STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Flagler Hospital, Inc./CON #10033
400 Health Park Boulevard
St. Augustine, Florida  32086

Authorized Representative:  W. Eugene Nelson
Health Strategies, Inc.
(850) 222-7110

2. Service District/Subdistrict/County

District 4 (Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia Counties)/St. Johns County

B. PUBLIC HEARING

A public hearing was not held or requested regarding the establishment of a new seven-bed Level II Neonatal Intensive Care Unit (NICU) in District 4 (St. Johns County). However, the applicant submits letters of support for the project as presented below:

The application includes 11 letters of support for this project. The Agency received no support letters independently and there were no letters of opposition. In summary, the 11 letters are identified as follows: four are from practicing physicians; three are from hospital executives; one is from the local county health department director, one is from an academician and two are from mothers that gave birth at Flagler Hospital whose children required NICU services. Each letter is discussed briefly below.

Physician Luis Anderson, a Flagler board-certified pediatrician, indicates that there has been an increase in the number of high-risk premature deliveries at Flagler. He also indicates that he has not intubated a newborn in over two years and that Flagler nursing and physician staff have “limited neonatal experience”. Dr. Anderson states that transfers to nearby NICU facilities due to a lack of NICU services at Flagler leads to a
“tremendous delay in treatment and also a reduction of the effectiveness of treatment”. Dr Anderson concludes that a Level II NICU at Flagler would improve the hospital’s ability to immediately address the needs of high-risk premature infants.

Physician Eric Pulsfus of ObGyn Associates of St. Augustine (St. Johns County, Florida), indicates traumatic deliveries are sent to Jacksonville. The doctor states that distance negatively impacts quality of care. Dr. Anderson contends that patients that are high risk and have limited resources have trouble getting to Jacksonville on a regular basis for their care prior to delivery. He concludes that it would be very beneficial for St. Johns County patients to have (local) access to Level II NICU services.

Mahammed M. Akhiyat, MD, Department Chief, Obstetrics and Gynecology, Putnam Community Medical Center, Palatka, Florida states that according to the District 3 local health council (WellFlorida Council, Inc.) which does not specifically serve District 4, Putnam County had the state’s highest infant mortality rate (14.0) for 2004-2006¹, that the nearest NICU to Palatka (Putnam County) is at Shands Children’s Hospital (Gainesville, Alachua County), which is stated to be some 55 miles away², that a NICU at Flagler Hospital (Flagler) may reduce traveling by up to 15 miles and that in an emergency, such distance could mean life or death. The letter from Dr. Hussein Zabad is materially identical to the one from Dr. Akhiyat.

Bruce Baldwin, CEO of Putnam Community Medical Center, offers a letter that is materially identical to those from Dr. Akhiyat and Dr. Zabad (stated previously). Mr. Baldwin further states approval would greatly improve access to care and clinical outcomes to the region.

A. Hugh Greene, FACHE, President and CEO of Baptist Health (Baptist Hospital-Jacksonville) states that approval of the application would ensure comprehensiveness of care, since Flagler is already a provider of obstetrical services³.

¹ According to the Florida Department of Health (DOH), Office of Planning, Evaluation and Data Analysis, for 2005-2007, Putnam County had an average infant mortality rate of 11 per 1,000 live births while the statewide average was 7.2 for that period. For the year 2007 alone, Putnam County had an infant mortality rate of 4.6 per 1,000 live births (the third lowest infant mortality rate of the 7 counties that comprise District 4), with a statewide infant mortality rate of 7.1 for that period per http://www.floridacharts.com/charts/DisplayHTML.aspx?ReportType=1370&County1=54&County2=64&County3=45&County4=55&year=2007.
² According to Mapquest, the distance between Putnam Community Medical Center and Shands Children’s Hospital is 42.37 miles.
³ Obstetrics is a licensed service as shown in Flagler’s current Agency licensure and is also confirmed in the Agency’s July 2008 Hospital Beds and Services List.
Steven Blumberg, Vice President, Planning and Business Development at Shands-Jacksonville, states that Level II and Level III NICUs at Shands-Jacksonville operate at “high occupancy levels”. Mr. Blumberg further indicates that approval of the project would help relieve capacity pressures at his facility. He concludes that “most importantly, Flagler’s program will improve access to care and minimize travel burdens for local families”.

Dawn Allicock, MD, MPH, Director of the St. Johns County Health Department indicates approval would “greatly enhance access to necessary care for the residents of St. Johns County”. Dr. Allicock further indicates that about 49 percent of admissions to Flagler’s maternity services department are Medicaid recipients and that low income residents are disproportionately burdened by the lack of a local Level II NICU and that this is a barrier to care for those that are transportation challenged. Though Dr. Allicock states there are “many reported instances” of this scenario, the number of patients impacted is not provided. This is similar to other letters of support for this project.

Physician Mark Hudak, an academician, Professor and Associate Chairman of Pediatrics, Chief, Division of Neonatology, Assistant Dean of Managed Care, University of Florida College of Medicine-Jacksonville, indicates that a Level II NICU at Flagler would “greatly enhance access to care for patients living in St. Johns, Putnam and Flagler Counties”. The doctor states Flagler transfers patients in need of NICU services to either Shands-Jacksonville or Wolfson Children’s Hospital (Jacksonville). Dr. Hudak advises that the UF College of Medicine/Jacksonville has an agreement with Flagler to provide clinical oversight of Flagler’s NICU if it is approved.

The two letters from mothers that gave birth at Flagler are complimentary of the services they received at Flagler. However, both discuss problems with delivery and the traumatic experience they encountered when separated from their children who needed NICU care. Both contend that families would greatly benefit with an NICU available locally at Flagler instead of having to utilize NICUs in Alachua and Duval Counties, respectively.

C. PROJECT SUMMARY

Flagler Hospital, Inc. (CON #10033) is a not-for-profit Class 1 general hospital licensed to operate 316 beds as follows: 281 acute care beds; 21 adult psychiatric beds and a 14-bed skilled nursing unit (SNU). The

---

4 CON Application #10033 also includes a transfer agreement signed by executives of Shands Jacksonville Medical Center, Inc. and Flagler Hospital, effective April 7, 2004.
hospital serves primarily three counties – northern Flagler County, northeastern Putnam County and all of St. Johns County. The applicant proposes to establish a seven-bed Level II Neonatal Intensive Care Unit (NICU) program at Flagler Hospital located in St. Augustine, Florida (District 4, St. Johns County). If approved the Level II NICU program will be part of an integrated neonatal delivery network lead by Shands-Jacksonville and the University of Florida College of Medicine-Jacksonville, Department of Pediatrics.

The applicant justifies a seven-bed NICU project for several reasons. The applicant’s forecasts and population growth estimates indicate seven beds will be adequate to meet demand at least through calendar year (CY) 2014. The NICU will be within existing obstetrical space with the consequential decrease in obstetrical space being overcome by new space already in development. Quality is to be realized at the NICU through association with the Shands-Jacksonville neonatal care delivery network.

Flagler Hospital Inc. also states that there is a mal-distribution of existing NICU resources in the district, with six of the eight existing programs located in Duval County and a 75-mile gap between the recently authorized (through exemption #E0700009) NICU program at Baptist Medical Center South [Duval County] and Halifax Medical Center [Volusia County]. The applicant indicates that Flagler Hospital serves the area lying within this gap and that Medicaid and other transportation-disadvantaged, low income residents located in its service area must travel substantially greater distances to access NICU services. The applicant further states that out-migration by those with private insurance precludes it reaching the 1,500 delivery volume required to obtain a CON exemption for Level II NICU services, with those having financial means are stated to be more likely to seek delivery at a facility with NICU services.

The project involves 4,690 total gross square feet (GSF) of renovation (no new construction) with a cost of $655,900. The total cost of the project is $1,175,123. Total project costs include the following: building and equipment costs; project development and start-up costs.

Per Schedule C, the applicant proposes the following conditions:

- A minimum of total annual Level II NICU patient days attributable to patients classified as Medicaid, charity and/or self-pay, combined. Flagler Hospital did not specify a percentage of care of the unit’s total patient days in its condition; but, Schedule 7B indicates that 55.50 percent of the unit’s total annual patient days will be provided to
Medicaid and Medicaid HMO patients. The applicant states in Item 3 g. that it proposes to condition the project to 54 percent of the unit’s total annual patient days being provided to Medicaid charity and self-pay patients.

- Flagler will notify the Agency of its compliance with this condition via submission of the reports required pursuant to Rule 59C-1.013(4), Florida Administrative Code. Since condition compliance reporting is required by statute and rule, the Agency does not condition this on the certificate of need.

D. REVIEW PROCEDURE

The evaluation process is structured by the certificate of need review criteria found in Section 408.035, Florida Statutes. These criteria form the basis for the goals of the review process. The goals represent desirable outcomes to be attained by successful applicants who demonstrate an overall compliance with the criteria. Analysis of an applicant’s capability to undertake the proposed project successfully is conducted by assessing the responses provided in the application, and independent information gathered by the reviewer.

Applications are analyzed to identify strengths and weaknesses in each proposal. If more than one application is submitted for the same type of project in the same district (subdistrict), applications are comparatively reviewed to determine which applicant best meets the review criteria.

Section 59C-1.010(2)(b), Florida Administrative Code, allows no application amendment information subsequent to the application being deemed complete. The burden of proof to entitlement of a certificate rests with the applicant. As such, the applicant is responsible for the representations in the application. This is attested to as part of the application in the certification of the applicant.

As part of the fact-finding, the consultant, Steve Love, analyzed the application in its entirety with consultation from the Financial Analyst, Felton Bradley, who evaluated the financial data, and the Architect, Scott Waltz, who evaluated the architectural and the schematic drawings.
E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA

The following indicate the level of conformity of the proposed project with the criteria and application content requirements found in Florida Statutes, Sections 408.035, and 408.037; applicable rules of the State of Florida, Chapter 59C-1 and 59C-2 and Florida Administrative Code.

1. Fixed Need Pool

a. Does the project proposed respond to need as published by a fixed need pool? Chapters 59C-1.008 and 59C-1.042, Florida Administrative Code.

In Volume 34, Number 30, dated July 25, 2008 of the Florida Administrative Weekly, zero need was published for Level II NICU beds in District 4.

Section 408.036(3)(l), Florida Statutes allows a hospital that experienced a minimum of 1,500 births during the previous 12-month period to establish a 10-bed Level II NICU outside of comparative review if it could meet other criteria that are largely set forth in CON rules for comparative review and discussed below in E.2. The applicant states that the facility realized 1,235 births in CY 2007\(^5\) and therefore did not meet the minimum number of births to qualify for a CON exemption. Consequently, the applicant is applying outside of the fixed need pool and outside the exemption criteria and is applying under special (not normal) circumstances.

b. Regardless of whether bed need is shown under the need formula, the establishment of new Level II neonatal intensive care services within a district shall not normally be approved unless the average occupancy rate for Level II beds in the district equals or exceeds 80 percent for the most recent 12-month period ending six months prior to the beginning date of the quarter of the publication of the fixed need pool.

As of July 25, 2008, District 4 had 83 licensed Level II NICU beds and 11 approved Level II NICU beds\(^6\). Florida Hospital Bed Need Projections and Service Utilizations by District, July 2008 Batching Cycle, reported that

---

\(^5\) Agency hospital discharge data indicates 871 live births (DRGs 390 and 391) for the first three quarters of 2007 and 308 live births (DRGs 794 and 795) for the fourth quarter of 2007; this totals 1,179 live births for CY2007. Applicable DRGs changed for the last quarter of 2007.

\(^6\) The approved beds consist of 10 at Baptist Medical Center South (Exemption #0700009) and one at St. Vincent’s Medical Center (Notification #0700028).
the Level II NICU beds in District 4 experienced an average occupancy rate of 73.00 percent during the period January 2007 through December 2007.

### Level II NICU Bed Utilization - District 4
Calendar Year (CY) 2007

<table>
<thead>
<tr>
<th>Hospital</th>
<th># Beds</th>
<th>Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orange Park Medical Center</td>
<td>4</td>
<td>52.05%</td>
</tr>
<tr>
<td>Baptist Medical Center</td>
<td>24</td>
<td>96.22%</td>
</tr>
<tr>
<td>Memorial Hospital Jacksonville</td>
<td>10</td>
<td>73.01%</td>
</tr>
<tr>
<td>Shands Jacksonville Medical Center</td>
<td>16</td>
<td>78.97%</td>
</tr>
<tr>
<td>St. Luke's Hospital</td>
<td>10</td>
<td>46.22%</td>
</tr>
<tr>
<td>St. Vincent's Medical Center</td>
<td>10</td>
<td>46.58%</td>
</tr>
<tr>
<td>Halifax Medical Center</td>
<td>9</td>
<td>68.89%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>83</strong></td>
<td><strong>73.00%</strong></td>
</tr>
</tbody>
</table>

Source: Florida Hospital Bed Need Projections and Service Utilizations by District, July 2008 Batching Cycle.

c. **Conversion of Underutilized Acute Care Beds.** New Level II neonatal intensive care unit beds shall normally be approved only if the applicant converts a number of acute care beds as defined in Rule 59C-1.038, excluding specialty beds, which is equal to the number of Level II beds proposed, unless the applicant can reasonably project an occupancy rate of 75 percent for the applicable planning horizon, based on historical utilization patterns, for all acute care beds, excluding specialty beds. If the conversion of the number of acute care beds which equals the number of proposed Level II beds would result in an acute care occupancy exceeding 75 percent for the applicable planning horizon, the applicant shall only be required to convert the number of beds necessary to achieve a projected 75 percent acute care occupancy for the applicable planning horizon, excluding specialty beds.

The applicant does not propose to convert acute care beds in order to establish the proposed Level II NICU. However, it is noted that effective July 1, 2004, Section 408.036(5)(c) of the Florida Statutes allows a hospital to add acute care beds in any hospital not located in a statutorily defined “low-growth” county. As of this writing, no county in District 4 meets the definition of “low-growth”. Therefore, even if the applicant had proposed to delicense beds, it could add them back immediately.

d. **Other Special Circumstances:**

Below is a table to account for District 4 Level II NICU occupancy rates for Calendar Year 2003 through Calendar Year 2007.
During the five-year period ending CY 2007, District 4 Level II total patient days were fewest in 2004 (19,761 total patient days) and greatest in 2007 (22,116 total patient days). Percentage occupancy was least in 2004 (58.71 percent) and greatest in 2007 (73.00 percent). District-wide, on a year-by-year basis, total patient days rose from 2004 to 2005 (by an additional 2,645 patient days over the prior year) and from 2006 to 2007 (by an additional 1,025 patient days over the prior year). Patient days correspondingly declined from 2003 to 2004 (2,244 fewer patient days than the prior year) and from 2005 to 2006 (1,315 fewer patient days than the prior year).

District 4 is projected to experience a 5.61 percent growth in its child-bearing age (age 15-44) female population and a 10.05 percent growth in total population over the next five years. Flagler Hospital is located in the city of St. Augustine, in St. Johns County. Over the next five years,
St. Johns County is projected to experience an 11.25 percent growth of its age 15-44 female population and a 15.17 percent in its total population. By January 1, 2014, it is anticipated there will be 4,255 more women of child-bearing age in St. Johns County than in January 2009.

Flagler contends that 11 special (not normal) circumstances exist to warrant establishing a new Level II NICU program in District 4⁷: These are briefly stated below:

- Existing NICU programs in District 4 are geographically mal-distributed, with six of the eight programs (including the recent exemption granted to Baptist Medical Center South) being in Duval County.
- A 75-mile gap between Level II NICU services at (recently exemption approved) Baptist Medical Center South [Duval County] and Halifax Medical Center [Volusia County]. The proposed Flagler Level II NICU program will serve the area lying within this gap.
- Rapid population growth among women of prime child-bearing age resulting in a sharp rise in service area births in recent years, with an expectation of continued growth.
- A transportation challenge for Medicaid and low income residents of Flagler’s service area that are in need of NICU services.
- Flagler service area residents with private insurance are more likely to seek delivery at NICU facilities.
- Delivery out-migration of privately insured patients negatively impacts Flagler’s ability to reach the 1,500 delivery volume required to obtain a CON exemption for a Level II NICU and an expectation this trend will continue at least through 2015.
- Potential continuation and intensification of delivery out-migration with the recent granting of a Level II NICU CON exemption at Baptist Medical Center South, such that Flagler may continue to lag in reaching a 1,500 delivery volume and continue to preclude lower income residents in Flagler’s service area from obtaining local NICU services.
- Project approval would allow Flagler to compete with programs now offering NICU services, keeping “at-risk” obstetrical patients local and forecasting Flagler to exceed a 1,500 delivery volume by 2012.
- During CY 2007, 43 newborns needing NICU services were transferred from Flagler to NICU facilities.
- Project approval would afford Flagler NICU patients the same neonatology group now serving Shands-Jacksonville.
- No adverse impact on obstetrical services at existing Level II NICU providers.

⁷ CON Application #10033, page #’s 10 and 11.
The applicant features these “not normal” circumstances under the following major categories: distribution of NICU services within District 4; service area composition and characteristics; utilization patterns among service area residents; disparities in access to NICU services; utilization forecast and impact on existing providers.

Below is a summary of each of the major features stated above that the applicant believes justifies the special “not normal” circumstances.

Distribution of NICU Services within District 4

The applicant states that of the 25,229 live births in District 4 in 2006, 13,687 or 54 percent occurred in Duval County but that Duval County facilities have 70 of the 82 Level II NICU beds, or 84 percent, of the applicable beds in the district. The applicant further reports 2,412 live births in the Flagler Hospital service area for the period. A 25-mile radius of Flagler would capture appreciably all of St. Johns County, northern Flagler County and northeastern Putnam County – Flagler’s stated primary service area. The applicant also indicates that in 2007 combined Level II and III NICU occupancy rates for District 4 were 78 percent. The Level II NICU occupancy for the same period was 73 percent as previously stated. Flagler points out that project approval would reduce demand for Level II NICU services at Shands-Jacksonville and allow the latter facility to increase beds at the Level III NICU operations there. The applicant concludes that a mal-distribution exists in that Duval County residents accounted for just over half (54 percent) of all live births in District 4 in 2006 but that 84 percent of Level II NICU beds are located in that county.

Below are two maps to account for existing Level II NICU facilities in District 4, the recently CON approved (by Exemption #E0700009) at Baptist Hospital South and the proposed project site. The first map accounts for all the Level II NICUs in the district and the second enlarges Duval County to show all the applicable NICUs in that county.

---

8 CON Application #10033, page #12, Table 2 – Live Births by County: 2006
9 Ibid, page #15, Table 3 – District 4 NICU Occupancy Rates: CY 2007
10 It has been previously stated from CY 2003-2007, the annual occupancy rate at its Level II NICU did not reach the 80 percent threshold for any of the five years, the nearest being 78.87 percent in 2007 and the lowest being 68.00 in 2005.
The applicant indicates it primarily serves residents of St. Johns County. In CY 2007, Flagler reports 832 OB discharges and 837 newborns at the hospital were St. Johns County residents, or 67.4 percent of the hospital's total OB discharges and 66.1 percent of its total births\textsuperscript{11}. OB discharges in total are reported at 1,235 with 1,266 newborns. Flagler

\textsuperscript{11} CON Application #10033, page #16, Table 4 – Flagler Hospital OB and Newborn Discharges
reports 11 zip codes account for 89.8 percent of its OB discharges and 88.8 percent of its newborn discharges. Two of the zip codes are in northern Flagler County (zip codes 32137 and 32164) two are in northeastern Putnam County (zip codes 32131 and 32177) and seven are in St. Johns County (zip codes 32033, 32080, 32084, 32086, 32092, 32095 and 32145). The applicant explains that per Claritas data, from 2008 to 2013, overall population in these zip codes will increase by 43,720 residents (a 20.6 percent increase) and the female age 15-44 (primary child-bearing age) population will increase by 6,473 or by 15.8 percent. Female population age 15-44 growth estimates indicate Flagler’s primary service area will exceed that of District 4 overall for the same period, with Flagler County projected to experience a steeper rise. The applicant contends that as the female age 15-44 population rises at a disproportionately higher rate than the district overall, so will the need for NICU services, as proposed in the project.

Utilization Patterns among Service Area Residents

Flagler reports that in CY 2007, it experienced 45 percent of all St. Johns County resident OB discharges. However, its share of Medicaid and self-pay was higher. Flagler’s share of OB discharges of St. Johns County residents covered by Medicaid was 78 percent, covered by self-pay was 66 percent and covered by private insurance was 28 percent. Conversely, the applicant states that for the same period, NICUs serving St. Johns County residents (as well as other district counties) accounted for 27 percent of St. Johns County resident OB deliveries, but realized only a 13 percent Medicaid draw, an 18 percent self-pay draw and enjoyed a 34 percent private insurance reimbursement. This indicates that Flagler captures a disproportionately higher rate of Medicaid and self-pay OB discharges than NICU facilities overall and a disproportionately lower rate of those who are privately insured. The applicant states that residents of the two northernmost St. Johns County zip codes (32092 and 32095) also enjoy the highest median household income ($59,247 and $52,045, respectively) of the 11 zip codes referenced. Correspondingly, these two zip codes are reported to have a 21 percent Medicaid payer mix and a 73 percent private insurance payer mix, compared to the other nine designated zip codes at 52 percent Medicaid and 41 percent private insurance pay, respectively. This shows a correlation between greater income, a higher rate of private insurance and a higher rate of migration to NICU facilities. The applicant concludes that the recently approved exemption for Level II

---

12 Ibid, Table 5 – Flagler Hospital Discharges by Zip
13 Ibid, page #17 – Flagler Hospital Service Area Diagram
14 Ibid, page #18, Table 6 – Projected Population Growth
15 Ibid, page #21
16 Ibid
17 Ibid, page #24 – OB Payer Mix within Service Area: CY 2007 Diagram
NICU services at Baptist Medical Center South (E0700009) will primarily benefit residents of the Flagler service area living toward northernmost St. Johns County in the highest median household income zip codes (32092 and 32095). The applicant states that if its project is not approved, the Baptist Medical Center South Level II NICU exemption will also erode Flagler’s OB delivery market share, particularly among the more affluent residents of those zip codes and will negatively impact the payer mix at Flagler’s OB delivery services. Flagler shows that in CY 2007, 1,266 newborns were discharged at its facility. Of these 1,220 were discharged to home, 43 were transferred to other acute care hospitals, two were transferred to other institutions and one expired. Of Flagler’s 2007 newborn discharges, 80.8 percent were classified as “normal” newborns (or 1,023 of a 1,266 total), per DRG reference.

Disparities in Access to NICU Services

During CY 2007, the applicant states Medicaid paid for 46 percent of all OB deliveries to service area residents. The two northernmost zip codes in Flagler Hospital’s 11 zip code service area had the lowest percentage of Medicaid OB deliveries and the shortest driving times to NICU facilities. With project approval, driving times will be substantially reduced in the case of all but one of the remaining nine zip codes (zip code 32164), which is primarily served by Florida Hospital-Ormond and Halifax Medical Center. This indicates that a greater number of Medicaid-paid OB deliveries in need of NICU services will be nearer to residents in eight of the 11 zip codes. The reduced driving time is estimated to be from 39 to 22 minutes placing them on par with low Medicaid areas’ 20-minute drive time. The applicant’s analysis defines the five zip codes with the highest Medicaid percentage as those having 65 to 58 percent Medicaid of zip code total discharges and low Medicaid those with 45 to 16 percent. Flagler’s analysis includes Baptist Hospital South, which has a 10-bed Level II NICU exemption pending licensure.

---

18 Ibid, page #23 - CY 2007 discharge data shows Flagler has 54 percent of zip code 32095 and 18 percent of 32092 OB market share compared to Baptist South at 22 and 42 percent, respectively.
19 Ibid, page #25, Table 9 – Flagler Hospital Newborn Discharges by Discharge Status
20 Ibid, Table 10 – Flagler Hospital Newborn Discharges by DRG
21 Ibid, page #28, Table 12 – Average Driving Time to Nearest NICU
22 The applicant indicates that drive times for the service area and zip code combinations are weighted based on the number of females age 15-44 in each zip code.
Utilization Forecast

Flagler estimates, that the 11 zip code service area will generate 3,038 OB discharges and 3,142 newborn discharges by 2012 (the third year of operation). With project approval, the applicant estimates 109 additional newborn discharges by 2010, 150 by 2011 and 155 by 2012. Peak census is estimated to reach 5.3 in year one, 6.8 in year two and 7.0 in year three, with estimated occupancy rates at 37.1 percent, 52.1 percent and 53.7 percent, respectively and an average daily census (ADC) of 2.6, 3.6 and 3.8, respectively. With project approval, the net gain in OB deliveries, by 2012 is estimated to be 125 and a total OB delivery count of 1,528, with a net gain of 125 OB deliveries as a result of the project. Flagler contends that if it does not have a Level II NICU it will most likely not be able to obtain the 1,500 births required for exemption based on the likelihood that expectant mothers undergoing problem pregnancies elect to deliver at a hospital with a NICU. The applicant states its estimates preserve the current OB market share balance between Flagler and Baptist Hospital South and points out that Baptist South’s parent organization supports Flagler’s NICU. As noted earlier, A. Hugh Greene, President and CEO of Baptist Health provided a letter of support indicating that the approval of Flagler’s NICU is appropriate to ensure comprehensiveness of care.

Impact of Existing Providers

Flagler provides five reasons for little to no negative impact to existing NICU providers, should this project be approved.

- The applicant will continue to transfer Level III NICU cases to Shands-Jacksonville and executive staff of Shands-Jacksonville provide letters of support for this project.
- Existing NICU programs will experience minor losses in the number of high-risk OB deliveries now deferred from Flagler.
- Putnam Community Medical Center may experience a reduction in high-risk OB discharges and executive staff of this facility provide letters of support for this project.
- Baptist Medical Center South will maintain, rather than expand its market share within the two zip code areas where Flagler Hospital and Baptist Medical Center South compete for obstetrical and newborn patients. The CEO and president of Baptist Health supports this project.

---

23 Ibid, page #29, Table 13 – Service Area Forecasts: 2010-2013
24 Ibid, page #31, Table 16 – Projected Newborn Discharges/Flagler Hospital: 2010-2012
26 Ibid, page #33, Table 20 – Projected OB Deliveries/Flagler Hospital: 2010-2012
Each hospital providing obstetrical services to residents of the 11 zip code service area will discharge a few less OB patients in future years compared to the number they would have obtained without the proposed NICU program at Flagler. The applicant indicates that its project will capture 112 admissions that would otherwise go to existing Level II facilities and Baptist South’s proposed NICU based on each hospital’s current market share, exclusive of Flagler Hospital discharges. However, only Putnam Community Hospital and Orange Park Medical Center are expected to discharge fewer OB patients than in CY 2007. Putnam is projected to discharge 16 fewer patients but the applicant notes that in CY 2007 Putnam provided 22 deliveries to women with high-risk pregnancies and states that Putnam supports the applicant’s project because it recognizes the need to provide these patients with a NICU program. The applicant projects the impact on Orange Park Medical Center to be minimal in that Orange Park is projected to lose only two patients. This is consistent with the applicant’s CY 2007 service area discharge data which shows Orange Park has only one zip of the 11 with a double digit percent of the total at 12 percent. Orange Park served six patients or less (two with none) in 10 of the 11 zip codes.

As previously discussed in section E1.b above, District 4 experienced a Level II NICU occupancy rate of 73.00 percent for CY 2007, which is below the 80 percent occupancy threshold for Level II services and therefore need for Level II beds was not published for District 4 by the Agency. Quarterly occupancy rates for Level II NICU beds in District 4 rose in the last three quarters of CY 2007 and exceeded the 80 percent threshold for one quarter (the last quarter of that year [December 2007]).

The applicant’s project would increase access to Level II NICU services for its service area residents in the 11 zip code service area, especially St. Johns County residents. The applicant contends that the 1,500 exemption threshold will probably not be met should it not get this project based on its staff obstetricians reporting expectant mothers with problem pregnancies will chose hospitals with NICUs. Medicaid and Medicaid HMOs are projected to comprise 55.50 percent of the unit’s total patient days and the applicant offers to condition to a minimum, which per Schedule 7B would be 55.5 percent. Flagler has the support of the two facilities that it projects would be most impacted by its project, Baptist South and Putnam Community Hospital, which is a District 3 facility. The applicant has the support of Shands Jacksonville which indicates the applicant will utilize the University of Florida neonatal physician group, will improve access to care and minimize travel burdens for local families. Shands Jacksonville also contends that the project will relieve capacity issues on its program.
2. **Agency Rule Preferences**

Please indicate how each applicable preference for the type of service proposed is met. Chapter 59C-1.042, Florida Administrative Code.

Note: References to Level III NICU preferences are deleted where not relevant.

a. **Rule 59C-1.042(3)(k), Florida Administrative Code - Services to Medically Indigent and Medicaid Patients.** In a comparative review, preference shall be given to hospitals which propose to provide neonatal intensive care services to Children’s Medical Services patients, Medicaid patients, and non-Children’s Medical Services patients who are defined as charity care patients according to the Health Care Board, Florida Hospital Uniform Reporting System Manual, Chapter III, Section 3223. The applicant shall estimate, based on its historical patient data by type of payer, the percentage of neonatal intensive care services patient days that will be allocated to:

1. Charity care patient;
2. Medicaid patients;
3. Private pay patients, including self-pay; and
4. Regional Perinatal Intensive Care Center Program and Step Down Neonatal Special Care Unit patients.

There is no other applicant in the current review cycle so comparative review is not applicable. Flagler expects to provide services to all patients who require Level II NICU care.

The applicant projects the following payor mix for the second year of operations for its proposed seven-bed Level II NICU program.

<table>
<thead>
<tr>
<th>Payer</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Pay</td>
<td>4.9%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>55.1%</td>
</tr>
<tr>
<td>Medicaid HMO</td>
<td>0.4%</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>7.6%</td>
</tr>
<tr>
<td>Other Managed Care</td>
<td>31.8%</td>
</tr>
<tr>
<td>Other Payers</td>
<td>0.2%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Source: CON Application #10033, Schedule 7B.*

Notes to Schedule 7B indicate that bad debt and charity are grouped in the self-pay category and self-pay write-off is assumed as charity. The applicant’s response to Item 3. g. indicates that charity care will consist of 1.1 percent of year one and year two Level II NICU patient days.
The applicant is not a regional perinatal intensive care center. Refer to E.4.g. below for further discussion.

b. Rule 59C-1.042(4), Florida Administrative Code - Level II and Level III Service Continuity. To help assure the continuity of services provided to neonatal intensive care services patients:

(1) Hospitals may be approved for Level II neonatal intensive care services without providing Level III services.

The applicant is not currently approved to offer Level II NICU services at its facility. Such approval is the purpose of this project.

(2) Applicants proposing to provide Level II neonatal intensive care services shall ensure developmental follow-up on patients after discharge to monitor the outcome of care and assure necessary referrals to community resources.

The applicant states that developmental follow-up will be accomplished through the developmentalist, parents, neonatal nurse clinician and the NICU discharge team. Referrals, as necessary, will be provided. A social worker assigned to the unit after discharge will monitor the outcome of care.

c. Rule 59C-1.042(5), Florida Administrative Code - Minimum Unit Size. Hospitals proposing the establishment of new Level II neonatal intensive care services shall propose a Level II neonatal intensive care unit with a minimum of 10 beds. Hospitals under contract with the Department of Health and Rehabilitative Services’ Children’s Medical Services Program for the provision of regional perinatal intensive care center or step-down neonatal special care unit are exempt from these requirements.

The applicant proposes to establish a seven-bed Level II NICU. Flagler reiterates that its forecasts and anticipated population growth in the service area support the need for only seven beds. The applicant also states that the NICU is being created within the existing obstetrical space and will result in the loss of six Labor, Delivery and Recovery (LDR) rooms. The project would result in 10 remaining LDR rooms and any less would soon become problematic from an obstetrical perspective. Creation of a 10-bed NICU would require loss of another LDR room without adding additional value to the NICU service. The applicant correctly states that unit size is simply one of many criteria in assessing need for an additional program. The existing facility is not a regional perinatal intensive care center or step-down neonatal special care unit.
d. Rule 59C-1.042(6) Florida Administrative Code - Minimum Birth Volume Requirement. Hospitals applying for Level II neonatal intensive care services shall not normally be approved unless the hospital has a minimum service volume of 1,000 live births for the most recent 12-month period ending six months prior to the beginning date of the quarter of the publication of the fixed bed need pool. Specialty children’s hospitals are exempt from these requirements.

For the period January 2007 through December 2007, the applicant indicates Agency hospital discharge data shows that there were 1,235 live births at Flagler. This live birth total exceeds the minimum service volume of 1,000 live births as specified in this rule preference.

e. Rule 59C-1.042(7) Florida Administrative Code - Geographic Access. Level II neonatal intensive care services shall be available within two hours ground travel time under normal traffic conditions for 90 percent of the population in the service district.

Level II NICU services are available and accessible within the two hours ground time to 90 percent of the residents of District 4. The applicant has the support of Baptist Medical Center and Shands Jacksonville Medical Center, whose facilities are the two largest Level II NICU providers and the only Level III NICU providers in the district.

f. Rule 59C-1.042(8) Florida Administrative Code - Quality of Care Standards.

(1) Physician Staffing: Level II neonatal intensive care services shall be directed by a neonatologist or a group of neonatologists who are on active staff of the hospital with unlimited privileges and provide 24-hour coverage, and who are either board-certified or board-eligible in neonatal-perinatal medicine.

The applicant states that neonatology expertise will be provided by a group of board-certified neonatologists in neonatal-perinatal medicine, with the Level II NICU to be staffed by clinicians with the University of Florida (UF) College of Medicine-Jacksonville, Department of Pediatrics. All neonatologists will be on active staff of Flagler, with full privileges, providing continuous 24-hour per day and seven-day per week coverage. The applicant indicates that UF shall appoint an appropriately trained and experienced university physician as the medical director of Flagler’s neonatology services unit. The applicant includes, in the physician curriculum vitae of the application, 13 resumes of applicable staff
physicians. One of these resumes is from Mark Hudak, MD, Professor and Associate Chairman of Pediatrics, Chief, Division of Neonatology, Assistant Dean of Managed Care, University of Florida College of Medicine-Jacksonville, who also includes a letter of support for this project confirming that Shands has established an agreement with Flagler to provide clinical oversight of Flagler’s NICU.

(2) **Nursing Staffing:** The nursing staff in Level II neonatal intensive care units shall be under the supervision of a head nurse with experience and training in neonatal intensive care nursing. The head nurse shall be a registered professional nurse. At least one-half of the nursing personnel assigned to each work shift in Level II neonatal intensive care units must be registered nurses.

Flagler Hospital states the newborn nursery and Level II nursery will be supervised by a registered nurse (RN), with training and experience in a NICU and that all nurses assigned to Flagler’s NICU will be RNs. Flagler states that it currently employs five RNs who have been trained and employed in at least a Level II nursery.

Schedule 6A shows that the nursing staff FTEs added by this project will be for 5.5 FTEs, all being RNs with the count remaining constant for both years one and two.

(3) **Special Skills of Nursing Staff:** Nurses in Level II neonatal intensive care units shall be trained to administer cardiorespiratory monitoring, assist in ventilation, administer I.V. fluids, provide pre-operative and post-operative care of newborns requiring surgery, manage neonates being transported, and provide emergency treatment of conditions such as apnea, seizures, and respiratory distress.

The applicant indicates that all RNs and respiratory therapists (RTs) assigned to the Level II NICU will be trained in the skills listed above prior to opening the proposed NICU. All nursing staff will be certified in the Neonatal Resuscitation Program (NRP) and the Sugar, Temperature, Assisted Breathing, Blood Pressure, Lab Work, and Emotional Support to Family (STABLE) Program. The applicant states that the STABLE program addresses post-resuscitation/pre-transport stabilization care of sick newborns.

---

27 The applicant does not include curriculum vitae for related and support clinicians (such as registered nurses (RNs), respiratory therapists (RTs) and registered dieticians (RDs).
(4) **Respiratory Therapy Technician Staffing:** At least one certified respiratory care practitioner therapist with expertise in the care of Neonates shall be available in the hospitals with Level II neonatal intensive care services at all times. There shall be at least one respiratory therapist technician for every four infants receiving assisted ventilation.

The applicant states there will be at least one respiratory therapist (RT) available in the hospital on a 24-hour basis with neonatal experience and that all RTs at Flagler are required to maintain NRP certification. The applicant indicates an average daily census (ADC) in the proposed Level II NICU of 2.6 during the first year of operation and 3.6 during the second. Based on this estimate, the applicant anticipates no challenges in meeting the required ratio of RT technicians.

(5) **Blood Gases Determination and Ancillary Service Requirements:** Blood gas determination shall be available and accessible on a 24-hour basis in all hospitals with Level II neonatal intensive care services.

The applicant indicates that its facility has blood gas determinations available and accessible on a 24-hour basis, with all RTs being compliant with applicable required clinical competencies pertaining to the blood gas lab, in accordance with CLIA (Clinical Laboratory Improvement Amendments), U.S. Food and Drug Administration and Joint Commission requirements.

(6) **Hospitals providing Level II neonatal intensive care services shall provide on-site, on a 24-hour basis, x-ray, obstetric ultrasound, and clinical laboratory services. Anesthesia shall be available on an on-call basis within 30 minutes. Clinical laboratory services shall have the capability to perform microstudies.**

The applicant indicates all services specified in the above standard are currently available on-site at Flagler. On-site x-ray, obstetric ultrasound, and clinical laboratory services will be performed within the NICU. Flagler’s clinical laboratory has the capability to perform micro studies.
Nutritional Services: Each hospital with Level II neonatal intensive care services shall have a dietician or nutritionist to provide information on patient dietary needs while in the hospital and to provide the patient’s family instruction or counseling regarding the appropriate nutritional and dietary needs of the patient after discharge.

The applicant states a registered dietician with special expertise in neonates is available to work with the planned NICU’s neonatologists, nursing and social work staff as well as each family to provide dietary and nutritional counseling, during hospitalization and after discharge.

Social Services: Each hospital with Level II neonatal intensive care services shall make available the services of the hospital’s social service department to patients’ families which shall include, but not be limited to, family counseling and referral to appropriate agencies for services. Children potentially eligible for the Medicaid, Children’s Medical Services, or Developmental Services Programs shall be referred to the appropriate eligibility worker for eligibility determination.

Flagler states that a social worker familiar with neonatal developmental needs and the resources and needs of NICU families will be assigned to the project at the Flagler’s social services department.

The stated objective of social services is that appropriate arrangements are made in preparation for discharge, matching patient and family needs to appropriate community resources.

Developmental Disabilities Intervention Services: Each hospital that provides Level II neonatal intensive care services shall provide in-hospital intervention services for infants identified as being at high risk for developmental disabilities to include developmental assessment, intervention, and parental support and education.

The applicant states that in-hospital services for infants identified as being at-risk for developmental disabilities will be provided to NICU patients at Flagler by the unit consultant developmentalist. Flagler indicates that priority will be given to babies eligible for the State’s Early Intervention Program and assessment will be available for all NICU babies utilizing such tools as the NIDCAP Naturalistic Observation of Newborn Behavior; Brazelton Neonatal Behavioral Assessments Scale and the Neonatal Oral Motor
Assessment Scale (NOMAS). According to the application, the developmentalist, parents, neonatal nurse clinician and the NICU discharge team will work together to identify developmental needs of babies at discharge and make referrals as necessary to ensure those needs are met.

(10) **Discharge Planning:** Each hospital that provides Level II neonatal intensive care services shall have an interdisciplinary staff responsible for discharge planning. Each hospital shall designate a person responsible for discharge planning.

The applicant states one of the RNs assigned to the NICU has the designated responsibility for coordinating discharge planning for each neonate, with interdisciplinary support, from other team members, as appropriate, to ensure optimal discharge operations. Flagler indicates that discharge planning will address the infant’s medical and social needs following discharge in terms of rehabilitative therapies, breastfeeding, family support and counseling, and referral to community resources as needed.

g. **Rule 59C-1.042(9), Florida Administrative Code - Level II Neonatal Intensive Care Unit Standards:** The following standards shall apply to Level II neonatal intensive care services:

(1) **Nurse to Neonate Staffing Ratio.** Hospitals shall have a nurse to neonate ratio of at least 1:4 in Level III neonatal intensive care units at all times. At least 50 percent of the nurses shall be registered nurses.

The applicant states the applicable ratio will be at least 1:4 and that all NICU nurses at Flagler will be RNs. According to Schedule 6A, an incremental (or reassignment from within Flagler) RN FTE count of 5.5 is anticipated for both year one and two of the project.

(2) **Requirements for Level II NICU Patient Stations.** Each patient station in a Level II NICU shall have, at a minimum:

a. Fifty square feet per infant;
b. Two wall mounted suction outlets preferably equipped with a unit alarm to signal loss of vacuum;
c. Eight electrical outlets;
d. Two oxygen outlets and an equal number of compressed air outlets and adequate provisions for mixing these gases;
e. An incubator or radiant warmer;
f. One heated humidifier and oxyhood;
g. One respiration or heart rate monitor;
h. One resuscitation bag and mask;
i. One infusion pump;
j. At least one oxygen analyzer for every three beds;
k. At least one non-invasive blood pressure monitoring device for every three beds;
l. At least one portable suction device; and
m. Not less than one ventilator for every three beds.

The applicant indicates that its proposed Level II NICU will comply with all of the above requirements, meeting or exceeding them. Refer to the architectural review below in E.4.f.

(3) Equipment Required to be Available to Each Level II NICU on demand:

a. An EKG machine with print-out capacity;
b. Transcutaneous oxygen monitoring equipment; and
c. Availability of continuous blood pressure measurement.

The applicant indicates that its proposed Level II NICU will comply with all of the above requirements, meeting or exceeding them.

i. Rule 59C-1.042(11) Florida Administrative Code - Emergency Transportation Services: Each hospital providing Level II neonatal intensive care services or Level III neonatal intensive care services shall have or participate in an emergency 24-hour patient transportation system.

(1) Provision of Emergency Transportation. Hospitals providing Level II or Level III neonatal intensive care services must operate a 24-hour emergency transportation system directly, or contract for this service, or participate through a written financial or non-financial agreement with a provider of emergency transportation services.

(2) Requirements for Emergency Transportation System. Emergency transportation system, as defined in paragraph (11)(a), shall conform to Chapter 64E-2.003, Florida Administrative Code.

The applicant states it currently transports all of its neonates requiring intensive care services to Shands-Jacksonville, that there is a transfer agreement between Flagler and Shands-Jacksonville and that they (Shands-Jacksonville) provide the transportation. The referenced (signed) transfer agreement is included in Support Materials-Transfer Agreement, effective April 7, 2004. Flagler
indicates it will review/revise the transfer agreement, as necessary, prior to project implementation. The NICU transport team consists of at least one neonate RN and RT qualified for transport duty. Applicable team members are stated to be available within 30 minutes or less on a 24-hour basis to perform transport services.

j. **Rule 59C-1.042(12) Florida Administrative Code - Transfer Agreements:** A hospital providing only Level II neonatal intensive care services shall provide documentation of a transfer agreement with a facility providing Level III neonatal intensive care services in the same or nearest service district for patients in need of Level III services. Facilities providing Level III neonatal intensive care services shall not unreasonably withhold consent to transfer agreements which provide for transfers based upon availability of service in the Level III facility, and which will be applied uniformly to all patients requiring transfer to Level III, as defined in subparagraph (2)(e)2. An applicant for Level II or Level III neonatal intensive care services shall include, as part of the application, a written protocol governing the transfer of neonatal intensive care services patients to other inpatient facilities.

As previously stated, the applicant includes in Support Materials-Transfer Agreement, a signed, April 7, 2004 transfer agreement between Flagler and Shands-Jacksonville (a Level II and Level III NICU provider).

k. **Rule 59C-1.042(13) Florida Administrative Code - Data Reporting Requirements:** All hospitals with Level II neonatal intensive care services shall provide the Agency or its designee with patient utilization and fiscal reports which contain data relating to patient utilization of Level II and Level III neonatal intensive care services.

1. **Utilization Data.**
2. **Patient Origin Data**

The applicant does not respond to this rule preference directly; rather, the applicant predicates on conditions that it will notify the Agency of its compliance via submission of the reports required pursuant to Rule 59C-1.013(4) Florida Administrative Code.

3. **Statutory Review Criteria**

a. **Is need for the project evidenced by the availability, quality of care, efficiency, accessibility, and extent of utilization of existing health care facilities and health services in the applicant’s service area?** ss. 408.035(1) (a), (b) and (e) Florida Statutes.
District 4’s Level II NICU’s experienced an average annual occupancy rate for the 12-month period ending December 31, 2007 of 73.00 percent and zero need for additional Level II NICU beds was published by the Agency.

Flagler Hospital is the only acute care general hospital and thus is the sole provider of hospital obstetrical services in St. Johns County. There is no NICU provider there, nor is there one in Baker, Flagler or Nassau Counties (all these being in District 4). However, the planning area for NICU beds is the district, not the county, as NICU services are considered tertiary. In this case, the district consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia Counties. NICU providers are located in Clay, Duval and Volusia Counties.

Most of Flagler’s Level II NICU patients are transported to Shands-Jacksonville and the letters of support section of the application include executive staff at the latter facility in support of the project. Executive staff of Baptist Health (another potentially negatively impacted NICU provider in the district) also supports this project, as shown in the letters of support section of the application. No other NICU provider in the district is anticipated to be significantly impacted and the Agency received no letters of opposition on this project.

The applicant previously indicates that NICU beds are mal-distributed in District 4, with the majority being in Duval County, making them less accessible (a greater transportation burden to residents and families), particularly to Medicaid and low-income residents of St. Johns County. This is supported by the St. Johns County Health Department Director, Dawn Allicock, MD, MPH. Travel distances and times, as indicated under E.3.d. of this report, are within the travel standard promulgated in CON Rule. The applicant makes reference to discussion with Deweece Ogden, Medical Health Care Program Analyst, Area 4 Medicaid Program Office about the challenges of negotiating bus transportation for a mother (or others) between Sunshine Bus (the St. Johns County transportation provider) and the Jacksonville Transit Authority and the inherent necessary transfers, confusion, stresses, dangers and timeframes in navigating such transit. As previously indicated under E.1. of this report, in none of the five years ending December 2007 did any Level II NICU in the following District 4 facilities experience an annual occupancy rate in excess of the 80 percent threshold: Halifax Medical Center; St. Luke’s Hospital; St. Vincent’s Medical Center and Shands-Jacksonville Medical Center.
Executive staff at Baptist Health support the project by stating in a support letter that, “the addition of a Level II NICU to support their existing service is appropriate to further ensure comprehensiveness of care”.

Regarding quality of care, the applicant contends that quality of care is enhanced by project approval in three primary areas: a reduction in the number of transports; a reduction in mother-infant separations when mothers remain at Flagler but the baby requires NICU care and a reduction in the number of perinatal wound break down or cesarean section wound breakdown as a result of a mother traveling to be with their ill infant in Jacksonville.

Need for the project is evidenced by the availability, quality of care and expected extent of utilization of existing health care facilities and health services in the applicant’s service area. As noted earlier, existing providers that already receive infants from Flagler in need of Level II NICU care support the project.

b. Does the applicant have a history of providing quality of care? Has the applicant demonstrated the ability of providing quality care? ss. 408.035(1) (c) Florida Statutes.

Flagler Hospital includes in its application current Agency licensure as a 316-bed Class 1 hospital as follows: 281 acute care beds; 21 adult psychiatric beds and 14 SNU beds. In its Joint Commission Quality Report Section, the applicant is shown to have Joint Commission hospital and pathology and clinical laboratory accreditations. It also has accreditation as a Primary Stroke Center. In 2004 Flagler Hospital received the Hospital Quality Alliance Participant Award and in 2005 the Hospital Magnet Award (both confirmed by Joint Commission documentation). In addition to these certifications and awards, the applicant also submits the following quality protocols: a 44-page 2007-2008 Performance Improvement Plan and a 15-page 2008 Utilization Review Plan.

Below is a sample of some of the 25 other recent awards attested to by the applicant:

- Top five percent in the nation for Patient Safety (HealthGrades, 2006).
- North Florida’s First Magnet Hospital (American Nurses Credentialing Center).
- Best cardiac surgery program in Florida (HealthGrades 2006).

---

28 CON Application #10033, page #'s 52 and 53
CON Action Number: 10033

- Women’s Health Excellence Award 2006-2008 (HealthGrades).
- Vascular Excellence Award 2006 and 2008 (HealthGrades).
- One of Three Top Florida Hospitals, Advance for Nurses Magazine 2007.

The applicant does not provide documentation to verify any of the samples of the 25 awards in the list found immediately above, nor in any of the 25 listed in the application. The applicant also attests to a Patient Bill of Rights and a Patient Rights and Protection Policy but does not include either for Agency review.

There were four confirmed complaints and two confirmed complaints without deficiency for Flagler Hospital, Inc. for the three-year period ending September 24, 2008. For the three-year period, the following four confirmed complaint categories were verified by Agency records with one complaint for each of the following: lack of assessment; medical services; nursing services and pressure sores. For the same period, the following two complaints were confirmed without deficiency: dietary and life safety code.

The applicant has a history of providing quality of care and demonstrates the ability to provide quality of care. Quality of care in Flagler’s Level II NICU should be enhanced as Flagler’s program will become part of an integrated neonatal care delivery network led by Shands Jacksonville and the University of Florida College of Medicine, Department of Pediatrics. This allows quality care at Flagler for patients that are currently transferred from Flagler to Shands Jacksonville and will eliminate transfer cost, quality concerns associated (separation of mother and child being one) and alleviate some of the capacity issues affecting Shands Jacksonville. As previously stated, Shands has established an agreement with Flagler to provide clinical oversight of Flagler’s NICU.

c. What resources, including health manpower, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? ss. 408.035(1)(d) Florida Statutes.

The financial impact of the project will include the projected cost of $1,175,123 and incremental operating cost in year two of $2,109,318.

Analysis: The audited financial statements of Flagler Hospital, Inc. for the fiscal years ending September 30, 2006 and 2007 were analyzes for the purpose of evaluating the applicant’s ability to provide the capital and operational funding necessary to implement the project.
Short-Term Position:
The applicant’s current ratio of 1.3 indicates current assets are slightly greater than current liabilities, an adequate position. The ratio of cash flow to current liabilities of 0.8 is above average, a good position. The working capital (current assets less current liabilities) of $7.7 million is a measure of excess liquidity that could be used to fund capital projects. Overall, the applicant has an adequate short-term position.

Long-Term Position:
The long-term debt to equity ratio of 0.6 is average and indicates long-term debt is less than equity, an adequate position. The cash flow to assets ratio of 8.0 percent is above average, an adequate position. The most recent year had excess revenues over expenses of a negative 2.5 million, which resulted in an operating margin of -1.4 percent. It should be noted that the operating loss was offset by a non-operating investment income of 4.9 million. Overall, the applicant has an adequate long-term position.

Capital Requirements:
Schedule 2 indicates the applicant has capital projects totaling $4.3 million. Schedule 2 does not include current maturities of long-term debt. According to the audit current maturities of long-term debt total $5.3 million by September 2009.

Available Capital:
Funding for the project will come from the applicant’s own operations and/or other internal funds. As of September 30, 2007, (financial statements) Flagler has $7.7 million in working capital. Additionally, Flagler generated cash from operation of approximately $19.3 million and has 67.7 of the $70.8 million in board designated funds that are available if deemed necessary. The hospital has a $27 million beneficial interest in net assets to the Foundation.

Conclusion: Funding for this project and the entire capital budget should be available as needed.
Flagler Hospital, Inc.

<table>
<thead>
<tr>
<th></th>
<th>9/30/2007</th>
<th>9/30/2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Assets</td>
<td>$31,221,617</td>
<td>$29,391,543</td>
</tr>
<tr>
<td>Cash and Current Investment</td>
<td>$2,146,015</td>
<td>$1,030,153</td>
</tr>
<tr>
<td>Board Designated Funds</td>
<td>$63,747,349</td>
<td>$52,605,264</td>
</tr>
<tr>
<td>Total Assets</td>
<td>$241,988,046</td>
<td>$230,195,579</td>
</tr>
<tr>
<td>Current Liabilities</td>
<td>$23,532,924</td>
<td>$19,203,288</td>
</tr>
<tr>
<td>Total Liabilities</td>
<td>$106,028,665</td>
<td>$104,424,404</td>
</tr>
<tr>
<td>Net Assets</td>
<td>$135,959,381</td>
<td>$125,771,175</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$177,798,103</td>
<td>$177,859,524</td>
</tr>
<tr>
<td>Interest Expense</td>
<td>$3,409,325</td>
<td>$3,269,313</td>
</tr>
<tr>
<td>Excess of Revenues Over Expenses</td>
<td>($2,518,046)</td>
<td>($735,063)</td>
</tr>
<tr>
<td>Cash Flow from Operations</td>
<td>$19,309,702</td>
<td>$15,630,987</td>
</tr>
<tr>
<td>Working Capital</td>
<td>$7,688,693</td>
<td>$10,188,255</td>
</tr>
</tbody>
</table>

**FINANCIAL RATIOS**

<table>
<thead>
<tr>
<th></th>
<th>9/30/2007</th>
<th>9/30/2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Ratio (CA/CL)</td>
<td>1.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Cash Flow to Current Liabilities (CFO/CL)</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Long-Term Debt to Net Assets (TL-CL/NA)</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>Times Interest Earned (NPO+ Int/Int)</td>
<td>0.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Net Assets to Total Assets (TE/TA)</td>
<td>56.2%</td>
<td>54.6%</td>
</tr>
<tr>
<td>Operating Margin (ER/TR)</td>
<td>-1.4%</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Return on Assets (ER/TA)</td>
<td>-1.0%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Operating Cash Flow to Assets (CFO/TA)</td>
<td>8.0%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

d. **What is the immediate and long-term financial feasibility of the proposal? ss. 408.035(1) (f), Florida Statutes.**

A comparison of the applicant’s estimated control group values provides for an objective evaluation of financial feasibility, (the likelihood that the services can be provided under the parameters and conditions contained in Schedules 7 and 8), and efficiency, (the degree of economies achievable through the management skills of the applicant). In general, projections that approximate the median are the most desirable, and balance the opposing forces of feasibility and efficiency. In other words, as estimates approach the highest in the group, it is more likely that the project is feasible, because fewer economies must be realized to achieve the desired outcome. Conversely, as estimates approach the lowest in the group, it is less likely that the project is feasible, because a much higher level of economies must be realized to achieve the desired
outcome. These relationships hold true for a constant intensity of service through the relevant range of outcomes. As these relationships go beyond the relevant range of outcomes, revenues and expenses may, go either beyond what the market will tolerate, or may decrease to levels where activities are no longer sustainable.

Comparative data were derived from hospitals in peer groups that reported data in 2006; the applicant will be compared to the 33 hospitals in peer (Group 6). This group includes the applicant and 11 of the 33 facilities in the group that have an approved NICU II program. Comparative data for the NICU II program on a stand-alone basis were derived from hospitals with approved and operational NICU II programs in 2006. Per diem rates are projected to increase by an average of 3.7 percent per year. Inflation adjustments were based on the new CMS Market Basket, 3rd Quarter, 2008.

Gross revenues, net revenues, and costs were obtained from Schedules 7 and 8 in the financial portion of the application. These were compared to the control group as a calculated amount per adjusted patient day.

Projected net revenue per adjusted patient day (NRAPD) of $1,522 in year one and $1,566 in year two is between the control group lowest and median values of $1,385 and $1,788 in year one and $1,424 and $1,839 in year two. With net revenues per adjusted patient day falling between the lowest and median values, the facility is expected to consume health care resources in proportion to the services provided. (See Table below).

The applicant’s NRAPD in fiscal year 2006 was reported as $1,544. The difference in the NRAPD reported in 2006 and the year two projected NRAPD of $1,566 results in an average compound annual increase of approximately 0.28 percent. This level of increase is well below the inflation percentage outlined in the CMS Market Basket, 3rd Quarter 2008, and index. Net revenues appear to be understated, understating revenues is a conservative assumption and therefore reasonable.

Projected cost per adjusted patient day of $1,519 in year one and $1,556 in year two fall between the control group’s lowest and median values of $1,497 and $1,743 in year one and $1,539 and $1,792 in year two. The lowest level is generally viewed as the practical lower limit on efficiency. With anticipated cost between the lowest and median value in the control group, the year two cost appear efficient. (See Table below).
The applicant’s CAPD in calendar year 2006 was reported as $1,552. The difference in the CAPD reported in 2006 and the year two projected CAPD of $1,556 results in an average compound annual increase of approximately 0.5 percent. This level of increase is well below both the three percent rate indicated in the notes to the projections and the inflation percentage outlined in the CMS Market Basket, 3rd Quarter, 2008 index. Projected cost appears to be understated.

The year two projected incremental cost per patient day (CPD) for the Level II neonatal patients is $1,353. The CPD falls between the control group lowest and median values of $779 and $2,351. The projected costs for the level II NICU program appear reasonable. The projected year two operating profit for the hospital of $1 million computes to an operating margin per adjusted patient day of $10 or 0.6 percent that equals the peer group median value of $10. In 2006 the hospital reported an operating margin of a negative $8 per adjusted patient day or a negative 0.5 percent. Both projected and historic margins are virtually at the break even point. Although CAPD were understated, the applicant also understated NRAPD at a proportional rate. The overall margin appears reasonable and the incremental profit added by this project of $75,468 is not considered material.

**Conclusion:** This project appears to be financially feasible and is not likely to have a material impact on the existing operations of the applicant.
### FLAGLER HOSPITAL, INC.

**CON #10033**

**2006 DATA Peer Group 6**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dec-11</th>
<th>YEAR 2 ACTIVITY PER DAY</th>
<th>VALUES ADJUSTED FOR INFLATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Services</td>
<td>80,673,810</td>
<td>767</td>
<td>Highest: 1,540, Median: 833, Lowest: 524</td>
</tr>
<tr>
<td>Inpatient Ambulatory</td>
<td>159,871</td>
<td>2</td>
<td>Highest: 312, Median: 137, Lowest: 40</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>67,721,185</td>
<td>644</td>
<td>Highest: 0, Median: 0, Lowest: 0</td>
</tr>
<tr>
<td>Inpatient Ancillary Services</td>
<td>299,396,829</td>
<td>2,848</td>
<td>Highest: 7,037, Median: 3,746, Lowest: 2,077</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>235,055,254</td>
<td>2,236</td>
<td>Highest: 3,550, Median: 2,423, Lowest: 1,501</td>
</tr>
<tr>
<td>Total Patient Services Rev.</td>
<td>683,006,949</td>
<td>6,496</td>
<td>Highest: 11,583, Median: 7,057, Lowest: 4,157</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>2,085,577</td>
<td>20</td>
<td>Highest: 130, Median: 16, Lowest: 0</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>685,092,526</td>
<td>6,516</td>
<td>Highest: 11,589, Median: 7,095, Lowest: 4,183</td>
</tr>
</tbody>
</table>

**Deductions from Revenue** | 520,493,650 | 4,951 | 0 | 0 | 0 |

| **Net Revenues** | 164,598,876 | 1,566 | 2,583 | 1,839 | 1,424 |

**Expenses**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dec-11</th>
<th>YEAR 2</th>
<th>VALUES NOT ADJUSTED FOR INFLATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine</td>
<td>43,435,133</td>
<td>413</td>
<td>Highest: 391, Median: 291, Lowest: 180</td>
</tr>
<tr>
<td>Ancillary</td>
<td>37,779,198</td>
<td>359</td>
<td>Highest: 969, Median: 637, Lowest: 455</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>9,153,388</td>
<td>87</td>
<td>Highest: 0, Median: 0, Lowest: 0</td>
</tr>
<tr>
<td>Total Patient Care Cost</td>
<td>90,367,719</td>
<td>860</td>
<td>Highest: 0, Median: 0, Lowest: 0</td>
</tr>
<tr>
<td>Admin. and Overhead</td>
<td>49,906,438</td>
<td>475</td>
<td>Highest: 0, Median: 0, Lowest: 0</td>
</tr>
<tr>
<td>Property</td>
<td>23,276,395</td>
<td>221</td>
<td>Highest: 0, Median: 0, Lowest: 0</td>
</tr>
<tr>
<td>Total Overhead Expense</td>
<td>73,182,833</td>
<td>696</td>
<td>Highest: 1,175, Median: 747, Lowest: 546</td>
</tr>
<tr>
<td>Other Operating Expense</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>163,550,552</td>
<td>1,556</td>
<td>2,445</td>
</tr>
</tbody>
</table>

| Patient Days | 68,744 |
| Adjusted Patient Days | 105,136 |
| Total Bed Days Available | 117,895 |
| Adj. Factor | 0.6539 |
| Total Number of Beds | 323 |
| Percent Occupancy | 58.31% |

<table>
<thead>
<tr>
<th>Payer Type</th>
<th>Dec-11</th>
<th>YEAR 2</th>
<th>VALUES ADJUSTED FOR INFLATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Pay</td>
<td>4,510</td>
<td>6.6%</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>5,899</td>
<td>8.6%</td>
<td></td>
</tr>
<tr>
<td>Medicaid HMO</td>
<td>342</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>39,639</td>
<td>57.7%</td>
<td></td>
</tr>
<tr>
<td>Medicare HMO</td>
<td>1,881</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>3,679</td>
<td>5.4%</td>
<td></td>
</tr>
<tr>
<td>HMO/PPO</td>
<td>11,380</td>
<td>16.6%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1,414</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>68,744</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
e. Will the proposed project foster competition to promote quality and cost-effectiveness? ss. 408.035(1) (g), Florida Statutes.

**Analysis:** General economic theory indicates that competition ultimately leads to lower costs and better quality. However, in the health care industry there are several significant barriers to competition.

**Price-Based Competition is Limited** - Medicare and Medicaid account for almost 60 percent of hospital charges in Florida, while HMO/PPOs account for approximately 30 percent of charges. While HMO/PPOs negotiate prices, fixed price government payers like Medicare and Medicaid do not. Therefore price-based competition is limited to non-government fixed price payers. Price-based competition is further restricted as Medicare reimbursement in many cases is seen as the starting point for price negotiation among non-government payers.

**The User and Purchaser of Healthcare are Often Different** – Roughly 90 percent of hospital charges in Florida are from Medicare, Medicaid, and HMO/PPOs. The individuals covered by these payers pay little to none of the costs for the services received. Since the user is not paying the full cost directly for service, there is no incentive to shop around for the best deal. This further makes price-based competition irrelevant.

**Information Gap for Consumers** – Price is not the only way to compete for patients, quality of care is another area in which hospitals can compete. However, there is a lack of information for consumers and a lack of consensus when it comes to quality measures. In recent years there have been new tools made available to consumers to close this gap. However, transparency alone will not be sufficient to shrink the information gap. The consumer information must be presented in a manor that the consumer can easily interpret and understand. The beneficial effects of economic competition are the result of informed choices by consumers.

In addition to the above barriers to competition, a recent study presented in The Dartmouth Atlas of Health Care 2008 suggests that the primary cost driver in Medicare payments is availability of medical resources. The study found that excess supply of medical resources (beds, doctors, equipment, specialist, etc.) was highly correlated with higher cost per patient. Despite the higher costs, the study also found slightly lower quality outcomes. This is contrary to the economic theory of supply and demand in which excess supply leads to lower price in a competitive market. The study illustrates the weakness in the link between supply and demand and suggests that more choices lead to higher utilization in the health care industry as consumers explore all alternatives without regard to the overall cost per treatment or the quality of outcomes.
**Conclusion**: With the addition of a NICU II program, the applicant will be able to market and compete against other facilities for these services. However, due to the health care industry’s existing barriers in consumer based competition, this project will not likely foster the type competition generally expected to promote quality and cost-effectiveness.

**f. Are the proposed costs and methods of construction reasonable? Do they comply with statutory and rule requirements?** ss. 408.035(1)(h), Florida Statutes; Chapter 59A-3, Florida Administrative Code.

The applicant proposes to establish a seven-bed Level II NICU program at Flagler Hospital located in St. Augustine, Florida. The project will include the renovation of existing second floor labor/delivery/recovery/post-partum (LDRP) rooms to create a NICU suite resulting in the loss of six LDRPs. In a separate project the facility is constructing a new postpartum unit on the fourth floor. Once the new postpartum is finished the remaining second floor LDRPs will be converted to labor/delivery/recovery rooms (LDRs).

The new NICU is located in the corner of an existing LDRP suite. The infant care areas are arranged in “horse shoe” pattern around a center nurse station. All infant care areas except for bay #7 have direct access to daylight as required. The project narrative indicates that motorized shades will be installed on exterior windows to allow for control of daylight. An air-borne infection isolation room has not been included in NICU, but the narrative indicates that a new air-borne infection isolation room will be constructed in the fourth floor level I nursery to meet the requirement of the AIA Guidelines for Design and Construction of Health Care Facilities. Additional sinks will need to be added to meet the requirement for having a hand washing sink within 20 feet of each bassinette. It also appears that some minor modifications will be required to create an eight-foot wide aisle between the nurse station and required clear space of the infant care area. The clear floor space of the infant care area must be exclusive of the required eight-foot aisle.

The schematic plans provide a partial list of anticipated applicable codes including NFPA Life Safety Code and the Florida Building code. A complete listing of applicable codes and dates of the codes will be required for future submissions.

The cost estimate for construction appears to be reasonable. Some changes are required to comply with AIA Guidelines for Design and Construction of Health Care Facilities, but these changes should not have a significant impact on costs.

The schedule for construction from the time of building permit to final inspection is reasonable.
The design appears to provide all the functional spaces required for the residents and staff. Some changes will be required, but these changes should be easily accommodated within the physical constraints of the project area and the project budget.

The architectural review of the application shall not be construed as an in-depth effort to determine complete compliance with all applicable codes and standards. The final responsibility for facility compliance ultimately rests with the owner.

g. Does the applicant have a history of providing health services to Medicaid patients and the medically indigent? Does the applicant propose to provide health services to Medicaid patients and the medically indigent? ss. 408.035(1) (i), Florida Statutes.

| Medicaid and Charity Care of the Applicant Compared to District 4 Fiscal Year 2006 |
|--------------------------------------------------|-------------------------------|
| Applicant                                      | FY 06 Conventional Medicaid Days | FY 06 Gross Charity Percentage of Charges |
| Flagler Hospital                               | 11.4%                          | 3.0%                                      |
| District 4 Average                            | 14.0%                          | 3.7%                                      |

Source: FY 2006 Actual Data/AHCA

The applicant reports it is a disproportionate share hospital. For FY 2006, the applicant reports 71,676 total patient days and of those days, 7,937 Medicaid patient days (11.1 percent Medicaid). For the same year, charity patient days are reported at 795 (1.1 percent charity). For FY 2007, the applicant reports 69,232 total patient days and of those days, 7,294 Medicaid patient days (10.5 percent Medicaid). For the same year, charity patient days are reported at 877 (1.3 percent charity).

The applicant projects 55.5 percent Medicaid/Medicaid HMO patient days in year one and year two of the project. Schedule 7B indicates that self-pay is estimated at 4.9 percent for both year one and year two. The applicant indicates in its response here that charity care will account for 1.1 percent for the first two years of operation; however, these estimates are not conditioned in Schedule C. Flagler states that its projected overall Medicaid/charity care and self-pay in Schedule 7B may actually decline and that its condition reflected in Schedule C is actually 54 percent total Medicaid, charity and self-pay.

---

29 CON #10033, page #69
F. SUMMARY

Flagler Hospital, Inc. (CON #10033) proposes to establish a seven-bed Level II NICU to be located at Flagler Hospital (District 4, St. Johns County).

The project involves 4,690 total gross square feet (GSF) of renovation (no new construction) and renovation cost of $655,900. The total project cost is $1,175,123.

Need:

The proposed project is not in response to published need. Level II NICU beds in District 4 experienced an average occupancy rate of 73.00 percent during the period January 2007 through December 2007. The applicant contends that area circumstances warrant approval of a new Level II NICU in District 4 (in St. Johns County).

Level II NICU services are available and accessible within the two hours ground time to 90 percent of the residents of District 4. Such travel distances and times are within the travel standard promulgated in CON Rule.

However, the applicant describes 11 special (not normal) circumstances to justify the project.

The most prominent among these are: a geographic mal-distribution of Level II NICUs in District 4 with most of these beds in the district located in Duval County (including the recently CON approved by exemption Level II NICU beds); a 75-mile gap between Level II NICU services at (recently exemption approved) Baptist Medical Center South [Duval County] and Halifax Medical Center [Volusia County]; projected population growth among women of prime child-bearing age (15-44) in Flagler’s service area births transportation challenges for Medicaid and low income residents of Flagler’s service area keeping “at-risk” obstetrical patients local which will allow Flagler to exceed at 1,500 delivery volume by 2012; some 43 newborns needing NICU services were transferred from Flagler to NICU providers in 2007; the applicant has the support of Putnam Community Hospital which treated 22 high-risk pregnancies in CY 2007 and expects its NICU would many serve patients from Putnam; high quality NICU services due to a relationship with Shands-Jacksonville and no adverse impact on obstetrical services at existing Level II NICU providers in the district. Baptist Medical Center and
Shands Jacksonville, the district’s two largest Level II NICU providers, support the project indicating it will relieve pressures on their units and enhance quality of care for St. Augustine and the surrounding communities.

Quality of Care:

Flagler Hospital is Agency licensed, Joint Commission accredited and highlights numerous other recent awards; it is a quality care provider.

There were four confirmed complaints and two confirmed complaints without deficiency for Flagler Hospital, Inc. for the three-year period ending September 24, 2008. The four confirmed complaints were: lack of assessment; medical services; nursing services and pressure sores. The following complaints were confirmed without deficiency: dietary and life safety code.

Quality of care in Flagler’s Level II NICU should be assured as Flagler’s program will become part of an integrated neonatal care delivery network led by Shands Jacksonville and the University of Florida College of Medicine, Department of Pediatrics. Shands has established an agreement with Flagler to provide clinical oversight for Flagler’s NICU.

Medicaid/Indigent Care:

The applicant provided 11.4 percent of its total patient days to Medicaid and 3.0 percent to gross charity charges in FY 2006, compared to the District 4 average percentage of 14.0 percent total patient days to Medicaid and 3.7 percent to gross charity charges. Medicaid/Medicaid HMO patient days are projected to be 55.5 percent in Schedule 7B and self-pay is projected at 4.9 percent for both year one and year two. The applicant indicates it Item 3. g. that Level II NICU charity care is projected to be 1.1 percent in year one and year two.

The applicant conditions approval on the ‘Conditions page – Schedule C’, to a “minimum of total annual Level II NICU patient days attributable to patients classified as Medicaid, charity and/or self-pay, combined.” Flagler Hospital Inc., indicates it Item 3. g. that it proposes to condition approval to 54 percent Medicaid, charity and self-pay, which is consistent with the district average.

Financial/Cost:

Overall, the applicant has an adequate short-term and long-term position and funding, along with the entire capital budget, should be available as needed.
The project appears to be financially feasible and is not likely to have a material impact on the existing operations of the applicant.

**Architectural:**

The cost estimate for construction appears to be reasonable. Some changes are required to comply with AIA Guidelines for Design and Construction of Health Care Facilities, but these changes should not have a significant impact on costs.

The schedule for construction from the time of building permit to final inspection is reasonable.

The design appears to provide all the functional spaces required for the residents and staff. Some changes will be required, but these changes should be easily accommodated within the physical constraints of the project area and the project budget.

**RECOMMENDATION:**

Approve CON #10033 to Flagler Hospital, Inc. to establish a seven-bed Level II neonatal intensive care unit in 4,690 total gross square feet (GSF) of renovation (no new construction) at a renovation cost of $655,900. Total project cost is $1,175,123.

CONDITION: Flagler Hospital, Inc. will provide 54.0 percent of the seven-bed Level II NICU’s total annual patient days to Medicaid, Medicaid HMO, charity care and self-pay patients, combined.
AUTHORIZED FOR AGENCY ACTION

Authorized representatives of the Agency for Health Care Administration adopted the recommendation contained herein and released the State Agency Action Report.

DATE: ______________________

James B. McLemore
Health Services and Facilities Consultant Supervisor
Certificate of Need

Jeffrey N. Gregg
Chief, Bureau of Health Facility Regulation