STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

VITAS HEALTHCARE CORPORATION OF FLORIDA, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION and HEARTLAND SERVICES OF FLORIDA, INC., Respondents, and COMMUNITY HOSPICE OF NORTHEAST FLORIDA, INC., Intervenor.	)	Case No. 04-3856CON
COMMUNITY HOSPICE OF NORTHEAST FLORIDA, INC., Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, HEARTLAND SERVICES OF FLORIDA, INC., and VITAS HEALTHCARE CORPORATION OF FLORIDA, Respondents.	)	Case No. 04-3886CON

RECOMMENDED ORDER

These consolidated cases were heard by David M. Maloney, Administrative Law Judge of the Division of Administrative

Hearings, from February 21 through March 3, 2006, in Tallahassee, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

Vitas Healthcare Corporation of Florida, Inc., and Heartland Services of Florida, Inc., each filed applications with the Agency for Health Care Administration to establish a

new hospice program in Duval County, Hospice Service Area 4A, in the second batching cycle of 2004.

The issue in these consolidated cases is whether either, both or neither of the applications should be approved.

PRELIMINARY STATEMENT

On October 26, 2004, the Agency for Health Care Administration ("AHCA" or the "Agency") filed a notice with the Division of Administrative Hearings (DOAH.) The notice advised DOAH that AHCA had received a request for a formal administrative hearing from VITAS Healthcare Corporation of Florida, Inc. (VITAS or "VITAS the Applicant," see Finding of Fact 7., below.) The Agency requested DOAH to assign the matter to an administrative law judge and to conduct all proceedings required by law, including the submission of a recommended order to the Agency.

Attached to the notice was the Petition for Formal Administrative Hearing from VITAS. The petition referred to AHCA's preliminary decisions to deny the application of VITAS and to approve the application of Heartland Service of Florida, Inc. (Heartland).

It also referenced AHCA review of competing applications filed by Hospice of the Palm Coast, Inc. ("Palm Coast"), BayCare Home Care, Inc. ("BayCare") and Life Care Hospice, Inc. ("Life Care"), all of which had been preliminarily denied. VITAS

requested comparative review of its application with Heartland's and with Palm Coast, BayCare or Life Care should they seek administrative proceedings with regard to the denial of their applications.

As relief, VITAS requested that a DOAH administrative law judge recommend that its CON application for a new hospice in Duval County, Hospice Service Area 4A, be granted and all other applications comparatively reviewed with its application be denied, including Heartland's. As ultimate relief, VITAS requested that "AHCA adopt the Administrative Law Judge's factual findings and conclusions of law and issue final approval for its application to establish a new hospice program in Duval County, Service Area 4A." VITAS' Petition for Formal Administrative Hearing, p. 6.

Community Hospice of Northeast Florida, Inc. ("Community Hospice"), the provider of hospice services in Hospice Service Area 4A, Baker, Clay, Duval and Nassau Counties, also filed a petition with regard to the co-batched applicants subject to VITAS' petition. In its petition, Community Hospice alleged that its substantial interest in providing quality health care to hospice patients in the service area would be immediately, adversely and substantially affected if a final order is entered granting a CON to any one or more of the applicants. Community Hospice therefore requested that its petition be forwarded to

DOAH and consolidated with any petitions filed to challenge AHCA's initial decision regarding CONs 9782, 9783, 9784, 9785, and 9786 and that recommended and final orders be entered denying each of them.

The two petitions, assigned DOAH Case Nos. 04-3856CON and 04-3886CON, respectively, were subject to an Initial Order issued on October 27, 2004. The order designated the undersigned as the administrative law judge responsible for conducting the proceedings. The cases were consolidated[1] and set for hearing to commence in August of 2005.

Pursuant to a motion for continuance granted without objection, the case was re-scheduled for final hearing to commence on February 13, 2006. Pursuant to a request filed by Community Hospice, the case was rescheduled to commence one week later. Final hearing commenced on February 21, 2006, and ended on March 3, 2006.

Heartland proceeded first. It presented the testimony of six witnesses: Bruce Schroeder, assistant vice president of Manor Care, Inc.; Tara Brodbeck, assistant vice president and national hospice director for Heartland Home Health Care and Hospice, a subsidiary of Manor Care, accepted as an expert in hospice nursing, gerontological nursing, and hospice program development, operation and quality assurance; Deborah McMonagle, accepted as an expert in nursing and home health and hospice

operations; Sharon Gordon-Girvin, accepted as an expert in healthcare planning; Steven Jones, accepted as an expert in accounting and healthcare finance; and, Jeffrey N. Gregg, Chief of the Bureau of Health Facility Regulation at AHCA, accepted as an expert in CON review and health planning. Heartland offered 24 exhibits marked as Heartland Exhibit Nos. 1 (a composite of three volumes of Heartland's CON Application), 1A and 2-23. All were admitted into evidence.

VITAS proceeded next. It presented the testimony of seven witnesses: Deirdre Lawe, executive vice-president with VITAS Healthcare Corporation, accepted as an expert in nursing, hospice management and operations, and new hospice development; Sarah McKinnon, senior director of educational development with VITAS Healthcare Corporation and accepted as an expert in hospice education; Maureen Kramlinger, manager of bereavement services for VITAS Innovative Hospice Care of Central Florida, accepted as an expert in bereavement counseling, hospice chaplaincy, and hospice spiritual care; Ronald Fried, senior vice-president of development at VITAS Healthcare Corporation; Gary Miller, M.D., medical director of VITAS Healthcare Corporation's program in Central Florida, accepted as an expert in hospice and palliative care medicine; Lawrence Press, controller at VITAS Healthcare Corporation, accepted as an expert in healthcare accounting and finance; and Patricia

Greenberg, accepted as an expert in health planning, financial feasibility analysis, healthcare finance, and hospice operations.

VITAS offered 81 exhibits, marked for identification sequentially as VITAS 1-81. VITAS Exhibit No. 3 was subsequently withdrawn because it was a part of Heartland Exhibit No. 16. VITAS Exhibit No. 58 was rejected and proffered. The rest of VITAS' exhibits were admitted.

Community Hospice followed the cases-in-chief of Heartland and VITAS by presenting the testimony of 12 witnesses: Patrice C. Moore, accepted as an expert in hospice administration and operations; Susan Ponder-Stansel, president and CEO of Community Hospice; Dennis Ford, Ph.D, director of Neviaser Educational Institute at Community Hospice, an expert in hospice community and hospice professional education; Lee Ann Summersgill, community grief and loss manager at Community Hospice, accepted as an expert in bereavement, grief and loss; Annie Rini, program manager for the Community PedsCare program, accepted as an expert in pediatric nursing and pediatric palliative and hospice care; Mary Ella LeBlanc, community education manager at Community Hospice of Northeast Florida, an expert in community education; Cathy Jaeger, vice-president of patient care services at Community Hospice, accepted as an expert in hospice clinical and hospice administrative nursing;

Toula Wooten; Sherrie King, M.D., vice president of medical services at Community Hospice, accepted as an expert in hospice and palliative medicine and hospice medical direction; Lynne Mulder, accepted as an expert in healthcare planning; and Robert A. Beiseigel, accepted as an expert financial analyst and forensic financial analyst.

Community Hospice offered 59 exhibits at hearing and requested that official recognition be taken of four matters, two of which are on the DOAH website. Fifty-six of the exhibits were in notebooks produced by Community Hospice entitled "Community Hospice of Northeast Florida Inc.'s Exhibits." Pre-marked 1-56 by Community Hospice, the 56 exhibits were admitted. Official recognition was taken of two Community Hospice Exhibits: No. 58 (Recommended and Final Orders in Hope of Southwest Florida, Inc. vs. AHCA, et al., DOAH Case No. 03-3858CON, AHCA No. 2004009315) and No. 61 (Florida Administrative Code Rule 59C-1.0355.) Official recognition was also taken of the Recommended and Final Orders on the DOAH website in DOAH Case No. 03-4067 and the Recommended Order in DOAH Case No. 03-4066. Community Hospice also offered Exhibit No. 63, a composite exhibit composed of informational brochures and advertising and Exhibit No. 64, a Chemed Corporation graph. Both were admitted. Community Hospice Exhibit No. 66, the late-filed exhibit consisting of the deposition of Kathy Laporte, was

admitted into evidence and filed at DOAH on March 6, 2004, three days after the conclusion of the hearing.

Extensions of time were granted for the filing of proposed recommended orders. The parties all filed timely proposed recommended orders on June 30, 2006. This Recommended Order follows.

FINDINGS OF FACT

The Parties

a. AHCA

1. The Agency for Health Care Administration is designated by Section 408.034(1), Florida Statutes, "as the single state agency to issue . . . or deny certificates of need . . . in accordance with present and future federal and state statutes." Accordingly, it is the state agency responsible for issuing or denying the applications for certificates of need sought by Heartland and VITAS in this proceeding.

b. Heartland

2. Heartland is a subsidiary of Manor Care, Inc. ("Manor Care"), a company traded on the New York Stock Exchange. Manor Care through various subsidiaries operates approximately 279 nursing homes, 65 assisted living facilities, 89 rehabilitation clinics, and 94 home health agencies and hospices. To the extent these operations require buildings, Manor Care owns the majority of them.

3. While many companies offer one service or another of those offered by Manor Care, the company's ability to offer the variety of health care services in its portfolio enables it to provide continuum of care to its patients.

4. In Florida, Manor Care, through its subsidiaries, operates "just under 30 nursing homes, three . . . in the Jacksonville market." Tr. 31. It operates 11 assisted living facilities in Florida, 29 rehabilitation facilities (14 of which are in the Jacksonville area), and six home health operations.

5. Neither Heartland nor any of the healthcare companies with which it is affiliated through Manor Care operates a hospice program in Florida. But Manor Care operates 86 licensed hospice programs in the United States, the greatest number of any company operating hospices in the country. It commenced hospice operations in 1995 with approximately 58 patients; its hospice census at the time of hearing exceeded 5,600 patients.

6. Heartland's proposed hospice program will be similar to Manor Care's programs in other states, and Heartland will use Manor Care's considerable hospice experience outside of Florida to assist Heartland in operating the proposed hospice if its CON application is approved. Heartland's proposal to provide hospice services in the Jacksonville area, moreover, will offer the opportunity to enhance continuum of care for patients in the area who decide to choose Heartland for hospice in addition to

home health care, rehabilitation services or nursing home services.

c. VITAS

7. VITAS Healthcare Corporation of Florida, Inc., ("VITAS" or "VITAS the Applicant"), and the Petitioner in DOAH Case No. 04-3856CON, is a wholly-owned subsidiary of Vitas Healthcare Corporation ("VITAS the Parent.")

8. VITAS the Parent operates 39 hospice programs nationwide and provides services to more hospice patients than any other hospice provider in the country.

9. In 2004, VITAS the Parent merged with Comfort Care Holding, a subsidiary of Chemed Corporation (Chemed). As a result of the merger, VITAS the Parent became a wholly owned subsidiary of Chemed.

10. Chemed is a for-profit corporation that operates under the trade name Roto-Rooter and describes itself as North America's largest provider of plumbing and drain cleaning services. The acquisition of VITAS the Parent by Chemed was made to allow Chemed shareholders to realize 100% of the revenue and earnings of VITAS the Parent.

11. The Chemed acquisition was preceded by significant contributions of VITAS the Parent and its affiliates to the hospice movement in this country. A pioneer in the hospice movement, VITAS the Parent offered hospice services in Florida

more than 28 years ago. One of the first hospice programs in the country was a Miami-Dade program affiliated with VITAS the Parent. The program was organized by Huge Westbrook and Esther Colliflower, a Methodist minister and a nurse with an oncology background, respectively, who were both professors at Miami-Dade Community College teaching courses on death and dying issues.

12. VITAS the Parent was also instrumental in the development of hospice licensure standards in Florida and the establishment of the federal Medicare benefit for hospital services.

13. Over this three-decade stretch of time, VITAS the Parent has also been a leader in hospice research and development and has created pain management tools and hospice care manuals that are widely used by other hospice providers across the nation. For example, it developed the Missoula-VITAS quality of life index, licensed and used by over 150 hospices nationwide. The publication 20 Common Problems in End of Life Care was authored by employees of VITAS the Parent and is used as a textbook for delivery of hospice care.

14. In recent years, VITAS the Parent has provided hospice services to more hospice patients than any other hospice provider in the country. In 2004, VITAS programs admitted over 46,000 patients with an average daily census of 9,000. In 2005,

VITAS national admissions increased more than 8% to over 50,000 patients with an average daily census of over 10,000.

15. Provision of hospice services through VITAS the Parent's affiliates has expanded recently. In the past three years alone, 15 operational hospices affiliated with VITAS the Parent have been added. In the hospices operated around the country, all Medicare-certified, VITAS earned over $531 million in 2004, growing to over $600 million in 2005.

16. In Florida, affiliates of VITAS the Parent currently operate a number of licensed hospices. These include programs located in Miami-Dade County (Service Area 11), Broward County (Service Area 10), Palm Beach County (Service Area 9C), Orange, Osceola and Seminole Counties (Service Areas 7B and 7C), Brevard County (Service Area 7A), and Volusia and Flagler Counties (Service Area 4B).

17. Of licensed hospices operated in Florida by subsidiaries of VITAS the Parent, three are operated by VITAS the Applicant: one each in Dade, Broward, and Palm Beach County. VITAS the Applicant considers itself to be Florida’s largest hospice and the dominant existing licensed hospice provider in Florida. Whether all parties would agree with that characterization, there is no question about VITAS the Applicant's place among the subsidiaries of VITAS the Parent. VITAS the Applicant is the “major contributor of revenue to

Vitas Healthcare Corporation on a consolidated basis." Tr. 946. Described by the controller of VITAS the Parent as a "cash cow," VITAS the Applicant "makes VITAS [the Parent] as a whole a very healthy organization [financially]." Id.

18. In 2004, the hospice programs in Florida affiliated with VITAS the Parent collectively admitted more than 16,000 hospice patients. The average daily census for these programs was 3,500 with earnings of over $210 million.

19. All of the hospice programs affiliated with VITAS the Parent are in full compliance with Medicare conditions of participation and none have exceeded Medicare cost caps.

d. Community

20. Community Hospice of Northeast Florida ("Community" or "CHNF"), the Petitioner in DOAH Case No. 04-3886CON, is a not-for-profit Florida corporation, licensed by the State of Florida to operate Northeast Florida Community Hospice in Service Area 4A, serving Baker, Clay, Duval, Nassau and St. Johns Counties.

21. Community was established by a group of volunteers in 1978. Its mission is to improve the quality of life for hospice patients and families and to be the compassionate guide for end-of-life care in the community it serves. It has history of high quality of care, the breadth of which was demonstrated in multiple areas that included community education, bereavement, outreach, and pediatric hospice care. Community also operates a

separately licensed pharmacy and a durable medical equipment provider service.

22. Among the issues pled by CHNF's petition in DOAH Case No. 04-3886CON are the following:

> 15. Material issues of disputed fact to be resolved at hearing include, but are not limited to:
>
> * * *
>
> b. Whether Heartland's Application, and whether the CON Applications of any co-batched Applicant who files a Petitioner [VITAS], complies with the applicable criteria in Chapter 408, Fla. Stat., and Rules 59C-1.008, 59C-1.030 and 59C-1.0355, F.A.C.
>
> * * *
>
> 16. Community Hospice alleges that the specific statutes and rules at issue in this case include, but are not limited to, §408.035, §408.037, Fla. Stat., and Rules 59C-1.008, 59C-1.030, and 59C-1.0355, F.A.C.

Community Hospice of Northeast Florida, Inc.'s Petition for Formal Administrative Hearing, pp. 4-5.

Overview of Hospice Care

23. Hospice care is provided to patients who are terminally ill. As "end of life" care, it is entirely palliative; curative treatment is not a part of the hospice regimen. Hospice admission eligibility criteria require that the patient's condition be certified as terminal by an attending physician or hospice medical director with less than six months

to live and, of course, that the patient's wishes include hospice or palliative care services.

24. Hospice care is holistic. It provides physical, emotional, psychological and spiritual comfort and support to a dying patient and considers the patient and the patient's family to be a unit of care. Hospice services are provided by a team of professionals: physicians and nurses who provided skilled nursing care, home health aid services, social worker services, chaplain and religious counseling services and bereavement services for the family left of the patient after death.

25. Hospice care may be provided in location where a patient has lived or is temporarily residing such as a private home, family member's home, assisted living facility (ALF), nursing home, hospital or other institution.

26. There are four basic levels of hospice care: routine home care, general inpatient care, continuous care, and respite care.

27. The majority of hospice patients receive routine home care: care in their own residences whether it be their home, a family member's home, a nursing home, or an ALF. Routine home care comprises the vast majority of hospice patient days.

28. Continuous care is also provided in the patient's home. Unlike routine home care, continuous care is for emergency care or control of acute pain or symptom management.

The term "continuous" to describe this type of hospice care is something of a misnomer. Continuous care is typically intermittent but requires a minimum of 8 hours of one-on-one care in a 24-hour period with at least 50% of the care provided by a nurse. The continuous care patient usually has a higher level of acuity than the hospice patient that is receiving general inpatient care. Aside from the difference in acuity level, the continuous care patient is different from the patient receiving general inpatient care because the continuous care patient has made the choice to remain at home, despite the patient's need for emergent care, acute pain relief, or symptom management that is also appropriate in an inpatient setting.

29. As the term indicates, the hospice patient receiving general inpatient care is in an inpatient setting such as a hospital, the sub-acute unit in a nursing home or in a freestanding hospice unit. This type of care provides increased nursing care for patients with symptoms temporarily out of control and in need of round-the-clock nursing, although generally at a lower level of care than the continuous care hospice patient.

30. Respite care is provided to patients in an institutional setting such as a nursing home, ALF or a freestanding hospice unit in order to allow care givers at home,

such as family members, a short break or "respite" from the demands of caring for a terminally ill patient.

Medicare Reimbursement

31. Medicare provides reimbursement for hospice care and is by far the largest payer for hospice care. Medicare reimburses different rates for hospice based on each of the four basic levels of hospice care.

32. Hospice regulations consider certain hospice services to be "core services": nursing, social work, pastoral or other counseling, dietary counseling, and bereavement services.

Referral Sources

33. The main sources of referrals for hospice are hospitals, nursing homes, ALFs, and physician groups.

Stipulation

34. The Parties stipulated to the following:

> 1. AHCA published a fixed, numeric need for one new hospice program in District 4A for the first batching cycle of 2004. No challenges were filed to that published fixed need determination.
>
> 2. Vitas and Heartland each timely filed letters of intent, initial applications, and omissions responses proposing to establish a new hospice program in District 4A, in response to AHCA's published fixed need for one new program.
>
> 3. AHCA issued its State Agency Action Report preliminarily approving Heartland's CON application 9783, and preliminarily denying Vitas' CON application 9784. Notice

> of AHCA's decision was published in the September 10, 2004, *Florida Administrative Weekly*, Vol. 30, No. 37.
>
> 4. Community has a history of providing high quality hospice services in District 4A, and has standing in this proceeding. Heartland and Vitas each have the ability to provide high quality hospice services in District 4A, should their respective CON applications be approved. All parties reserve the right to present comparative evidence related to any party's quality of care.
>
> 5. All Parties agree that the project costs identified in Schedule 1 of each CON application are reasonable, appropriate, and are not in dispute or at issue in this proceeding.
>
> * * *
>
> 6. Heartland and Vitas each satisfy the CON review criteria contained in section 408.035(3) pertaining to ability of the applicant to provide quality of care and the applicant's record of providing quality of care.
>
> 7. The CON review criteria set forth in subsections 408.035(8)(cost and methods of proposed construction), and (10) (designation as a Gold Seal program nursing facility) are not applicable to this proceeding.

Agreed Joint Pre-hearing Stipulation, filed February 20, 2006.

Numeric Need in Service Area 4A

35. On April 29, 2004, AHCA published its determination that there is a fixed numeric need for one new hospice in Service Area 4A for the planning horizon at issue in this case.

The fixed need pool was calculated by AHCA using a fixed numeric need methodology for hospices.

36. The hospice numeric need methodology is found in Florida Administrative Code Rule 59C-1.0355 (the "Hospice Programs Rule"). Section (4) of the Hospice Programs Rule is entitled, "Criteria for Determination of Need for a New Hospice Program." It has several subsections, the first of which, subsection (a), bears the catch-line, "Numeric Need for a New Hospice Program." Subsection (a) sets out a particular need methodology for determining the numeric need for new hospice programs (the "Hospice Numeric Need Methodology").

The Hospice Numeric Need Methodology

37. Subsection (4)(a) of the Hospice Programs Rule, sets forth the Hospice Numeric Need Methodology. It is, in part, as follows:

> (4) Criteria for Determination of Need for a New Hospice Program.
>
> (a) Numeric Need for a New Hospice Program. Numeric need for an additional hospice program is demonstrated if the projected number of unserved patients who would elect a hospice program is 350 or greater. The net need for a new hospice program in a service area is calculated as follows:
>
> (HPH) - (HP) >= 350
>
> where:
>
> (HPH) is the projected number of patients electing a hospice program in the service

> area during the 12 month period beginning at the planning horizon.
>
> * * *
>
> (HP) is the number of patients admitted to hospice programs serving an area during the most recent 12-month period ending on June 30 or December 31. The number is derived from reports submitted under subsection (9) of this rule.
>
> 350 is the targeted minimum 12-month total of patients admitted to a hospice program.

Fla. Admin. Code R. 59C-1.0355.

38. Aside from the formula for calculating numeric need, quoted in the previous paragraph, the Hospice Numeric Need Methodology is quite detailed. It requires that a number of different values used by the methodology be determined prior to the calculation required by the numeric need formula. For example, it calls for assessments of the projected number of service area resident deaths in various categories dependent on age and whether the death was due to cancer or not. "Projected deaths" are defined and determined by the Hospice Need Methodology Rule as follows:

> "Projected" deaths means the number derived by first calculating a 3-year average resident death rate, which is the sum of the service area resident deaths for the three most recent calendar years available from the Department of Health and Rehabilitative Services' Office of Vital Statistics at least 3 months prior to publication of the fixed need pool, divided by the sum of the July 1 estimates of the <u>service area</u>

> population for the same 3 years. The resulting average death rate is multiplied by projected total population for the service area at the mid-point of the 12-month period which begins with the applicable planning horizon. Population estimates for each year will be the most recent population estimates published by the Office of the Governor at least 3 months prior to publication of the fixed need pool.

Fla. Admin. Code R. 59C-1.0355(4)(a) (emphasis supplied.) The underscored language in the Hospice Numeric Need Methodology, quoted above, clearly shows that population data, in the form of estimates and projections of certain populations of the service area, is taken into consideration in the calculation of numeric need.

39. In addition to the Hospice Need Methodology found in paragraph (a), Subsection (4) of the Hospice Programs Rule has several other paragraphs that relate to approval. Their application occurs on alternative bases when there is numeric need or in the absence of numeric need. These paragraphs relate to the effect of "licensed hospice programs," and "approved hospice programs," on determinations of numeric need greater than zero and "approval under special circumstances" in the absence of numeric need.

Licensed Programs and Approved Programs

40. Even if the Hospice Needs Methodology yields a numeric need for hospice programs in a hospice service area, "the agency

shall not normally approve a new hospice program . . . unless each hospice program serving that area has been licensed and operational for at least 2 years as of 3 weeks prior to publication of the fixed need pool." Fla. Admin. Code R. 59C-1.0355(4)(b).

41. Likewise, even where the methodology yields numeric need, "the agency shall not normally approve another hospice program for any service area that has an approved hospice program . . . not yet licensed." Fla. Admin. Code R. 59C-1.0355(4)(c).

42. Subsections (4)(b) and (c) of the Hospice Programs Rule immediately precede subsection (4)(d). Subsection (4)(d) is the converse of (4)(b) and (c). Instead of no approval despite numeric need, it provides for approval when there is no numeric need under special circumstances.

Special Circumstances

43. Subsection (4)(d) of the Hospice Program Rule bears the catchline: "Approval Under Special Circumstances." Those circumstances are detailed as follows:

> In the absence of numeric need identified in paragraph (4)(a), the applicant must demonstrate that circumstances exist to justify the approval of a new hospice. Evidence submitted by the applicant must document one or more of the following:
>
> 1. That a specific terminally ill population is not being served.

> 2. That a county or counties within the service area of a licensed hospice program are not being served.
>
> 3. That there are persons referred to hospice programs who are not being admitted within 48 hours (excluding cases where a later admission date has been requested). The applicant shall indicate the number of such persons.

Fla. Admin. Code R. 59C-1.0355(4)(d). A conclusion to be drawn from Subsection (4)(d) of the Hospice Programs Rule is that in the absence of a showing of special circumstances, the number of applications granted may not exceed the numeric need yielded by the Hospice Numeric Need Methodology. See Conclusions of Law, below.

Existing Providers

44. Service Area 4A is served currently by two hospice programs. Community has provided hospice services since 1978 and Haven Hospital (formerly North Central Florida Hospice based in Gainesville) since 2001.

45. Community has over 700 employees. During fiscal year 2004, Community cared for over 5,000 patients and their families. During the same time period, the average daily census was 844 patients and the average length of stay ("ALOS") was 61.5 days. Forty-two percent of the patients had cancer as their primary diagnosis. The remainder of the patients (58%) had a primary diagnosis that was not cancer.

46. Community provides services to hospice patients and families regardless of age, race, religion, gender, ethnic background, handicap, diagnosis or ability to pay and is certified to serve Medicare and Medicaid patients.

47. Community's roots in Service Area 4A are deep.

48. For example, its CEO and president, Ms. Susan Ponder-Stansel, has lived and worked continuously in Jacksonville and St. Augustine since 1980. She is a member of community organizations that provide an excellent vantage point on the needs of the community, including the Board of the District IV Health Planning Council, the Rural Health Network, and the Advisory Board of the Malone Cancer Institute at Baptist Medical Center.

49. Community is governed by a Board of Directors with 30 members, representatives of a multitude of the communities in Service Area 4A. The Board includes community volunteers, physicians and representatives of each of the major hospital systems. Hospital representatives on CHNF's Board ensure the best collaboration and outreach to hospital patients who are hospice eligible. It allows the formation of partnerships for the development of additional services to fill any gaps between hospice and hospital care.

50. Community encourages and receives input from its St. Augustine/St. Johns Advisory Board and its Clay County Advisory

Board, consisting of more than 20 members each. Advisory Board members advise CHNF of additional ways hospice services can be made accessible and available to the residents of those areas.

51. Community has made hospices services accessible and visible throughout the entire service area by strategically establishing offices and facilities to serve each of the metropolitan and the rural communities of the service area. As one might expect from any new hospice program, Heartland and VITAS the Applicant have only committed to office space in Duval County. VITAS proposes to rent such office space and might rent space elsewhere for satellite offices. Heartland proposes to establish its primary initial office in Duval; otherwise, it "will look at the need for satellite offices to ensure that the five-county are is covered." Tr. 274.

52. Community has a history of providing high quality hospice services in Service Area 4A. It provides all levels of hospice care, including respite and continuous care, and has demonstrated the capacity to organize and deliver core hospice and other hospice services in a manner consistent with all regulations and prevailing standards for hospice care.

53. Although most hospice patients prefer to remain in their own homes during the dying process, some symptoms require management with a higher level of 24-hour acute care. Three venues may be provided by a hospice to deliver general inpatient

care to a hospice patient. One method is to use beds scattered throughout an acute care hospital or nursing home as they are available ("scatter beds"). Another is to establish a hospital-based inpatient unit specifically dedicated to hospice patients operated in leased space and staffed by hospice employees. The third is to establish a freestanding hospice inpatient facility. Freestanding facilities are generally more home-like than scatter beds or dedicated space in a hospital.

54. Heartland and VITAS propose to contract with nursing homes and hospitals to provide general inpatient care on a scatter bed or single bed basis as needed.

55. Community offers such care in freestanding facilities, hospital-dedicated leased space, and scatter beds so it can allow the patient's needs to determine the venue of choice.

56. Community has two general inpatient facilities. The Hadlow Center of Caring is a 38-bed, freestanding Medicare certified facility centrally located in the service area and easily accessible from I-95, I-295, and US-1. The Morris Center is a 16-bed Medicare-certified dedicated facility located in Shands Hospital in the demographic and geographic center of metropolitan Jacksonville.

57. The Hadlow Center, notwithstanding its medical mission to provide crisis intervention for hospice patients, is designed and operated to create a home-like environment for patients and

families enduring end-of-life crisis. It has unlimited visiting hours. Patients can decorate their rooms with their own mementoes. Pets can visit. There are lanais and outdoor areas for patients and families to use. All 38 beds at Hadlow are certified for general inpatient care. Some of the beds are used by CHNF for residential patients -- patients eligible for routine home care, but who either have no caregiver at home, no home, or an unsafe environment at home. Although CHNF is reimbursed for the routine home care, it is not reimbursed by any third party payor for providing residential care. If the patient lacks the ability to pay, CHNF provides the residential bed at Hadlow free of charge.

58. The Morris Center is operationally similar to the Hadlow Center with many of the same amenities, but it is located in a hospital.

59. The Neviaser Educational Institute at Community Hospice of Northeast Florida is a department of the Hospice created in 2003 to provide education to the community and the hospice's employees on end-of-life issues. The Institute has grief and loss, professional education, and a community relations component.

60. Since its inception, the scope and breadth of the professional education provided by the Institute has been significant. In November of 2005, for example, the Institute

provided 1,874 hours of education to 1,421 persons (703 staff and 718 community). The hours of education were apportioned 1,448 to unlicensed professionals/students/lay persons, 371 to nurses, 41 to social workers and 13 those seeking continuing medical education (CME) credits.

61. Community is the only hospice in the state authorized by the Florida Medical Association to conduct CME.

62. Although the need for community education can never be fully met by any one provider, and additional education will likely always be needed, CHNF's community education and community grief and loss programs have been thoughtfully designed and delivered. They are efficacious in developing a larger community sense of how to manage grief and loss and in communicating the availability of hospice to deal with those issues.

63. Community PedsCare is an innovative program established by CHNF in collaboration with Wolfson Children's Hospital, Nemours Children's Clinic and the University of Florida. The program provides palliative and hospice services to children (up to 21 years of age) who have been diagnosed with a life-threatening disease, injury, illness or condition, and to the families of these children.

64. Community operates an in-house pharmacy allowing it to dispense prescribed medications to patients in their homes and

in CHNF's general inpatient facilities. Community operates its own in-house durable medical equipment department. This enables greater control to ensure prompt delivery when needed and timely pick-up which is not always of concern to for-profit contract vendors of durable medical equipment.

65. The location for CHNF's Gateway Mall Branch Office was specifically chosen to enhance access for African-Americans in the Service Area 4A, the preponderance of whom live proximate to metropolitan and Northwest Jacksonville.

66. The Morris Center for Caring, one of CHNF's general inpatient facilities, was located at Shands Hospital in downtown Jacksonville, specifically because it is in the geographic center of the City, and it is where most of the SA's African-Americans come to receive their healthcare.

67. CHNF has employed a Community Education Manager for the past two and a-half years. She was previously employed by the City of Jacksonville's Human Rights Division for three years to initiate a community dialogue of race relations. For the preceding 20 years she acquired an understanding of the Jacksonville and neighboring counties in Service Area 4A working as manager for a home health agency that, like hospice, primarily delivers healthcare in the patient's home. CHNF's Community Education Manager has had an excellent opportunity to observe how healthcare is, or is not, delivered to African-

Americans and minorities and has experience in the difficulties unique to educating African-Americans about the availability of home health and hospice.

68. The community education manager has developed outreach and education programs specifically targeting African-Americans, other ethnic group and Veterans.

69. A significant barrier to higher utilization of healthcare services by African-Americans, which is not unique to Jacksonville, is a historical distrust of healthcare, passed by word of mouth and based on the disparities in treatment African-Americans have experienced. Many physicians are not comfortable, even today, treating African-Americans. As a consequence of disparate treatment, African-Americans are less likely than their Caucasian counterparts to trust or allow a stranger to provide end-of-life care to themselves or a member of their family.

70. To address these barriers, CHNF has recognized that it takes time, persistence, consistency, and commitment to develop a trust in hospice that will overcome years of generalized mistrust of healthcare professionals and the healthcare delivery system.

71. Community management fully supports and historically has implemented diversity training for all of it staff.

72. Community has been very successful in increasing the number of African-American churches and corresponding faith based communities which will allow hospice to make educational presentations. There are a great number of African-American churches in Jacksonville. In FY 2005, CHNF made over 390 visits and made 24 presentations in African-American Churches.

73. Community has focused on African-American women and makes numerous presentations to African-American women's groups because, more often than not, women are the heads of households and are the caregivers to families and friends in the African-American community.

74. Community conducts conferences and workshops with clergy of a variety of denominations to address issues specific to African-American end of life and access to healthcare.

75. If for any reason, including lack of funds, the above programs were pulled back or diminished, it would be like starting over to rebuild trust in the African-American community.

76. Community hired an African-American public relations firm to tailor a number of CHNF brochures specifically to African-Americans. Community has developed effective printed material utilizing testimonials from African-Americans, and succinct wording about topics as varied as how to ask your physician questions, where to get caregiving information and the

availability of compassionate care at CHNF for African-Americans.

77. Community places articles and advertising in the Jacksonville First Coast Edition of Black Pages USA, which serves and is distributed to African-American families and businesses in Jacksonville, Orange Park, St. Augustine, Middleburg, Yulee, Callahan, Baldwin, Jacksonville beaches and surrounding areas.

78. Community's outreach to the African-American community in Service Area 4A is having success.

79. In short, CHNF is an available, high quality, full-service hospice. Because of its not-for-profit status and current economies of scale, CHNF is able and willing to fund unique and effective community and professional education, community outreach, and a variety of enhanced services to its patients, their families and the communities in Service Area 4A.

Heartland's Application

80. Heartland's hospice care is delivered by an interdisciplinary team. The team consists of a registered nurse, social worker, spiritual care coordinator, volunteer and bereavement coordinators, the attending physician, the hospice medical director, volunteers and therapists. The therapists come from a variety of disciplines: physical, occupational, speech and alternative therapies such as music, art, or massage

therapy. Which therapists comprise an individual patient's interdisciplinary team depends on the patient's plan of care.

81. On admission, Heartland patients are provided a hospice client handbook describing available hospice benefits for patients and families. Patients and their families are provided a telephone number to call with any questions or requests for assistance. Foreign language materials are available, as are interpreters and services for the deaf.

82. Heartland's hospice services are available 24 hours a day and seven days a week.

83. Upon hospice admission to Heartland, a plan of care is developed by the interdisciplinary team, including the physicians, in consultation with the patient and family to determine the kinds of care and services needed. Every 14 days the team meets to review each patient's plan of care to ensure the care is evaluated for effectiveness and any changes in services or care that may be needed.

84. Heartland's plan of care for each patient addresses all orders and treatments that are directed by physicians and the needed frequency and types of services and treatments. The plan is implemented by the entire interdisciplinary team, including the attending physician and the medical director. Patients may choose to have the hospice medical director assume patient care or may choose to retain their attending physicians.

In the latter case, the attending physician and the hospice medical director work closely together.

85. Each Heartland patient is assigned to a specific interdisciplinary team that oversees all of the patient's care. That team cares for the patient and family throughout the hospice stay irrespective of changes in the level of care needed. Continuity of care is therefore achieved.

86. Bereavement services are provided through the Heartland interdisciplinary team for families and communities up to 13 months post death. Services include one-on-one counseling, community grief support groups, and memorial services. Bereavement needs are anticipated and assessed upon admission and throughout the care, and assessed again after a death to ensure bereavement needs of the family are met. A bereavement plan of care is established with the family and the bereavement coordinator, which may include visits and other forms of contact. Grief support groups meet at locations that are convenient to community and family needs, which may be at a variety of community buildings.

87. Heartland has developed bereavement specialty programs that include spouses and children, including day or weekend childrens' camps throughout Heartland hospices across the country. Heartland has also provided specialty support groups for the spouses of veterans who have lost their lives in war.

Heartland programs hold memorial services for all of the patients who have died. One-on-one bereavement counseling is always available. The frequency of counseling depends on the needs of the individual.

88. Heartland's bereavement counselors have extensive experience in grief counseling. Some are also social workers. They are often called upon to conduct crisis intervention. Heartland, therefore, has specific required qualifications for bereavement counselors.

89. New employees, irrespective of their prior grief counseling experience, are trained through the use of an extensive bereavement manual. There is also an extensive training of spiritual care coordinators whose services are sometimes provided in conjunction with bereavement services.

90. Heartland utilizes a customer service training program called Circle of Care for extensive training of every employee. The program focuses on the ability to talk with patients and families and to identify and resolve conflicts in order to provide the best care possible.

91. Heartland provides an extensive volunteer training program with five levels. The training is tied to the nature of the volunteer jobs that will be performed, such as clerical tasks, administrative help or bereavement assistance. There is also training for volunteers who sit with patients when they are

dying as part of a vigil program that ensures patients do not die alone.

92. Licensed professionals may volunteer professional services as well.

93. Heartland volunteers are also involved in music therapy or enrichment programs. The volunteer coordinator works closely with activities directors in nursing homes to ensure that any nursing home resident who desires such therapy receives it, whether the resident is a hospice patient or not.

94. The volunteer program seeks to meet patient and family needs of greatly varied kinds. As but one example, the program could see to it that the lawn at the family home is mowed to relieve the patient and family of that responsibility. In addition to gardeners, the volunteers may meet needs such as those addressed by a beautician or a housekeeper. In sum, the program looks at "the whole picture of . . . needs" (tr. 89), of the patient and family.

95. Applicable rules require that hospices provide a minimum of 5% of direct patient care through volunteers. To that end, Heartland's volunteer training programs incorporate all CHAP and NHPCO standards and practice guidelines. Heartland, moreover, believes that every patient who so desires should receive volunteer assistance. During 2005, Heartland

hospice programs nationally provided over 178,000 hours of service by volunteers.

96. Heartland also offers a specialized spiritual care program directed by spiritual care coordinators with extensive training in dealing with bioethical issues, and assisting the hospice care teams with crisis intervention and spiritual needs. The focus is on spirituality, values, beliefs and desires, rather than on religion.

97. Heartland spiritual care coordinators and social workers also lead the Heartland suffering program consistent with Heartland's Sincerus Care philosophy. The spiritual care coordinators develop community plans and work with local and family clergy to coordinate the appropriate care for the patient and family. Heartland's chaplains are often called upon to provide funeral services.

98. Heartland employs social workers for the psychosocial needs of patients and families and to identify community resources beyond hospice services when needed. Social workers also assist with funeral plans and with examining financial eligibility for other types of community service that might be available for the patient and family. Social workers provide suffering assessments and advanced care planning and are instrumental in assisting with coping with chronic disease near the end of life.

99. Heartland's Sincerus Program was developed based on three years of extensive research of then available palliative care programs around the country. Some of the programs focused on specific disease categories, such as cardiac or cancer, and many were designed for a hospital-based delivery. A need for stronger programs when patients returned to their homes, however, was identified.

100. In the course of the development of the Sincerus program, Heartland determined that palliative care tools such as pain management, psychological assistance and help with activities of daily living were beneficial for patients with many non-terminal health conditions as well as those who were dying. Heartland developed clinical pathways that could be employed in both the home health care and hospice divisions of the company.

101. Sincerus Care is Heartland Hospice's program for its palliative care and holistic approach to both hospice and health care at home when the patient has not been admitted to hospice. It addresses unmet patient needs in the areas of psychosocial and spiritual support in this time of rapid advances in medical technology.

102. Heartland's research also determined that hospice patients across the country typically received better pain management than non-hospice patients with chronic diseases. For

many years up until the present, there have been millions of Americans with chronic disease. Half of those afflicted with chronic disease had two or more chronic diseases. Not all of those suffering from chronic disease, of course, are in a hospice; the majority, in fact, have not been admitted to hospice. Heartland decided to bring the best practices of hospice to all of its patients, including those with chronic disease in home care programs. It did so through Sincerus Care.

103. Heartland has also developed high quality national palliative care intervention processes. In developing the Sincerus Care approach addressing the body, mind and spirit, a need was identified for the development of a suffering assessment and initiative program. Previously, suffering had not been well researched. Heartland was the first national company to fold suffering assessments and initiatives into all of its programs for home care and hospice.

104. Suffering differs from pain. A person may experience pain without suffering or suffer without physical pain. There are three domains of suffering. One is physical suffering, in which a person has been affected by changes in physical abilities. Concern over body image related to surgeries or amputations is a subset of this domain of suffering. A second is personal family suffering. As the most common, it is related to fears that a patient or family may have about the unknown,

including whether they may experience uncontrollable pain. Third, is spiritual suffering. A patient may struggle with values and beliefs as they question why they are here, ask what they may have done wrong to deserve their situation or wonder why they do not believe in God.

105. Four typical vital signs are blood pressure, temperature, pulse, and respiration with pain as a fifth. Heartland's programs use suffering as a sixth vital sign. Heartland's spiritual care coordinators and social workers receive specific additional training on suffering assessment and interventions and techniques to minimize, improve or eliminate suffering as much as possible to improve quality of life.

106. Heartland uses a multifaceted approach to pain management because medication alone is not always sufficient to eliminate or alleviate pain. Heartland also finds it necessary to address aspects of suffering. Heartland's medical directors and physicians review the effectiveness of all the modalities for each patient's pain management to ensure that pain and symptoms are managed effectively. All of Heartland's staff receive specialized pain management training and awareness and sensitivity training.

107. Heartland's social workers, spiritual care coordinators, nurses, home health aides, and other staff also receive extensive training to learn how to deal with issues such

as oncology emergencies, care of an Alzheimer's patient, and the particular types of care needed during the last hours of life.

108. Heartland offers extensive community education based on assessment of each community's needs so that community outreach programs are developed to meet those specific community needs for end-of-life care. Many outreach programs have been developed by Heartland for underserved populations and ethnic populations. For example, through one of Heartland's Oklahoma offices, Heartland has a partnership with a Native-American tribe because typically Native Americans have not accessed hospice service as fully as other populations.

109. Heartland uses clinical pathways to follow each patient's care from admission through death to continuously assess suffering, psychological and physical needs and track what has occurred over time with the patient and what has been effective and what has not been effective. At the end of the stay, another assessment is preformed with regard to any changes in the patient's quality of life, whether their pain was successfully managed and whether they died in a place of their choosing.

110. Heartland identifies those patients with the most urgent needs or who are in a fragile state of health to ensure that the staff meets those needs. Heartland developed a "referral quick check" to assist nursing homes and assisted

living facilities who requested help in identifying patients who might be in need of hospice services. Heartland also provides a variety of information and brochures to patients, families, and the community for education to explain the nature of hospice care.

111. Heartland employs a multi-tiered quality assessment and assurance program. Quality improvement activities and meetings are held at each local hospice. In addition, quality assessment and assurance committees are used at the regional, division, and company-wide levels so that quality effectiveness is evaluated with respect to quality improvement programs throughout the organization to identify trends locally, regionally, divisionally, and company-wide to identify areas of improvement on a continuing basis.

112. In a number of cities, Heartland operates home health and hospice programs together. Home health involves skilled nursing or physical therapy and serves patients who are able to be rehabilitated, either through therapy or training to reach their maximum optimum level. Often patients who are in home care due to problems such as a broken hip, and are undergoing rehabilitation through physical therapy, also develop or have a terminal prognosis. While in Heartland's home care program, they can be assessed, cared for, and visited by a social worker and a chaplain. The Sincerus Care program that addresses

patients where they reside is able to transition patients from home care with rehabilitative types of care to the appropriate levels for terminal care. This transition ability is beneficial for patients.

113. Manor Care has over 65,000 employees and provides Heartland hospice programs with access to corporate support for staff recruitment, including a national contract with an advertising agency which allows freedom for local advertising preferences. The company also has a strong human resources department that assists the local programs with training in hiring practices and with extensive background screening processes to ensure the best employees for their programs.

114. Manor Care provides its subsidiaries and affiliates with many services such as consultants, accounting, financial services, and many other areas of support. Those overhead costs or management fees are annually allocated to various operating entities based on their ability to pay, and therefore would never be applied in a manner to financially harm a new hospice program.

115. Heartland's human resources department provides recruiters to assist with recruiting of administrative and director of nursing positions. Manor Care and Heartland also assist in funding the Job Corp program throughout the United States, which program assists people in obtaining skill sets to

obtain jobs in areas such as an LPN or a certified nursing assistant position. Despite a recognized national nursing shortage, Heartland has been able to appropriately staff all of its programs to ensure quality care.

116. Heartland hospice program medical directors are hired from the local community, and may be full-time, part-time, or contracted. Heartland requires all of its medical directors to become board-certified, or to be board-certified in their specialty and to have experience with terminally ill patients and to have an affiliation with a Medicare certified hospital. Heartland desires that all its medical directors be palliative care-certified. If a physician is not, then Heartland provides the education and training. Every Heartland hospice program has at least one medical director. Some have more than one medical director, each of whom supervises specific clinical teams.

117. Heartland's employee retention program includes providing scholarship and tuition reimbursement for nurses, LPNs, and social workers going to school or getting their master's degree, as well as home health aides who desire to become LPNs and RNS. This program also includes persons seeking certification in hospice and palliative care and physician certification for palliative care. The Heartland human resources department is active in each local program, with education and training of staff as part of the employee

retention program. In addition to Circle of Care training, the Heartland human resources department also provides leadership and management development training through online courses and educational materials.

118. Heartland has a dedicated team utilized for the implementation of new hospice programs. The team's primary responsibility is to set up each new program location, and includes an administrator, nursing supervisor and office staff who prepare manuals and documentation for use, acquire the furniture and leases, hire the local staff, and assist through the Medicare certification process. The implementation team is expected to function in the same manner with the new Service Area 4A program. Heartland has been very successful with its implementation teams in starting new programs. It is reasonable to expect it to be successful in Service Area 4A as well.

119. Heartland management has met with its affiliated Jacksonville nursing home and rehabilitation clinic directors to discuss methods of providing the best pertinent care for those also in need of hospice care. The administrator of Heartland South-Jacksonville, a nursing home, testified to the current contract with Community, which provides the nursing home residents with quality hospice care, and to the willingness to negotiate a similar contract with Heartland hospice. She supports Heartland's hospice proposal and believes it would be

beneficial for patients to have another high quality choice for hospice. She would also assist Heartland's implementation of a hospice program through exiting relationships with local physicians and other health care providers.

Vitas Application

120. An experienced provider of hospice services, VITAS is capable of providing in Service Area 4A the core services and related specialized services it provides in Dade, Broward and Palm Beach Counties. As an affiliate, moreover, of VITAS Healthcare Corporation, if its application were to be approved, Vitas would benefit from its affiliation with its parent and its parent’s subsidiaries.

121. Prior to submitting its application, VITAS representatives visited Service Area 4A to assess the market and any potential populations and areas of unmet needs. Mr. Ron Fried, a VITAS senior vice president for development, visited 26 of 32 nursing homes in Duval County, and additional nursing homes in other counties. He also visited with community leaders and organizations. Based on his assessments, he determined there was an unmet need in inner city areas, among nursing home residents and in the African-American community.

122. In addition to Mr. Fried’s on-the-ground survey, VITAS representatives also reviewed the published hospice admission and fixed need pool data, as well as data on deaths

and causes of death. They determined there was a large unmet need among the non-cancer patient population.

123. Offers of conditions on hospice programs "are typically rejected" (tr. 502) by AHCA. For state licensure purposes and for federal certification purposes, hospices have to treat any patient who is referred to them or who self-presents. Since hospices, in contrast to hospitals or nursing homes, have no choice in whether to take a patient, AHCA normally will make the comment in the SAAR that it is not necessary to condition an application.

124. While the Hospice Program Rule does not require that an application be conditioned in any way, it nonetheless provides for preferences among competing CON applications as a way to distinguish one competing application from another:

> Preferences for a New Hospice Program. The agency shall give preference to an applicant meeting one or more of the criteria specified in subparagraphs 1. through 5.:
>
> 1. Preference shall be given to an applicant who has a commitment to serve populations with unmet needs.
>
> 2. Preference shall be given to an applicant who proposes to provide the inpatient care component of the hospice program through contractual arrangements with existing health care facilities, unless the applicant demonstrates a more cost-efficient alternative.
>
> 3. Preference shall be given to an applicant who has a commitment to serve

> patients who do not have primary caregivers at home; the homeless; and patients with AIDS.
>
> 4. In the case of proposals for a hospice SA comprised of three or more counties, preference shall be given to an applicant who has a commitment to establish a physical presence in an underserved county or counties.
>
> 5. Preference shall be given to an applicant who proposes to provide services that are not specifically covered by private insurance, Medicaid, or Medicare.

Fla. Admin. Code R. 59C-1.0355(4)(e).

125. Despite the lack of necessity for conditions in hospice CON applications and the practice of AHCA in reviewing such applications and commenting on them in SAARs, VITAS offered specific conditions in its application. The purpose of the conditions, by and large, was to demonstrate VITAS' commitment to meet the preferences advanced in Subsection (4)(e) of the Hospice Program Rule. For example, having determined that there was a large unmet need in Service District 4A for the non-cancer population, it conditioned approval of its application on support of a commitment to serve those populations. VITAS conditioned approval of its CON on providing at least 67% of its patient days to non-cancer patients, including a condition for at least 10% of total days to be Alzheimer’s patients.

126. VITAS has demonstrated ability to meet the needs of the non-cancer population. Nationally, hospices have provided

one average around 43% of service to non-cancer patients according to the most recent data, while VITAS programs provided 57% of care to non-cancer patients. VITAS has focused significant attention and resources in development of clinical criteria to identify appropriate non-cancer admission, and in education of physicians about the benefits of the hospice for the non-cancer population.

127. While the Florida statewide average for hospice providers is 57.6% non-cancer, VITAS' programs had 67% non-cancer populations. As Patricia Greenberg, VITAS' health planning consultant explained, VITAS has established a niche in serving non-cancer patients, including its most recent start up programs in Brevard County with a 69% non-cancer population and Palm Beach County with a 76% non-cancer population.

128. Aside from agreeing to condition its CON on providing 67% of care to non-cancer patients, VITAS' application projects 274 non-cancer admissions in its second year of operations.

129. VITAS Healthcare Corporation and affiliates have a demonstrated history and commitment to serving large ethnic minority populations in metropolitan markets, including funding of full-time community outreach positions, partnership with the Rainbow Coalition/Operation Push organization, and participation in clergy forums and events aimed at the African-American community in the Jacksonville area. VITAS Healthcare

Corporation also "partnered with Duke Institute on Care at the End of Life housed at Duke Divinity School to provide in several areas of the country . . . ministers . . . to learn about end-of-life care issues and how . . . together [to] educate the community to assure access particularly for African Americans to hospice care." Tr. 627.

130. VITAS specifically conditioned its application on providing a minimum of 15% of its services to Medicaid and charity days, including those Medicaid-designated persons residing in nursing homes. As explained by Mr. Fried, this commitment was made to meet the unmet needs of the underserved inner-city, a largely African-American population with substantial unmet needs. VITAS has a corporate policy of social responsibility and provided over $7 million in charity care in 2004, growing to $8 million in 2005.

131. VITAS proposes to provide the inpatient care component of the hospice program through contractual arrangements with existing health care facilities.

132. Its financial pro formas do not include general inpatient care projections. The reason for the lack of these projections was explained at hearing by Ms. Law. The experience of VITAS the Parent through its affiliates is that with startups through the first two years, the projection is less than one-half percent, which rounded down to zero. Put another way,

VITAS expected that its average daily census for inpatient care in its first two years would be less than one patient and therefore the application "did not reflect the revenue or the expense" (tr. 661) associated with inpatient care.

133. There is no question, however, that the VITAS' application is clear that it proposes to provide inpatient care through contractual arrangements. The proposal is supported, despite not being reflected in the financial pro formas, by the experience nationally of VITAS the Parent, "one of the nation's leading providers of [hospice] inpatient care . . . run[ning] about 5% of [total] days of care." Tr. 660.

134. VITAS demonstrated a commitment to serve AIDS patients, the homeless, and patients without primary caregivers at home. VITAS conditioned its CON application on providing 2% of its admissions to AIDS/HIV patients or to serve at least 10% of all AIDS/HIV-related deaths in Service Area 4A. VITAS Healthcare Corporation and its affiliates have demonstrated a commitment to serve such patients; VITAS Healthcare Corporation has even sponsored programs to combat AIDS in sub-Saharan Africa.

135. VITAS' application proposes a physical location in Duval County, but it does not definitely propose a physical presence in any other county (whether underserved or not). While the application is viewed by VITAS as allocating funds for

multiple offices, at least a main office in Duval County and a satellite office somewhere in Service Area 4A, Mr. Fried testified that the funds so allocated "might" (tr. 877) support a satellite office in Nassau County but that VITAS "hadn't decided on a precise location. And I don't recall whether that included any satellite space elsewhere in the service area." Tr. 878.

136. VITAS proposes to provide services not specifically covered by private insurance, Medicare or Medicaid, for example, pet therapy, community education and outreach to combat AIDS.

137. VITAS conditioned its application on the implementation of an information technology system known as CarePlanIT. A hand-held, bed-side device, CarePlanIT allows caregivers to perform bed-side entry of notes and orders and to have immediate access to the full range of data stored in the company-wide database known as the VITAS Exchange.

CON Review Criteria

138. The Agency found in its SAAR (and continues to maintain) that both applicants generally meet all applicable CON review criteria. It approved Heartland's application and denied VITAS after comparative review that convinced AHCA that Heartland's was superior.

139. Heartland concedes that the “Vitas application generally addresses all applicable CON review criteria.”

Heartland Services Inc. And Agency for Health Care Administration Joint Proposed Recommended Order, p. 29. It is joined by CHNF in the contention, however, that compliance with certain CON requirements and review criteria is doubtful and the application information is flawed in a number of respects. VITAS' three opponents in this proceeding, moreover, charge that the VITAS' application is flawed in a manner that may be cause for dismissal under the circumstances of this case: that it does not contain an audited financial statement and therefore does not meet minimum application content requirements. The Agency did not dismiss VITAS' petition; Heartland, nonetheless, maintains that it should be dismissed as the result of the evidence in this proceeding for is failure to meet minimum application content requirements.

Application Content Requirements

140. Section 408.037, Florida Statutes (the "Application Content" Statute) governs the content of CON applications. It states, in part,

> (1) An application for a certificate of need must contain:
>
> * * *
>
> (c) An audited financial statement of the applicant. In an application submitted by a[] . . . hospice, financial condition documentation must include, but not be limited to, a balance sheet and a profit-

> and-loss statement of the 2 previous fiscal years' operation.

(Emphasis supplied.)

141. Heartland's CON application satisfies all of the application content requirements.

142. The application of VITAS does not.

143. VITAS' application contains audited consolidated financial statements for its parent and for the subsidiaries of VITAS the Parent. It does not contain a separate audited statement of VITAS the Applicant. The presence in the application of a consolidated financial statement of the parent and subsidiaries is not a substitute for the required audited financial statement of the applicant. See Fla. Admin. Code R. 59C-1.008(1)(c): ". . . Nor shall the audited financial statements of the applicant's parent corporation qualify as an audit of the applicant."

144. In short, the application fails to contain an audited statement of the VITAS the Applicant and therefore fails to meet minimum content requirements.

145. Although the Application Content Statute is phrased in mandatory terminology ("[a]n application . . . must contain"), VITAS' failure is not necessarily fatal to its application. The failure to strictly comply with the Application Content Statute may be forgiven by Section

408.039(5)(d), Florida Statutes (the "Forgiveness Statute") under certain circumstances:

> The applicant's failure to strictly comply with the requirements of s. 408.037(1) . . . is not cause for dismissal of the application, unless the failure to comply impairs the fairness of the proceeding or affects the correctness of the action taken by the agency.

VITAS maintains that the Forgiveness Statute forgives the application's lack of an audited financial statement of VITAS the Applicant.

The Case for Forgiveness

146. VITAS the Parent does not typically obtain separate audited financial statements for each of its subsidiaries. Instead, independent certified public accountants audit the financial statements of VITAS the Parent and its subsidiaries together in a consolidated fashion. After audit, a consolidated audited financial statement is issued by the independent CPAs.

147. If there is ever a need for a separate audited financial statement of any one of the subsidiaries, according to Lawrence Press, at the time of hearing the controller of VITAS the Parent (see tr. 929), then VITAS commissions an audited financial statement of any "separate legal entity" within the group, id., including VITAS the Applicant.

148. Whether the financial information submitted by VITAS supports the conclusion that the lack in the application of an

audited financial statement of the applicant may be forgiven depends on an examination and analysis of the information submitted. It begins with one of the documents attached to Schedule 3 in the application, the consolidated financial statements of VITAS the Parent and its subsidiaries (the "Audited Consolidated Financial Statements."

i. The Audited Consolidated Financial Statements

149. The Audited Consolidated Financial Statements cover two years: the year ended September 30, 2003 (the "2003 Consolidated Audit") and the year ended September 30, 2002 (the "2002 Consolidated Audit.") See VITAS' Certificate of Need Application, Vol. 1 of 4, Tab 3.

150. The Audited Consolidated Financial Statements contain two reports each entitled, "Report of Certified Public Accountants," one for the 2003 Consolidated Audit, the second for the 2002 Consolidated Audit. The first report is dated November 10, 2003; the second report is dated November 8, 2002.

151. The first report concludes:

> In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated position of Vitas Healthcare Corporation and Subsidiaries at September 30, 2003 and 2002, and the results of their operations and cash flows for each of the three years in the period ended September 30, 2003, in conformity with accounting principles generally accepted in the United States.

VITAS Certificate of Need Application, Vol. 1 of 4, Tab 3, p. 1 of the 2003 Consolidated Audit.[2]

152. Following the first report are the consolidated financial statements themselves. These are listed in the Table of Contents as follows: Consolidated Financial Statements; Consolidated Balance Sheets at September 30, 2003 and 2002; Consolidated Statements of Income for the years ended September 30, 2003, 2002 and 2001; Consolidated Statements of Changes in Redeemable Preferred Stock and Stockholders Deficit for the years ended September 30, 2003, 2002, 2001; Consolidated Statements of Cash Flows for the years ended September 30, 2003, 2002 and 2001; and Notes to Consolidated Financial Statements. See VITAS Certificate of Need Application, Vol. 1 of 4, Tab 3, Contents, Consolidated Financial Statements, September 30, 2003.

153. The second report contains an identical opinion, except for a change in dates to reflect that the statements are for the statement year ending in 2002 rather than 2003. The second report also contains a paragraph that does not appear in the first report:

> Our audits were conducted for the purpose of forming an opinion on the financial statements taken as a whole. The supplemental balance sheets as of September 30, 2002 and 2001, and statements of income for the years then ended which include Vitas Healthcare Corporation, Vitas Healthcare Corporation of Florida, . . . [and a number of other VITAS Healthcare

> Corporation Subsidiaries] are presented for the purpose of additional analysis and are not a required part of the financial statements of Vitas Healthcare Corporation and Subsidiaries. Such information has been subjected to the auditing procedures applied in our audits of the financial statements and, in our opinion, are fairly stated in all material respects in relation to the financial statements taken as a whole.

VITAS Certificate of Need Application, Vol. 1 of 4, Tab 3, p. 1 of the September 30, 2002, Consolidated Financial Statements.

154. Following the second report are consolidated financial statements of the same type as those following the first report, that is, detailed balance sheets, detailed statements of income, detailed statements of changes in redeemable preferred stock and stockholders deficit, detailed statements of cash flows, and notes. Unlike the information that follows the first report, however, there is other information listed in the Table of Contents for the 2002 Consolidated Audit. It is denominated "Other Financial Information." The Other Financial Information is described in the Contents page of the Consolidated Financial Statements for September 30, 2002, as "Supplemental Balance Sheets at September 31 [sic], 2002 and 2001" and "Supplemental Statements of Income for the years ended September 31 [sic], 2002 and 2001." It is this information that is "presented for additional analysis" as reported in the paragraph that appears in the 2002

report that is not present in the 2003 report. This is also the information that is reported in the same paragraph to have been subject to the auditing procedures applied in the Ernst & Young audits and found, in Ernst & Young's opinion, to be fairly stated.

155. The financial information attached to Schedule 3 in VITAS' application also contains another set of documents. These documents are not a part of the Audited Consolidated Financial Statements. Nor, accordingly, were they reviewed by Ernst & Young. They consist of three pages. The first page is a letter from Robin Johnson, CPA, that identifies her as vice president and controller of VITAS Healthcare Corporation. The letter is dated June 25, 2004 (the "Johnson Letter.")

156. Attached to the Johnson Letter are two pages. The first page is entitled, "Vitas Healthcare Corporation and Subsidiaries Consolidated Balance Sheets." The second page is entitled, "Vitas Healthcare Corporation and Subsidiaries Consolidated Statements of Income." The Johnson Letter refers to these pages as "[t]he . . . supplemental balance sheets as of September 30, 2003 and 2002 [2003 information] and the statements of income for the years then ended . . . ." Each of these two pages (the "Johnson Supplemental Balance Sheets and Statement of Income" or the "Johnson Supplemental Financial Information") contains 13 columns; the first column devoted to

“CONSOLIDATED VITAS,” the next twelve devoted to one of each of twelve subsidiaries. Of the 13 columns on each page, one column is devoted to financial information that pertains solely to “VITAS OF FLORIDA” or VITAS the Applicant.

157. The Johnson Letter and the Johnson Supplemental Financial Information were not audited by Ernst & Young or any other independent certified public accountant. Nonetheless, they appear in the VITAS application within the body of the Audited Consolidated Financial Statements. Mr. Beiseigle described them at hearing: “[T]hat information that’s sandwiched between the 2002 and 2003 audits of VITAS Healthcare Corporation.” Tr. 1701. Mr. Beiseigle’s description was quickly followed by a clarification from CHNF’s counsel, Mr. Newell: “He means physically in the book, not necessarily chronologically.” Id.

158. Mr. Newell's clarifying comment is confirmed by an examination of the application in evidence. Indeed, Mr. Beiseigle's description is accurate; the Johnson Letter and the Johnson Supplemental Financial Information is "sandwiched" between the 2003 Consolidated Audit and the 2002 Consolidated Audit. It appears in the midst of the Audited Consolidated Financial Statements, despite the fact that it is information that was not audited by Ernst & Young and not audited by any other independent certified public accountant.

159. The insertion of the Johnson Letter and Supplemental Balance Sheets and Statements of Income into the VITAS application in the midst of the Audited Consolidated Financial Statements was explained by VITAS through the testimony of Mr. Press, VITAS' controller at the time of hearing, and Ms. Greenberg, the primary author of the application who was responsible for compiling all four volumes of the application in their entirety. See Tr. 996.

ii. The Insertion of the Johnson Information

160. VITAS attempted to commission an audited financial statement of VITAS the Applicant standing alone. As Mr. Press testified, such an attempt would be in due course whenever there was a need for a separate audit of any of the individual VITAS subsidiaries. An example of a case of such a need is this one, when a CON application must contain an audited financial statement of the applicant. VITAS representatives, therefore, asked Ernst & Young to audit financial statements of VITAS the Applicant separately from the consolidated review it had conducted.

161. VITAS' request of Ernst & Young followed the audit of the Consolidated Financial Statements and was also made in the wake of ChemEd’s acquisition of VITAS the Parent. After the acquisition, ChemEd informed Ernst & Young that its responsibilities with regard to VITAS the Parent and its

subsidiaries would be assumed by ChemEd's accountants, PriceWaterhouse. Ernst & Young, therefore, declined the request by VITAS for an independent separate audit.

162. There is nothing of record to show that VITAS attempted to obtain either an exception from ChemEd to allow Ernst & Young to proceed with a separate audit or to show that VITAS attempted to obtain an audit of itself from PriceWaterhouse or some other certified public accountant firm besides Ernst & Young.

163. VITAS was aware that its application would lack minimum content without an "audited financial statement of the applicant." It attempted to cure its non-compliance with the statutory requirement by insertion into the application of the Johnson Letter and Johnson Supplemental Financial Information. VITAS had no illusions that the information would constitute an audited financial statement of the applicant. It knew the information had been generated internally and constituted "managerial accounting" rather than "financial accounting." It knew the information had not been audited externally by an independent certified public accountant.

164. In introduction of the Supplemental Information, the Johnson Letter reads, in part:

> VITAS Healthcare Corporation audits were conducted for the purpose of forming an opinion on the financial statements of Vitas

> Healthcare Corporation and Subsidiaries taken as a whole. The enclosed supplemental balance sheets as of September 30, 2003 and 2002, and the statements of income for years then ended which include . . . Vitas Healthcare Corporation of Florida . . . are presented for the purpose of additional analysis and are not a required part of the financial statements of VITAS Healthcare Corporation and Subsidiaries. Such information has been subjected to the auditing procedures applied in the audits of the financial statements and are fairly stated in all material respects in relation to the financial statements of VITAS Healthcare Corporation and Subsidiaries … taken as a whole.

VITAS CON Application 9784, Vol. 1 of 4, Tab 3 (no page no., emphasis supplied). The language in the Johnson Letter underscored above makes two claims paraphrased as follows: first, the balance sheets and statements of income have been subjected to the auditing procedures applied by Ernst & Young in the consolidated audit; second, the information in the balance sheets and statements of income is fairly stated in all material respects in relation to the Audited Consolidated Financial Statements.

165. It appears that the language of the letter, quoted above, was selected because it mirrors the language used by Ernst & Young to describe the "Other Financial Information" attached to the Ernst & Young 2002 consolidated audit. Whether that was why the language was selected or not, the inclusion in the letter was the subject of sharp criticism, see tr. 421-423,

by Steven Jones, a licensed certified public accountant in Florida and Heartland's expert in accounting and healthcare finance. He found the language contrary to provisions of the American Institute of Certified Public Accountants, provisions of the Florida Statutes and the Florida Administrative Code, and generally accepted auditing standards that address "independence, integrity and objectivity." See Tr. 421-23.

166. Whatever the motivation for including the two claims in the Johnson Letter, Ms. Johnson was not acting as an independent auditor. Nor could she have been so acting. Although a certified public accountant, as the controller of VITAS Healthcare Corporation, Ms. Johnson is quite the opposite of “independent” when it comes to VITAS the Parent and its subsidiaries, including the applicant in this case.

167. Thus the Johnson Letter cannot stand for the claim made within it that Johnson Supplemental Financial Information had been subject to the same auditing procedures as the information subject to the consolidated review.

168. Any light that Ms. Johnson might have shed on the claims in the letter did not materialize. Ms. Johnson did not testify at hearing. The task of proving compliance with the statutory requirement or how lack of strict compliance could be forgiven fell to Mr. Press and Ms. Greenberg. To the credit of both Mr. Press and Ms. Greenberg, neither claimed that the

Johnson Letter and Johnson Supplemental Information constituted audited financial statements. As Ms. Greenberg stated in cross-examination by Mr. Newell at hearing:

> Q. But there is a difference . . . between the Letter that accompanies the . . . audits by Ernst & Young . . . and this letter [Ms. Johnson's letter] . . .
>
> Now Ernst & Young did that in 2002, but based on your request and Ms. Johnson's willingness, she certified that this time, but she was not one of the independent auditors, was she?
>
> A. No, her role was to work with them and provide them with the financial statements, but she was not an independent auditor.
>
> * * *
>
> Q. Would you agree with me perhaps that one who uses language like that in the bottom of Ms. Johnson's letter, which is essentially identical to what external auditors used in the 2002 letter, might be the use of language in a manner that is to imply that a CPA is acting as independent certified public accountant in the audit of the attached statements.
>
> A. I don't understand the question. Ms. Johnson is a CPA and controller and she was providing that language.
>
> Q. We'll make sure – she was not an external auditor, was she?
>
> A. No, I think I already said that.

Tr. 1130, 1132, 1133.

169. Although Ms. Johnson's letter does not raise the supplemental information to the level of a financial statement

audited by an independent certified public accountant, VITAS presented evidence as to why the failure to file an audited financial statement of the applicant does not impair the fairness of the proceeding or would not impair the correctness of approving VITAS' application should AHCA do so.

170. For example, all of the data on the balance sheets and income statements for subsidiary corporations tie to the consolidated totals for VITAS Healthcare Corporation as a whole. The statements reveal that on a consolidated basis the company had over $13 million in net income in 2003. VITAS Healthcare Corporation of Florida supplies the majority of revenue and net income to VITAS Healthcare Corporation. In fact, it makes up for losses by other subsidiaries.

171. Ms. Greenberg opined that, as a financial analyst, she could determine ability to fund the project from the financial information supplied in the CON application.

172. First, the $200,000 startup cost is minimal. Second, all of the supplemental information ties back to the audited consolidated financial statements. Mr. Press made this point, too. Ms. Greenberg determined, moreover, that VITAS Healthcare Corporation of Florida has available to it $14.3 million in current assets, $14.9 million in total assets, $51 million in retained earnings, and over $29 million in net income. Quite

clearly, in her view, there are adequate funds available to fund the program of VITAS the Applicant in Service Area 4A.

173. In addition, Ms. Greenberg noted that the proposed method of funding is from future cash flows and is not based on historic information. The application includes a forecast of financial operations of VITAS Healthcare Corporation with and without approval of the proposed project. Under a conservative scenario, VITAS is expected to net over $26 million in income, an amount more than sufficient to fund a $200,000 project.

174. Ms. Greenberg's analysis was subject to criticism by Mr. Beiseigel, CHNF's expert health care financial analyst and forensic financial analyst.

175. His analysis began with appreciation of the import of the lack of an audited financial statement of the applicant. The analysis requires an understanding of the elements of an audited financial statement.

Elements and Import of an Audited Financial Statement

176. The elements of an independently audited financial statement include an audit opinion letter, a detailed balance sheet, detailed income statement, detailed statement of changes in owner's or stockholder's position, a detailed operating cash flow statement and detailed notes allowing a financial reviewer to determine the existence of contingent liabilities and the materiality of the financial statements. These elements are all

present in the Ernst & Young Audited Consolidated Financial Statements.

177. The import of the lack of an audited financial statement of VITAS the Applicant and the presence of the Johnson Letter and Johnson Supplemental Financial Information to cover the year ending September of 2003 in this case is obvious. All of the elements of an independently audited financial statement are not subject to review by financial analysts such as those employed by AHCA and analysts outside AHCA (Mr. Beiseigel, for example) who might have reviewed the independently audited financial statement for purposes of a contested proceeding at DOAH, as is the case here.

178. The Johnson Information that pertains to VITAS the Applicant was criticized in more detail on another basis: it does not contain any cash flow statements.

Cash Flow Statements

179. The Johnson Supplemental Financial Information does not include cash flow statements. In the SAAR, the Agency observed that cash flow data were not included in the application when it discussed compliance with Section 408.035(4), Florida Statutes, that is, what funds for capital and operating expenditures are available for project accomplishment and operation. Nonetheless, the SAAR concluded:

> Although the applicant [VITAS] did not provide historic cash flow data, the applicant showed healthy earnings. Even under the conservative analysis, the applicant has $6 million in working capital. Therefore, funding for this project and all capital projects should be available as needed.

Heartland 16, p. 64.

180. As part of its case that the failure to include an audited financial statement of the applicant should be forgiven, and that it was not necessary for it to provide cash flow data, VITAS points to the language that follows the statutory requirement that an application contain an audited financial statement:

> In an application submitted by a[] hospice, financial documentation must include, but need not be limited to, a balance sheet and a profit-and-loss statement of the previous 2 years' operation.

§ 408.037(1)(c), Fla. Stat. VITAS submitted balance sheets and income statements for 2003, albeit not audited.

181. Furthermore, Ms. Greenberg's point that the information provided to AHCA in the application demonstrates that VITAS the Applicant clearly has the financial wherewithal to fund the start-up costs associated with the application, costs that are minimal was adopted, in essence, by AHCA in the SAAR. Nonetheless, at hearing, AHCA supported Heartland and CHNF's argument that the lack of an audited financial statement

in VITAS' application is a material point to be considered in this proceeding when it comes to comparative review.

182. The Agency has never excused the lack of an audited financial statement of an applicant. Furthermore, Mr. Gregg testified that in a comparative review proceeding where one applicant provides an audited financial statement and another does not, to not take into consideration that one application was missing the required audit would impact the fairness of the proceeding:

> I would say that it impacts the fairness to the extent that it prevents us from comparing apples to apples.
>
> A completely audited financial statement is generally more reliable and . . . has been viewed by a CPA who is not typically involved with the organization, and the other [an internally generated management report] is less . . . reliable.

Tr. 512. As Mr. Gregg further testified in the context of comparative review, "I would say that there were uncertainties in the financial information that we got from VITAS. And we were more comfortable with the level of certainty of the financial information that we had from Heartland." Tr. 506. Thus, while AHCA did not dismiss VITAS' application for failure to meet minimum content requirements, it took into consideration the missing audit as it reviewed Heartland and VITAS' applications on a comparative basis after determining that the

two applicants generally meet the statutory and rule criteria for approving a CON application.

CON Review Criteria

183. Heartland demonstrated that it meets the statutory and review criteria for approval.

184. To do so, Heartland had to correct an error in the Heartland application that related to long-term financial feasibility. The application had assumed that continuous care patient days would amount to approximately 7% of total patient days for both Year One and Year Two. The assumption was made after looking at national data in which continuous care is presented in terms of hours while other patient service types are presented in terms of days.

185. The assumption was criticized by VITAS' witnesses. The criticism was discovered before hearing by Heartland. Mr. Jones realized the mistake, and therefore "recast those relative ratios, using a normal range for a continuous day, [so that] the percentage of continuous care produce[d] [is] substantially around 1 percent," tr. 412-13, an accurate percentage of continuous care for hospice programs. Mr. Jones also re-cast the pro formas to assume that continuous care should be reimbursed only at 15 hours per day rather than 24 hours per day (as the application had done) in response to another valid criticism by VITAS. VITAS moved to strike any

testimony or evidence that concerned the re-casting on the basis that it is an impermissible amendment to Heartland's application.

186. Ms. Greenberg also opined that Heartland projected salaries for some FTE positions were too low. Mr. Jones testified otherwise: that the salary estimates are generally reasonable.

187. Ms. Greenberg also criticized the Heartland application based on an assertion that the projections did not reflect an additional 5% expense per patient day ("PPD") for dual eligible Medicare/Medicaid patients who reside in nursing homes. For nursing home residents who elect hospice admission, the state no longer pays the nursing home its Medicaid room and board rate, but rather pays a geographic area average rate to the hospice, which on average is about 95% of the rate previously paid to the nursing home. Even though it is negotiable, hospices often pay the nursing home its normal rate, resulting in a hospice expense of about 5% PPD more than the hospice is reimbursed for room and board. Five percent of the average nursing home room and board rate in the Jacksonville area would equal approximately $7.50 PPD. Statewide, about 30% of nursing home patient days for hospice care is delivered to Medicaid dually eligible nursing home residents.

188. In the face of the criticism, Heartland demonstrated at hearing that its proposal is financially feasible in the long term, even if it were assumed: that Ms. Greenberg is correct about the salaries; that continuous care days should be 1% rather than 7% and reimbursed at only 15 hours per day instead of 24 hours per day; and, that the revenue for Medicaid nursing facility residents should be reduced at a rate of 5% PPD.

189. This demonstration was conducted by Mr. Jones in what he described as a "worst case scenario" analysis. The analysis used a model that reduced continuous care revenue and shifted the reduced days to routine care; correspondingly adjusted the staffing levels to the Heartland standard; accounted for the 5% PPD Medicaid nursing home resident differential; and increased salary expenses. The re-casting is reflected in Heartland Exhibit 15, a recast of Schedules 6, 7, and 8 in its CON application. The re-casting results in a projected loss in Year One, but a projected profit in Year Two of $88,596, a demonstration of long term financial feasibility.

190. The adjustments reflected in Heartland Exhibit 15, moreover, do not reflect every adjustment that would have to be made to fully recast the entire financial projections. If other expenses that would be reduced, such as drug costs and medical supplies, by a full recasting were included, the profit

projected for Year Two would higher than the $88,596 reflected in the exhibit.

191. In CON application proceedings, short-term financial feasibility is typically considered as the ability to fund the projected costs reflected on Schedule 1 of the application and to provide sufficient working capital for a start-up period.

192. Heartland's application demonstrates short term financial feasibility. Because the applicant is a company in the development stage, it obtained a funding commitment from Manor Care to meet its funding needs. The application contained Manor Care's audited financial statements demonstrating the ability to fund its commitment in addition to an audited financial statement of the applicant as required.

193. Manor Care is committed to providing all necessary funding and working capital requirements to Heartland to establish and operate the proposed hospice. Manor Care has the financial resources to fund the project. If needed, Manor Care also has approximately $230 million of unused debt capacity. It can clearly fund the $294,000 needed for the project. Manor Care, moreover, consistent with its policy with other subsidiaries, will not charge Heartland any interest on funds it provides for capital or operating expenses.

194. If the CON is approved, Manor Care is committed to moving forward with the development of the hospice program.

Neither Manor Care nor any of its affiliates has ever received a CON to develop a hospice in any state and not proceeded with development.

195. Testimony at trial bolstered the Agency's conclusion in its SAAR that VITAS, despite the missing audited financial statement of VITAS the Applicant, should be able to fund the hospice program it proposes for Service Area 4A in the short term.

196. The financial information supplied by VITAS, however, because of the lack of an audited financial statement of the applicant, was not as certain as that of Heartland, a matter that was determinative in the Agency's comparative review of the two applications.

Comparative Review

197. The financial information in Heartland's application was more certain than the financial information in the application of VITAS. Since Heartland provided an "audited financial statement of the applicant" and VITAS did not, Heartland must be viewed as providing a greater level of certitude about its financial position.

198. The Agency opined that there is a second factor that makes Heartland's application superior. Currently, there are hospice programs operated either by VITAS the Applicant or affiliated with VITAS the Parent in Service Areas 11 (Dade and

Monroe Counties), 10 (Broward County), 9C (Palm Beach County), 7A (Brevard County), 7B (Flagler and Volusia Counties), and 7C (Orange County.) Hospice programs affiliated with VITAS the Parent now serve the eastern coast of Florida from Key West to the service area adjacent to Service Area 4A in the northeast corner of the state and inland covering the most populous area of Central Florida. The introduction of Heartland, a nationally recognized quality hospice provider, into Florida will foster competition that, in AHCA's view, will benefit patients and families through providing a choice in hospice care.

CONCLUSIONS OF LAW

199. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. §§ 120.568, 120.57 and 408.039(5), Fla. Stat.

200. As applicants, Heartland and VITAS each have the burden to prove by a preponderance of the evidence that its CON application should be approved. See Boca Raton Artificial Kidney Center, Inc. v. Department of Health and Rehabilitative Services, 475 So. 2d 260 (Fla. 1st DCA 1985). The award of a CON must be based on a balanced consideration of all applicable statutory and rule criteria. Humana, Inc. v. Department of Health and Rehabilitative Services, 469 So. 2d (Fla. 1st DCA 1985), citing Department of Health and Rehabilitative Services v. Johnson & Johnson Home Health Care, Inc., 447 So. 2d 361, 363

(Fla. 1st DCA 1984). The appropriate weight accorded each individual criterion contained in the statute regarding CON applications is not fixed, but depends on the facts and circumstances of each case. Collier Medical Center, Inc. v. Department of Health and Rehabilitative Services, 462 So. 2d 83 (Fla. 1st DCA 1985).

Standing

201. Community has standing to file its petition and participate in this proceeding as an intervenor pursuant to the stipulation of the parties.

Fixed Need Pool

202. The Agency's publication of a fixed need pool determination of the need for one additional hospice program in Service Area 4A creates a rebuttable presumption of need of an additional hospice program in Service Area 4A. There was no challenge to the published fixed need pool and the presumption of need for one additional hospice program was not rebutted in this proceeding.

203. Under Subsection (4)(d) of the Hospice Program Rule, only one application can be approved in this proceeding unless special circumstances are proven:

> Approval Under Special Circumstances. In the absence of numeric need identified in paragraph (4)(a), the applicant must demonstrate that circumstances exist to justify the approval of a new hospice.

Fla. Admin. Code R. 59C-1.0355(4)(d). Community argues that special circumstances come into play only when the numeric need calculation results in no numeric need: ". . . a FNP [fixed need pool] of "0" is the sole condition precedent in the FNP methodology for considering or approving special circumstances as an additional basis to approve a program." Community cites to both the quoted provision, above, and to Subsection (3)(b) of the Hospice Program Rule.

204. While CHNF's interpretation is not without some merit, it is overly literal. The language can be interpreted to mean that an applicant has the opportunity to prove special circumstances for the approval of applications in excess of whatever value is produced for a fixed need pool so that if a fixed need pool is one, as in this case, special circumstances may justify the approval of two applications. The better interpretation is that the rule allows the applicants in this case, if they so choose, to prove special circumstances that would allow the approval of both applications.

205. VITAS' claim, therefore, that more than one application for a new hospice program could be approved could only stand if at least one of the three special circumstances listed in Subsection (4)(d) of the Hospice Program Rule was proven. None of the three was proven. It was not proven that a

specific terminally ill population in the service area or a county within the service area of a licensed hospice program is not being served. Nor was it proven that there are persons in the service area referred to hospice programs who are not being admitted within 48 hours of the referral.

206. In this proceeding, therefore, only one application can be approved. Each applicant must prove that, on balance, it meets the statutory and rule criteria for the approval of its application. If both Heartland and Vitas meet the applicable criteria, then comparative review determines which of the two should be approved. Both applications have obstacles to overcome if they are to be approved. VITAS has the problem of the missing audited financial statement. Heartland must meet the argument from VITAS that it impermissibly amended its application.

An Impermissible Amendment?

207. Upon its filing, a CON application is reviewed by AHCA in accordance with the procedures set forth in Florida Administrative Code Rule 59C-1.010. Once deemed complete by AHCA, an applicant is prohibited from amending its application: "[s]ubsequent to an application being deemed complete . . ., no further application information or amendment will be accepted by the agency." Fla. Admin. Code R. 59C-1.010(3)(b).

208. The seminal case regarding the prohibition against CON application amendments is Gulf Court Nursing Center v. Department of Health and Rehabilitative Services, 483 So. 2d 700 (Fla. 1st DCA 1985). The issue in Gulf Court was whether the Agency's predecessor, HRS, could evaluate a CON application at final hearing against need projections contained in a health plan that was developed after the application had been filed. Id. at 703.

209. Prior to Gulf Court, the practice of HRS was to allow applicants at final hearing to rely on new bed need projections pertaining to a planning horizon and a health plan subsequent in time to the planning horizon and health plan contained in their applications. In Gulf Court, the court ruled that HRS' practice was inconsistent with the concepts of batching cycles and comparative review.

210. Within a few years of the Gulf Court decision, the court decided another "impermissible amendment" case: Manor Care, Inc. v. Department of Health and Rehabilitative Services, 558 So. 2d 26 (Fla. 1st DCA 1989). In Manor Care, a CON applicant, after its application had been deemed complete, submitted "updates" to its application. At a formal administrative hearing, the applicant proceeded with the "updated" application. The updates changed the design of the facility. They changed the original design containing three

beds per room to one containing two beds per room. The square footage of the facility was increased and the applicant altered a Medicaid commitment. The Recommended Order found the updates to constitute an impermissible and unauthorized amendment. Noting that evidence was not submitted in support of the Manor Care's original amendment, the hearing officer recommended denial of the application. Manor Care's application was denied by HRS, and the court affirmed.

211. In the course of its opinion, the court observed the following with regard to amendments to applications:

> HRS has interpreted its rules, in light of Gulf Court, as precluding the amendment of a completed application after initial agency review, except upon a change of circumstances beyond the applicant's control. [emphasis supplied] See e.g., Good Samaritan Health Systems Inc. v. Department of Health and Rehabilitative Services, 9 FALR 2343, at 2365 (May 5, 1987). HRS adopted a similar approach in Health Care & Retirement Corporation of America v. Department of Health and Rehabilitative Services, 8 FALR 4650 (September 24, 1986). That decision was reversed on appeal in Health Care & Retirement Corporation v. Department of Health and Rehabilitative Services, 516 So. 2d 292 (Fla. 1st DCA 1987), where the court emphasized that Gulf Court did not address the amendment of an application upon exceptional circumstances or prohibit the presentation of updated current information. In Health Care the court further indicated that the amended application involved in that case contained only an insignificant "new element" and has been recognized by HRS

> as "within the general scope" of the original application.

Manor Care, 558 So. 2d at 28-29.

212. VITAS recognizes that there are circumstances under which new information that differs from information in a CON application may be received after an application has been deemed complete. Those circumstances are when there has been a change of circumstances beyond the applicant's control. In an attempt to follow the language quoted above from Manor Care, the argument is as follows:

> Rule 59C-1.010(3)(b) prevents amendment at hearing except as to non-material changes regarding matters or changes of circumstances beyond the applicant's control and of which the applicant had no knowledge at the time of filing the original application. See, e.g., Maple Leaf of Lee County Health Care, Inc. v. HRS, 601 So.2d 1238, 1240 (Fla. 1st DCA 1992) (data available at the time of application should be used to determine bed need); Hillsborough County Hospital v. HRS, 12 F.A.L.R. 785, 818 (HRS 89-1286 1990) (changes to staffing, equipment, and beds excluded because matters were known to the applicant prior to application); Charter Medical-Orange County, Inc. v. HRS, 11 F.A.L.R. 1087 (HRS 87-4748 1989) (explaining "control" and indicating that if the applicant knew or reasonably should have known about the information and should have included it in the application, then the new information cannot be considered).

Recommended Order submitted by VITAS, pp. 45-6. VITAS correctly points out that Heartland submitted revised Schedules 6, 7, and

8 not simply to correct a mathematical computation as was allowed in HCA Health Services of Florida, Inc. v. AHCA, Case No. 02-0454 (DOAH December 24, 2002) (AHCA February 19, 2003). In that case, no information beyond that included in the initial CON application was required to correct the mistake.

213. Since the correct percentage attributable to continuous care was a matter that Heartland should have reasonably known at the time it submitted its application, VITAS contends that to allow it do make the correction now is an impermissable amendment. VITAS further concludes that because the original pro formas in the application are in error, Heartland has failed to establish that its proposed hospice is financially feasible, "a fundamental and fatal defect, which standing alone, prevents approval of Heartland's application." Id. at 46.

214. Heartland steers the argument in the direction of the holding of the court in Health Care and Retirement Corporation of America v. Department of Health and Rehabilitative Services, cited at the end of the quote from Manor Care. In particular, Heartland argues that the new information with regard to Schedules 6, 7, and 8 was within the scope of the application when filed. Correction of the information in its pro formas did not introduce a new element into the proceeding and therefore

does not constitute an impermissible amendment to the application.

215. Heartland's argument is the better of the two. If information in an application is incorrect, it must be corrected even if the correction is made after the application is deemed complete. The correction will be allowed so long as the information does not change the nature and scope of the application. See NME Hospitals Inc. v. Department of Health and Rehabilitative Services, Case No. 90-7037 (DOAH February 25, 1992)(Department of Health and Rehabilitative Services April 8, 1992)(to the extent that evidence explains or elaborates on assertions made in a CON application, and the evidence does not change the nature and scope of the proposal, such evidence does not constitute and impermissable amendment).

CON Review Criteria

216. On balance, the applications of both Heartland and VITAS satisfy applicable CON review criteria in Section 408.035, Florida Statutes, and Florida Administrative Code Rules 59C-1.030 and 59C-1.0355. The applications conform with the Agency preferences set forth in Florida Administrative Code Rule 59C-1.0355(4)(e). Both applications comply with Florida Administrative Code Rule 59C-1.008.

217. Heartland's application complies with Section 408.037(1), Florida Statutes. VITAS' application, however, does

not because it does not contain an audited financial statement of the applicant.

218. The correctness of the Agency's determination that VITAS' application was complete was placed in issue in this proceeding by CHNF's petition. See paragraph 23, supra.

219. The issue is a valid one in this formal administrative proceeding, despite AHCA's decision not to dismiss the VITAS petition for failure to include an audited financial statement of the applicant. See Manor Care, 558 So. 2d at 28.

220. VITAS' contention that the failure can be overlooked through the application of Section 408.035(5)(d) fails.

221. That statute forgives an applicant's failure, under certain circumstances, to "strictly comply" with application content requirements. There are a number of examples of what could constitute failure to strictly comply. Clerical error would be one example. See Beverly Enterprises-Florida, Inc. v. AHCA, Case No. 92-5410 (DOAH December 4, 1992) in which CON applications were found to be complete despite that the audited financial statements of the applicants were missing the "assets" page from the balance sheets because of a copying error. The case provides other extenuating circumstances for why the Applicant could be allowed to supply the missing information in its audited financial statement. The case also gives several

other examples, "substantial compliance" and harmless, scrivener's errors, that could be considered failure to strictly comply:

> A different line of cases includes Martin Memorial Hospital Association v. DHRS, 584 So.2d 39 (Fla. 4th DCA 1991), in which the application of the correct applicant/license holder was allowed review, although its resolution said it would complete the project "within the cost guidelines" rather than "at or below . . . costs", as required by statute. The court in Martin Memorial, supra., held that the applicant was in substantial compliance with the statute. Similarly, in South Broward Hospital District d/b/a Memorial Hospital v. DHRS, et al., 14 FALR 3163 (1992), obviously inconsistent dates on the custodian's certificate and the corporate resolution were considered harmless, scrivener's errors.

Beverly Enterprises-Florida, Inc., supra, at 4.

222. Failure to file an audited financial statement of the applicant, however, does not constitute mere failure to strictly comply. It constitutes utter failure to comply with a statutory requirement.

223. The provision in the Application Content Statute devoted to audited financial statements is composed of two sentences. The first requires that financial statements be audited and of the applicant: "(1) An application for a certificate of need must contain: . . . (c) [a]n audited

financial statement of the applicant." § 408.307, Fla. Stat. The second sentence immediately follows:

> In an application submitted by an existing health care facility, health maintenance organization, or hospice, financial condition documentation must include, but not be limited to, a balance sheet and a profit-and-loss statement of the 2 previous fiscal years' operation.

§ 408.037(1)(c), Fla. Stat. In addition to claiming the benefit of the Forgiveness Statute, VITAS maintains that it has complied with the Application Content Statute if it meets the second sentence but not the first. VITAS claims compliance, therefore, by submitting the Other Financial Information contained in the Ernst & Young 2002 Audit in the Audited Consolidated Financial Statements and the Johnson Supplemental Information for the year ending September 30, 2003: two years' worth of balance sheets and profit-and-loss statements. The VITAS construction ignores the existence of the first, obviously central, sentence. The second sentence does not relieve a hospice from providing an audited financial statement of the applicant (which could consist of only <u>one</u> year's worth of financial information). Rather, the second sentence imposes the additional requirement on hospices that the audited financial statement must contain at least two years of balance sheets and profit-and-loss statements audited by an independent certified public accountant, in addition to the rest of the financial information contained in

an audited financial statement for one year. Thus, the second sentence, in no way relieved VITAS from providing an audited financial statement of VITAS the Applicant.

224. The term "audited financial statement" is defined by AHCA rule:

> (4) "Audited financial statement" means all pages of the financial statements of the applicant that have been examined by an independent certified public accountant in accordance with generally accepted auditing standards as set forth in Statements on Auditing Standards published by the American Institute of Certified Public Accountants, on which the certified public accountant expresses an opinion as to the fairness with which the financial statements present financial position, results of operations, and changes in financial position in conformity with generally accepted accounting principles as established by the American Institute of Certified Public Accountants and the Financial Accounting Standards Board.

Fla. Admin. Code R. 59C-1.002.

225. An examination of AHCA's definition in the context of expert opinion in this proceeding about the elements of an audited financial statement, and the meaning and purpose of an audit, reveals the deficiency in the financial statements VITAS supplied in its application.

226. The information failed first because it was not of the applicant. To counter this deficiency, VITAS points out that the 2002 Ernst & Young Audit reviewed balance sheets and

statements of income (the Other Financial Information) that contained individual columns dedicated to VITAS the Applicant. The 2002 Audit Report, moreover, contained a statement from Ernst & Young that the Other Financial Information was subject to the same auditing procedures conducted in the consolidated audit and that the Other Financial Information was fairly stated.

227. Whether the presence of the Other Financial Information and Ernst & Young's statement in the 2002 Audit Report could constitute substantial compliance with the statutory requirement of an audited financial statement of the applicant or not, there is no such statement in the 2003 Audit Report with regard to the Johnson Supplemental Financial Information. The Johnson Financial Supplemental Information, despite the claim made in the Johnson Letter, was neither reviewed nor reported on by an independent certified public accountant. It was internally generated by VITAS and then inserted into the Audited Consolidated Financial Statement. It was not audited information. From AHCA's definition and the testimony at hearing, it is concluded that the central import of an audit is that it contains financial information reviewed and reported on by an independent certified public accountant. Since the Johnson information was not audited by an independent certified public accountant, as VITAS admitted at hearing,

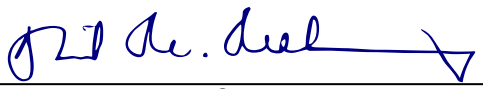
VITAS' failure in compliance was not a failure to strictly comply. Accord Alachua General Hospital, Inc. v. AHCA, Case No. 93-6264, (DOAH October 5, 1994) (AHCA March 15, 1995). Put simply, the 2003 financial information supplied under cover of the Johnson Letter completely failed to comply with the statutory requirement.

228. The VITAS application should be dismissed.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Agency for Health Care Administration approve CON Application 9783 filed by Heartland Services of Florida, Inc., and deny CON Application 9784 filed by Vitas Healthcare Corporation of Florida.

DONE AND ENTERED this 18th day of October, 2006, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 18th day of October, 2006.

ENDNOTES

[1]/ The order of consolidation also consolidated with these two cases Case No. 04-3857. The petition in that case had been filed by North Central Florida Hospice, Inc. ("North Central"), another existing provider of hospice services in Hospice Service Area 4A. North Central voluntarily dismissed its petition on May 12, 2005.

[2]/ The pages of the application are not bates-stamped. There is another page 1 in the materials attached to Schedule 3 behind Tab 3 in Vol. 1 of the application. This page 1 is part of the statements dated September 30, 2003.

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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.