital District v. AHCA and

Plantation General Hospital, L.P., FALR 1995 WL 1052639, DOAH Case No. 93-4881 (F.O. 6/15/95), AHCA rejected the conclusion that unused licensed beds (which could easily be put back into service) should be omitted from the inventory but, in so doing, allowed evidence related to the accuracy of the reported utilization. In considering what is reality in this case, AHCA's expert took the position, consistent with the rules that observation and 23-hour patients are not acute care inpatients because they are not admitted for 24-hour stays; but, the expert also testified in support of the approval of the application for 20 beds. That position was advanced without her apparently subsequent concession that some portion of the combined 23- and 24-hour data, based on Medicare policy, would most likely be inpatients. Deposition of Elfie Stamm at pps. 77 and 89 (6/21/99).

74. The rules give some direction for determining the meaning of "inpatient" and "acute care bed" as used in the rule which provides that "occupancy rate [is] based on inpatient utilization of all licensed acute care beds." Rule 59C-1.038(5), Florida Administrative Code. For example, an acute care bed is defined in the CON Section of the Florida Administrative Code, as follows:

> "Acute care bed" means a patient accommodation or space licensed by the agency pursuant to Chapter 395, Part I, F.S., and regulated under Rule 59C-1.038, F.A.C. Acute care beds exclude neonatal intensive care beds, comprehensive medical rehabilitation

> beds, hospital inpatient psychiatric beds, hospital inpatient substance abuse beds, beds in distinct part skilled nursing units, and beds in long term care hospitals licensed pursuant to Chapter 395, Part I, F.S.

Rules 59C-1.002(2) and 59C-1.038(2)(a), Florida Administrative Code. In rules establishing a hospital uniform reporting system and data collection requirement, AHCA has adopted the following definitions:

> (1) "Acute care" means inpatient general routine care provided to patients who are in an acute phase of illness, which includes the concentrated and continuous observation and care provided in the intensive care units of an institution.

Rule 59E-7.011(1), Florida Administrative Code.

> (4) 'Inpatient' means a patient who has an admission order given by a licensed physician or other individual who has been granted admitting privileges by the hospital. This shall include obstetric patients who experience a length of stay of twenty-four hours or less. Short stay and observation patients are excluded.

Rule 59E-7.011(4), Florida Administrative Code.

> (16) "Inpatient admission" means a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient if formally admitted by the hospital as an inpatient by physician order with the expectation that the individual would remain at least overnight and occupy a bed.

Rule 59E-5.101(16), Florida Administrative Code. The rules support the inclusion of all patients who were expected to remain overnight in beds not in the categories excluded in the

definition of an acute care bed. Therefore, Medicare patients who are classified as outpatients or 23-hour patients but who otherwise meet the definition of inpatients are properly considered in the utilization data.

75. The health planning experts testified that just over 80% occupancy in acute care indicates the need for additional beds. That position supports AHCA's expert's position, as articulated for the agency, that:

> If your beds are at 80 percent or more then our interpretation, and I think the Court's interpretation has been that then you're automatically entitled to additional beds.

Deposition of Elfie Stamm, at p. 52 (6/21/99).

76. There are no cases cited in this record which support AHCA's expert's conclusion regarding court interpretations. The expert's opinion that valid health care principles support AHCA's position that 80% is a standard which more likely than not tends to indicate additional need is accepted principles and the 1997 rule change increasing hospital-specific occupancy from 75% to 80% distinguish this case from those in which AHCA held that 75% was a threshold requirement. AHCA is not required to interpret the rule in a manner which results in illogical or unintended consequences. See Sarasota County Public Hospital, supra.

77. Having proved that it more likely than not exceeded 80% occupancy in 1997, based on the range of acute care only and actual acute care bed utilization, JFK met the requirement of the rule related to facility-specific occupancy.

78. Independently of meeting the rule occupancy requirement, JFK demonstrated (1) the large number of patients admissions through its emergency room and, (2) the backlog of patients in more intense care, monitored beds are special circumstances.

79. Other statutory and rule criteria include those stipulated, in Subsections 408.035(1)(e), (f), (g), (h) - as related to training health professionals, (j), (k), and (2), Florida Statutes, as not at issue or not applicable to this proposal.

80. JFK's historical and proposed commitment to Medicaid and indigent patients, and its level of Medicare service meet the requirements of the local health plan, Rule 59C-1.030, Rule 59C-1.038(6)(a), and Subsection 408.035(1)(a) criteria.

81. In general, JFK meets the local health plan goals for Medicaid/indigent care, conversion of beds, and non-duplication of services, as required by Subsection 408.035(1)(a). The proposal reduces the continuum of care at JFK, and is inconsistent with Subsection 408.035(1)(o).

82. JFK established that Good Samaritan and St. Mary's, and other hospitals in the district are not accessible, appropriate, or adequate for the types of patients at JFK, due to distinct markets, service areas, and medical staff. As a result of the large proportion of patients arriving by ambulance at JFK, there are no visible alternatives to JFK's proposal, which is

consistent with the need criteria of Subsections 408.035(1)(b) and (d).

83. JFK demonstrated its resources should be used for the conversion of skilled nursing to acute beds. JFK did not demonstrate that its services in new beds will be accessible to all residents, and therefore, only partially satisfies the criteria at issue in Subsection 408.035(1)(h).

84. JFK demonstrated that it can achieve sufficient utilization, and that the proposal is financially feasible in the long term, as required in Subsection 408.035(1)(i).

85. JFK's proposal will not adversely impact costs or competition for acute care beds, in compliance with Subsection 408.035(1)(l). Having failed to demonstrate any adverse impact from the JFK proposal, Good Samaritan and St. Mary's have failed to demonstrate standing, as required by Subsection 408.039(5), Florida Statutes.

86. On balance, JFK's proposal satisfies the applicable CON criteria, and the addition of 20 beds is also justified by "not normal" or special circumstances.

RECOMMENDATION

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

1. That a final order be entered issuing CON 9099 to convert 20 skilled nursing beds to 20 acute care beds at Columbia/JFK Medical Center, L.P., d/b/a JFK Medical Center, on

condition that a minimum of 5% of new acute care patient days will be provided to Medicaid and charity patients.

2. The file of the Division of Administrative Hearings, DOAH Case No. 99-0714 is hereby closed.

DONE AND ENTERED this 7th day of April, 2000, in Tallahassee, Leon County, Florida.

ELEANOR M. HUNTER
Administrative Law Judge
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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.