

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Tenet St. Mary's Inc. d/b/a St. Mary's Medical Center/CON #9516
901 45th Street
West Palm Beach, Florida

Authorized Representative: Bob Greene
(469) 893-6018

2. Service District/Subdistrict/County

District 9

B. PUBLIC HEARING

No public hearing was held regarding the following proposed project and no letters of support were submitted by the applicant.

C. PROJECT SUMMARY

Tenet St. Mary's, Inc. (CON #9516), owns and operates St. Mary's Medical Center, a 460-bed for-profit general hospital. St. Mary's is licensed for 338 acute care beds, 22 Level II Neonatal Intensive Care Unit (NICU) beds, 10 Level III NICU beds, 40 adult psychiatric beds and 50 comprehensive medical rehabilitation beds. The applicant is a subsidiary of Tenet Healthcare Corporation, which also owns Good Samaritan Hospital. The applicant proposes to expand its existing 10-bed Level III neonatal intensive care unit by 10 beds,-reduce its acute care beds by 10 and delicense eight Level III beds at Good Samaritan Hospital. The proposal will result in an increase of two additional Level III NICU beds in the district. In December of 1999 the Agency approved CON #9255 for the addition of Level III beds at St. Mary's. That proposal was to expand the Level III unit by eight beds and close the eight-bed Level III NICU at Good Samaritan. However, IHS the prior owner of the hospital and the unimplemented CON, sold St. Mary's and Good Samaritan Hospital to Tenet. Tenet neglected to transfer the CON as part of the transfer of hospital ownership.

Therefore, the eight beds have remained at Good Samaritan Hospital since 1999, unused at zero occupancy. The applicant has proposed to condition the application for 45 percent Medicaid/charity patients, continue as a RPICC provider and delicense Good Samaritan Medical Center's eight Level III beds.

The proposed project cost is projected to be \$1,478,503 and will involve 1,782 GSF of renovation and \$355,698 in construction costs.

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, Cheryl Clark, analyzed the application in its entirety with consultation from the Financial Analyst, Roger Bell, who evaluated the financial data, and the Architect, Joel Hill 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(s) with the criteria and application content requirements found in Florida Statutes, sections 408.035, and 408.037; applicable rules of the State of Florida, Chapters 59C-1 and 59C-2, Florida Administrative Code; and Local Health Plans.

1. Fixed Need Pool

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

In Volume 27, Number 30, dated July 27, 2001 of the Florida Administrative Weekly, a fixed need pool of zero beds was published for Level II Neonatal Intensive Care Unit beds in District 9 for the January 2004 planning horizon.

District 9 has 23 licensed Level III Neonatal Intensive Care beds and four approved Level III beds, as of July 27, 2001. The 23 beds have a 12-month occupancy rate of 71.50 percent. Three Level III beds at Bethesda Memorial, although licensed in October of 2000, reported zero occupancy as of June 2001.

St. Mary's is applying for beds outside of the fixed need pool, and indicates it 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 unit beds 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 stated above, the 23 Level III NICU beds in District 9 experienced an occupancy rate of 71.50 percent for the most recent reporting period. The Level III beds in the district does not exceed 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.

- c. **Special Circumstances for the Approval of Additional Neonatal Intensive Care Unit Beds at Existing Providers, Ch. 59C-1.042(3)(g), Florida Administrative Code. Need for additional Level III Neonatal Intensive Care beds at hospitals with Level III Neonatal Intensive Care services seeking additional Level III beds is demonstrated in the absence of need shown under the formula specified in paragraph (3)(e) of this rule if the occupancy rate for their Level III beds exceeded an average of 90 percent as computed by the Agency for the same time period specified in subparagraph (3)(e).**

Conversion of Under-utilized Acute Care Beds. New Level II or Level III 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 or Level III 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.

Tenet St. Mary's Inc. meets the "special circumstances" defined in rule with a Level III NICU occupancy rate of 126.97 percent for the period specified in rule. The applicant is also applying to convert an equal number of underutilized acute care beds.

Tenet St. Mary's Hospital, Inc. (CON #9516) states that the application is being filed based on not normal circumstances experienced at St. Mary's. They are as follows:

- AHCA approved the addition of Level III beds at St. Mary's via CON #9255, which was issued to St. Mary's previous owner for eight beds. Due to an oversight in transferring ownership of the hospital, the CON was not transferred to the new owner, thus requiring this application as, in essence, a replacement application.
- Waiver from RPICC to operate the NICU beds in overflow areas due to lack of alternatives for placement of Regional Perinatal Intensive Care Center (RPICC) babies.
- Excess occupancy during the past two years, with quarterly occupancy averaging over 130 percent at times.
- Increasing transport activity from outlying area hospitals.
- Closure of Good Samaritan's Level III NICU for consolidation of this tertiary service at St. Mary's.
- Increasing number of births at St. Mary's in the past, which are estimated to continue in the future.

According to AHCA Hospital Bed Need Projections- July 2001 batching cycle for the period of January – December 2000, St. Mary's average annual occupancy was at 126.97 percent. Additionally, the Treasure Coast Health Council indicates that St. Mary's Level II and Level III NICU units experienced over 100.00 percent occupancy for the second quarter of 2001. St. Mary's is also seeking expansion of its Level II unit in a separate application (CON #9515).

The applicant states that it is important to consider monthly fluctuations to depict the significant occupancy issues being faced by the Level II NICU. The applicant provided a table on page 9 that provides the monthly information for two years, which reflect a continuous average occupancy of 100 percent. According to the applicant, St. Mary's exceeded 100 percent capacity nine months of the year ending June 30, 2000 and 12 months in the year ending June 30, 2001 for a combined total of 21 months.

The applicant indicates that the high occupancy and daily peaks indicate an actual need for as many as 26 Level III NICU beds at St. Mary's. At this level the applicant indicates that there would be sufficient beds for all patients and the high peaks will be met at an 80 percent occupancy level. However, the applicant indicates that its physical plant can accommodate 10 additional beds without significant renovation. The 10 beds will increase the Level III NICU to 20 beds.

The applicant provided a need analysis based on the hospital's experience and the projected number of births in District 9. The applicant determined a live birth to Level III patient day ratio of based on 2000 data of 1.43. The applicant indicates that St. Mary's had 3,250 live births in 2000 (AHCA data shows 3,412) and anticipates only a slight increase in live births at the hospital in 2004 to 3,305. The applicant applied the 1.43 ratio of Level III patient days to live births and determined that the 2004 Level III NICU patient days would be 4,726. Occupancy in a 20-bed unit would be 64.73 percent. The applicant states that it believes the Level III patient day to live birth ratio will increase in 2004 to 1.69, based on hospital-specific historical analysis. This is a fairly high ratio, even for a RPICC provider. Applying the 3,305 live births to that increased ratio results in projected Level III patient days of 5,585 and expected occupancy in the 20-bed unit of 76.5 percent in 2004, below the 80 percent standard for NICU services. The applicant's projections may be somewhat higher, but are not completely unreasonable.

As noted above, as a RPICC provider, the applicant also anticipates an increase in the number of Level III neonates transferred from area hospitals. Historical data provided by the applicant on the number of transfers it receives each year shows that transfers increased from 107 in 1997 to 172 in 2000. Further, this trend has continued into 2001. The applicant looked at average transfers per month to determine that transfers increased by 12.6 percent between 2000 and 2001. Based on the anticipated increases in live births and hospital historical experience, it appears reasonable for the applicant to anticipate this number to continue to increase.

The applicant is proposing the transfer of beds from Good Samaritan Hospital to St. Mary's Hospital within the district. The following criteria should be considered in the review of bed transfer proposals. The applicant did not specifically respond to these criteria.

- **Efficiency:** The applicant's projected cost per adjusted patient day of \$1,056 in year one and \$1,149 in year two are between the group lowest and median values of \$704 and \$1,145 in year one and \$723 and \$1,176 in year two. The application is considered efficient when compared to the control group.
- **Access:** As stated above, the unit has exceeded its licensed occupancy for 11 months of the year and meets hospital-specific rule requirements to add beds because of high occupancy. The excess occupancy is somewhat attributed to the closing of Good Samaritan Hospital's NICU Level III in 1999. The applicant states that the proposed project will provide a reallocation of the licensed beds from underutilized acute care beds to over-utilized Level III NICU beds and more appropriately meet the needs of the patients, physicians and staff. The applicant is proposing to delicense the eight-bed Level III unit at Good Samaritan, therefore, only adding two beds to the districts Level III inventory.
- **Quality of Care:** The applicant's ability to provide quality of care is documented. Quality of care would be enhanced by alleviating the overcrowding in the unit.
- **Competition:** The services proposed are reasonably priced in comparison to other providers and should have a positive impact on competition to promote quality assurance and cost-effectiveness.

2. Local Health Plan Preferences

Is need for the project proposed supported by the applicable district plan? ss. 408.035(1)(a), Florida Statutes and Ch. 59C-1.030(2)(c), Florida Administrative Code.

The District 9 October 2000 CON Allocation Factors Report provides the following preferences for applications pertaining to neonatal intensive care beds:

- 1. Priority shall be given to applicants who demonstrate a commitment to or have an historical record of serving Medicaid, charity, indigent and underserved populations.**

Tenet St. Mary's, Inc. (CON #9516) has a commitment to and has a history of serving Medicaid, charity and indigent populations. The applicant is one of eleven designated RPICC providers in the state. The table below provided by the applicant is the historical payor mix experience for neonates at the hospital for DRG 385-390. The applicant has agreed to condition approval of the CON on providing 45 percent of its annual patient days to Medicaid/charity patients. The applicant notes that RPICC admissions are included in the Medicaid and other line items in the table below.

Percent of DRG 385-DRG 390 Admissions by Payor at St. Mary's Medicaid Center				
Payor	1997	1998	1999	2000
Medicaid	61.9	61.5	56.7	55.6
Government	0.3	1.4	3.1	1.9
Self/Pay/Underinsured	7.4	7.1	4.6	5.2
All Other	30.4	30.0	35.6	37.3
Total	100.0	100.0	100.0	100.0

Source: AHCA database and Hospital historical information

3. Agency Rule Preferences

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

- a. Ch. 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.**

See local preference above and refer to E.4.i. below for further discussion.

- b. Ch. 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. In a comparative review, preference for the approval of Level II beds shall be given to hospitals, which have both Level II neonatal intensive care unit beds and Level III Neonatal Intensive Care Unit beds.**

St. Mary’s Hospital has Level II and Level III NICU beds and therefore has continuity of care.

- (2) Applicants proposing to provide Level II or Level III 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.**

Through the Child Development Center, established by the applicant in 1991, a team conducts follow-up checks on discharged patients, monitors outcomes of care, and makes appropriate referrals for care.

- c. Ch. 59C-1.042(5), Florida Administrative Code - Minimum Unit Size.**

The hospital is currently licensed for 10 Level III beds, this unit size is below the 15-bed minimum. Approval of this proposal would increase the number of beds to 20, above the minimum. The applicant's Level II unit consists of 22 beds, which is above the 10-bed minimum for Level II units.

- d. Ch. 59C-1.042(6) - Minimum Birth Volume Requirement. Hospitals applying for Level III neonatal intensive care services shall not normally be approved unless the hospital has a minimum service volume of 1,500 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.**

According to AHCA discharge data St. Mary's Hospital had 3,590 births for the 12-month period ending December 2000. This is well above the minimum 1,500 births.

- e. Ch. 59C-1.042(7) - Geographic Access. Level II and Level III 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.**

Currently Level II and Level III NICU services are available and accessible within the two hours ground time to 90 percent of the residents of District 11.

f. **Ch. 59C-1.042(8) - Quality of Care Standards.**

- (1) Physician Staffing: Level II or III 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.**

According to the applicant the NICU units are staffed by eight neonatologists, all of whom are board-certified in pediatrics and neonatology by the American Board of Pediatrics. The NICU medical director is David Kanter who is board-certified in neonatology and pediatrics. In addition the applicant states that there are 39 pediatric sub-specialists on St. Mary's Medicaid staff.

- (2) Nursing Staffing: The nursing staff in Level II and Level III 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 and Level III neonatal intensive care units must be registered nurses.**

The neonatal intensive care unit is under the direction of Mary Jo Bulfin, RNC, BSN. The applicant indicates that 80 percent of the nursing personnel assigned to each work shift in the unit are registered nurses.

- (3) Special Skills of Nursing Staff: Nurses in Level II and Level III neonatal intensive care units shall be trained to administer cardio-respiratory 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 states that the hospital nursing staff already has the required competencies. All NICU staff members are required to maintain NPR Certification through the American Heart Association and American Academy of Pediatrics. The general NICU and specific competencies among NICU nurses and respiratory therapists at St. Mary's are shown in the following table provided by the applicant.

Skill/Competency	RN and LPN	Respiratory Therapists
Neonatal Resuscitation Program	84	14
Neonatal Transport	20	12
Neonatal Resuscitation Program	8	1
CPR Instructor	5	-
NICU Nursing Skills Lab	84	14
NICU Respiratory Therapists	-	10
Special Procedures/Conscious Sedation	8	-
Post Anesthesia Recovery	42	-

Source: CON #9516 page 28

- (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 or Level III 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 that its staff meets the requirements of at least one certified/registered respiratory care practitioner with expertise in the care of neonates to be available 24 hours a day.

- (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 or Level III Neonatal Intensive Care services. Hospitals providing Level II or Level III 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.**

St. Mary's Hospital has blood gas determination available 24 hours, seven days a week. The hospital provides all the above including on-site x-ray, and clinical laboratory services 24 hours, seven days a week. Anesthesiologists are on staff and anesthesia is available within 30 minutes.

- (6) Nutritional Services: Each hospital with Level II or Level III 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.**

According to the applicant it has designated registered and licensed dietitians assigned to the NICU. Amanda Held is responsible for the nutrition services provided in the NICU.

- (7) Social Services: Each hospital with Level II or Level III 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.**

The applicant describes the duties of the social worker in assisting the patient's family, including identification and referral to needed resources in the community.

- (8) Developmental Disabilities Intervention Services: Each hospital that provides Level II or Level III 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 provides in-hospital intervention services for infants identified as being high risk for developmental disabilities to include developmental assessment, intervention, physical, speech and audiology therapy along with parental support, and education.

- (9) **Discharge Planning: Each hospital that provides Level II or Level III Neonatal Intensive Care services shall have an interdisciplinary staff responsible for discharge planning. Each hospital shall designate a person responsible for discharge planning.**

According to the applicant it has an interdisciplinary staff responsible for discharge planning of all hospital patients that provide family counseling and referrals to appropriate community agencies. Kim Bainter RN, is the lead person on the unit for discharge planning.

- g. **Ch. 59C-1.042(9) - Level III Neonatal Intensive Care Unit Standards: The following standards shall apply to Level III Neonatal Intensive Care services:**

- (1) **Pediatric Cardiologist. A facility providing Level III Neonatal Intensive Care services shall have a pediatric cardiologist, who is either board certified or board eligible in pediatric cardiology, available for consultation at all times.**

According to the applicant, there are four pediatric cardiologists on staff at St. Mary's. The applicant included the resumes of the physicians listed below in the application. All cardiologists are board-certified in pediatric cardiology.

- Maximo Aguirre
- Harry Bayron
- Renato Dubois
- Patricia Sherron

- (2) **Nurse to Neonate Staffing Ratio. Hospitals shall have a nurse to neonate ratio of at least 1:4 in Level II NICUs at all times. At least 50 percent of the nurses shall be registered nurses.**

According to the hospital it exceeds the requirement that 80 percent of the nurses be registered nurses according to the applicant. Schedule 6 shows adequate staffing for the proposed project.

- (3) **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 it is in compliance with all of the requirements above. Refer to the architectural review below in E.4.h.

- (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 to continuous blood pressure measurement.**

The applicant indicates that it has all the required equipment above.

i. Ch. 59C-1.042(11) - 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 Section 10D-66.52, Florida Administrative Code.

The applicant has its own transport team under the direction of John Bankston, MD, the transport medical director. The applicant states that in conjunction with Dr. Bankston, there are 20 NICU registered nurses and 12 respiratory therapists who provide neonatal transport in a geographical area extending north to Indian River and west to Glades. Transfer agreements are included in the application.

j. Ch. 59C-1.042(12) - 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.

See previous response above.

- k. **Ch. 59C-1.042(13) - Data Reporting Requirements: All hospitals with Level II or Level III 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.**

The applicant indicates that it will continue to provide all data required by the Agency in this section of the rule.

4. 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(2), 408.035(7), Florida Statutes.**

The applicant’s main reason for the expansion of the Level III NICU is the excess occupancy currently experienced in the 10-bed unit over the last two years. As stated previously, the unit has exceeded its licensed occupancy for 11 months of the year. The excess occupancy is somewhat attributed to the closing of Good Samaritan Hospital’s NICU Level III in 1999. The applicant states that the proposed project will provide a reallocation of the licensed beds from underutilized acute care beds to over-utilized Level III NICU beds and more appropriately meet the needs of the patients, physicians and staff. The applicant is proposing to delicense the eight-bed Level III unit at Good Samaritan, therefore, only adding two beds to the districts Level III inventory.

The table below represents the period January through December 2000 utilization data for each Level III NICU provider in the district:

DISTRICT 9 LEVEL III NICU OCCUPANCY					
County	Hospital	Level III Beds	Bed Days	Patient Days	Percent Occupancy
Palm Beach	Bethesda Memorial Hospital (bed conv. 10/31/00)	3	186	0	00.0%
<i>Palm Beach</i>	<i>Good Samaritan Hospital</i>	<i>8</i>	<i>2,989</i>	<i>0</i>	<i>0.00%</i>
<i>Palm Beach</i>	<i>St. Mary’s Hospital</i>	<i>10</i>	<i>3,660</i>	<i>4,647</i>	<i>126.97%</i>
Palm Beach	West Boca Medical Center	5	1,830	1,372	74.97%
Total		26	8,414	6,019	71.50%

Source: Florida Hospital Bed and Service Utilization by District, Vol. II, July 2001.

As reflected in the table above, District 9's utilization does not exceed 80 percent. However, the applicant is proposing to transfer the eight beds not in use at Good Samaritan and if those bed days are removed from the chart above, the total beds days would equal 5,486 and occupancy would be over 100 percent. As noted previously, there are four approved beds at West Boca Medical Center and the applicant is requesting to add two beds to the district inventory. Quality of care would be enhanced by alleviating the overcrowding in the unit. The services proposed are reasonably priced in comparison to other providers and should have a positive impact on competition to promote quality assurance and cost-effectiveness.

Need for the project is evidenced by the availability, quality of care, efficiency, accessibility and extent of utilization at St. Mary's.

- b. Does the applicant have a history of providing quality of care? Has the applicant demonstrated the ability to provide quality care? Please discuss your licensure history within and outside of Florida, and discuss any accreditation(s) held. ss. 408.035(3), 408.035(12), Florida Statutes.**

The applicant is accredited by the Joint Commission on Accreditation of Healthcare Organizations. The applicant currently has a Performance Improvement Plan in place and states that the plan promotes awareness and provide guidance in the systematic, continuous improvement of clinical practice, support services and leadership, fundamental to achieving the hospital's mission of performance excellence.

- c. Is the applicant proposing special health care services for its service area that are not reasonably and economically accessible in adjacent service areas? ss. 408.035(4), Florida Statutes.**

The proposed project does not involve special equipment or services that are not reasonably or economically accessible in adjacent districts.

- d. Is this project to be located in a research or teaching hospital? Will the program affect the clinical needs of health professional training programs in the service area? ss. 408.035(5), Florida Statutes.**

The proposed project will not be located in a teaching hospital. According to the applicant the project will affect the clinical needs of health professional training programs. St. Mary's has several programs in place to provide clinical and continuing education for its staff and for other interested persons in the community.

e. **What resources, including health manpower, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? ss. 408.035(6), Florida Statutes. *Please include the following in your response:***

- **a detailed listing of the needed capital expenditures (Schedule 1);**
- **a complete listing of all capital projects (Schedule 2);**
- **source of funds (Schedule 3);**
- **a detailed financial projection, including a statement of the projected revenue and expenses for the first two years of operation; and a statement of the assumptions made (Schedules 7, 7A; or 7B; and 8 or 8A); and an audited financial statement of the applicant.**

Tenet St. Mary's Inc. was incorporated in the State of Florida on April 6, 2001. To satisfy the Florida Statutes requiring an audit of the applicant the balance sheet as of May 31, 2001 was presented. This financial statement indicated the total assets consisted of \$1,000 due from Tenet HealthSystem Medical, Inc. The offsetting credit account was shareholder's equity - common stock of \$1,000.

Effective July 1, 2001 the applicant acquired certain assets of St. Mary's Medical Center. The projections in this application are for the operation of St. Mary's Medical Center. The applicant's ultimate parent is Tenet Healthcare Corporation.

Schedule 2 indicates the applicant has total capital projects of \$25.8 million.

Schedule 2 notes and Schedule 3 indicates funding for these projects will come from the ultimate parent, Tenet Healthcare Corporation. A letter attached behind Schedule 2 from Tenet Healthcare Corporation states it will provide funding for this project and all other capital needs. The audited financial statements of Tenet Healthcare Corporation reveals \$13 billion in assets, \$4 billion in shareholders' equity, \$249 million in operating profits, and \$582 million cash flows from operations.

The strong financial position of the ultimate parent, Tenet Healthcare Corporation, along with its commitment to provide funding for the applicant provide adequate proof of the availability of funding for the capital projects list.

f. What is the immediate and long-term financial feasibility of the proposal? ss. 408.035(8), Florida Statutes.

A comparison of the applicant's estimates to the 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 skill and management 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, either go 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 1999; the applicant will be compared to the hospitals in group 5. Per diem rates are projected to increase by an average of 3.6 percent per year. Inflation adjustments were based on the most current Florida Hospital Input Price Index.

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. The adjustment is made to factor out the outpatient revenues in the per patient day computation.

Net revenue per adjusted patient day (NRAPD) of \$1,144 in year one and \$1,246 in year two is identical to the control group median for year one and between the control group median and highest values of \$1,175 and \$1,560 in year two. The highest level is generally viewed as the practical upper limit on economies of operation. With net revenues falling between the median and highest level, the facility is expected to consume health care resources in proportion to the services provided. (See Comparative Table). The 1999 actual NRAPD for this hospital was \$918, which was a little below the median of \$1,036 in that year.

Projected cost per adjusted patient day of \$1,056 in year one and \$1,149 in year two is between the group lowest and median values of \$704 and \$1,145 in year one and \$723 and \$1,176 in year two. This application is considered cost-efficient when compared to the control group. (See Comparative Table). The 1999 actual CAPD for this hospital was \$1,087, which was between the median and highest in the group. The increase in costs from 1999 to year one, 2004 was \$18, or less than two percent over the four-year period. The administrative and overhead costs of \$125 per patient day in year one and \$152 in year two are significantly below the group's lowest of \$328 in year one and \$337 in year two. The hospital's administrative and overhead costs per patient day in 1999 was \$401, which was just below the highest in the group. It is not likely the administrative and overhead costs would be as low as projected.

The year two operating profit for the hospital of \$13.8 million computes to an operating margin per adjusted patient day of \$97 which falls between the peer group median and highest of \$5 and \$287. The operating margin computes to 7.8 percent, which is good for Florida hospitals. The 1999 financial data submitted to the agency shows the hospital with an operating loss margin per adjusted patient day of \$-168. This project contributes \$323,402 to the facility's operating margin.

The projected revenues, total costs, and profits are reasonable when compared to the group data. There are significant deviations from the historical data, especially in the area of the administrative and overhead costs and the operating margin. However, since the hospital is being reorganized under new ownership the historical activities may not be that comparable to the projections. Even though, there is serious doubt the administrative and overhead costs would be as low as projected. This understatement of cost in the one category could carry over to reflect the possibility of projected total costs being too low. In the financial analyst's opinion, considering the projections taken as a whole, this project is financially feasible.

COMPARATIVE TABLE

CON # 9516					
Tenet St. Mary's	2004	YEAR 2	<u>INFLATION ADJ. VALUES</u>		
1999 DATA Peer Group 3	ACTIVITY	ACTIVITY PER DAY	Highest	Median	Lowest
ROUTINE SERVICES	not available		709	500	263
INPATIENT AMBULATORY	not available		80	38	17
INPATIENT ANCILLARY SERVICES	not available		3,443	1,699	910
OUTPATIENT SERVICES	not available		1,816	1,202	230
OTHER OPERATING REVENUE	not available		142	12	1
TOTAL REVENUE	not available		5,513	3,483	1,436
DEDUCTIONS FROM REVENUE	not available		*	*	*
	175,984,24				
NET REVENUES	2	1,246	1,560	1,175	743
EXPENSES					
ROUTINE	49,545,429	351	259	206	133
ANCILLARY	68,047,358	482	560	380	211
AMBULATORY	23,178,113				
OVERHEAD	21,446,743	152	611	523	337
OTHER	0	0			
	162,217,64				
TOTAL EXPENSES	3	1,149	1,297	1,176	723
OPERATING INCOME	13,766,599	97	287	5	-199
		7.8%			
PATIENT DAYS	95,302		NOT INFLATION ADJUSTED		
ADJUSTED PATIENT DAYS	141,209				
TOTAL BED DAYS AVAILABLE	171,550				
ADJ. FACTOR	0.6749				
TOTAL NUMBER OF BEDS	470				
PERCENT OCCUPANCY	55.6%		88.0%	51.0%	22.0%
<u>PAYER TYPE</u>	PATIENT	% TOTAL			
	DAYS				
MEDICARE	not available		76.0%	44.0%	22.0%
COMMERCIAL	not available				
MEDICAID	not available		22.0%	7.0%	1.0%
PRIVATE	not available				
HMO/PPO	not available		60.0%	37.0%	5.0%
OTHER	not available				
TOTAL	not available				

g. Will the proposed project foster competition to promote quality and cost-effectiveness? ss. 408.035(9), Florida Statutes. Please discuss the effect of the proposed project on any of the following:

- **applicant facility (if a hospital);**
- **current patient care costs and charges (if an existing facility);**
- **reduction in charges to patients; and**
- **improvement in quality of services provided.**

Schedule 7 was not presented for the hospital; therefore the managed care percentage could not be calculated. The hospital's 1999 managed care level was 32.6 percent, which was less than the median for the group of 37 percent. If a similar level of managed care is assumed, it will have minimal positive impact on competition, to promote quality assurance and cost-effectiveness.

The proposed NICU III project was compared to all other hospitals in the state with approved NICU III programs. Schedule 7, total gross revenue for the NICU III only is projected to be \$20,633,273 for year two. With 6,360 patient days anticipated the gross revenue (gross charges) per patient day computes to \$3,244. This is between the median and the highest in the state of \$2,544 and \$5,205, which indicates, the services are reasonably priced in comparison to other providers and should have a positive impact on competition to promote quality assurance and cost-effectiveness.

h. Are the proposed costs and methods of construction reasonable?. Do they comply with statutory and rule requirements? ss. 408.035(10), Florida, Statutes; Ch. 59A-3 or 59A-4, Florida Administrative Code. Please address those items found in "Architectural Criteria" (Schedule 9).

The proposal is to add 10 new Level III NICU beds to the hospital's existing program by the conversion of 10 acute care beds. There are 1,782 square feet of the existing facility involved in this project. According to the applicant, this CON is supposed to be essentially the same as CON #9255, which was approved by AHCA in December 1999.

The plan sent with this CON has significant architectural concerns. Chapter 59A-3 of the Florida Administrative Code requires 8' clear from the foot of one isolette to the foot of another. Neither the nurseries labeled "New" or "Expanded" have this required clearance. There were no large scale drawings of the areas in question, but from scaling the 1/8" plans, it is possible that the beds in the "new" nursery may have almost enough clearance and they could possibly be separated a few more inches and be in compliance with the code.

Without further information, the plans submitted cannot be recommended for approval unless this clearance requirement is waived.

The nursery labeled “expanded” does not appear to be able to meet the code requirement above without some re-design. Two of the four beds are located next to what appear to be structural columns or chases and cannot be relocated further apart in their current location. There appears to be the possibility of deleting an existing door and relocating the beds to meet the separation requirement.

The Level III nurseries have sufficient hand wash stations.

CON #9515 has been filed concurrently with, and is related to this CON. The other request is to add seven Level II NICU beds. Both projects, if approved, would be located in the same area of the hospital. It is not clear what dependencies there are between these two applications. The proposed new Level II beds from the other application are shown on the plan with this application. However, CON #9515 has the same serious architectural issue, mainly the clearance issue. Additionally, CON #9515 has an issue with the lack of the required hand washing stations.

The NICU suite appears to satisfy the requirements for ancillary spaces. These support areas are not arranged in the best possible places, but most of the walls and rooms are existing. There is not “a control center in a location that offers a view of all of the neonatal stations”. The nurses’ station is probably intended to fulfill this function, but it does not have the overview required. However, this too is an existing condition and given the level of staffing in the NICU, it is probably not a major issue.

A list of applicable codes did not appear to be in the application, but any construction will have to be in conformance with applicable codes and rules when design development takes place. The new Florida Building Code will be in force before the project is finalized.

The schematic plans submitted were done by an architectural firm that has extensive healthcare experience. It is evident that the applicant has worked out a detailed program of spaces and needs with the designer. The resulting design is as well planned as possible given the existing conditions. However, the clearance requirements above must be rectified.

Project costs seem to be acceptable, especially since this is a renovation.

Schedule 10 indicates that the architect/engineer contracts are expected to be signed by January 2002 and the projected completion date is January 2003. The schedule should be quite sufficient for design, AHCA review and construction since the beds are to be gained by the conversion of acute care beds.

- i. 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(11), Florida Statutes.**

Tenet St. Mary’s Hospital, Inc. has a history of providing health services to Medicaid patients, according to AHCA 1999 actual data, the hospital provided 21.9 percent of its patient days to Medicaid and 6.4 percent to charity. The applicant provides services above the district average of 6.8 percent Medicaid and 2.2 percent charity. The applicant is also a disproportionate share provider for FY 2001- 2002. The applicant commits to 45 percent Medicaid/charity and is a RPICC provider. The applicant provided the following table that shows the hospital’s overall payor mix experience for the past several years.

Percent of Total Admissions by Payor at St. Mary’s Medical Center				
Payor	1997	1998	1999	2000
Medicaid	32.0%	31.1%	29.2%	31.3%
Government	3.5%	3.9%	4.6%	4.8%
Self/Pay	9.0%	8.3%	8.0%	8.6%
All other	55.5%	56.7%	58.2%	55.3%
Total	100.0%	100.0%	100.0%	100.0%

Source: AHCA database and hospital historical information

Percent of DRG through DRG390 Admissions by Payor at St. Mary’s Medical Center				
Payor	1997	1998	1999	2000
Medicaid	61.9%	61.5%	56.7%	55.6%
Government	0.3%	1.4%	3.1%	1.9%
Self/Pay	7.4%	7.1%	4.6%	5.2%
All other	30.4%	30.0%	35.6%	37.3%
Total	100.0%	100.0%	100.0%	100.0%

Source: AHCA database and hospital historical information

F. SUMMARY

St. Mary's proposes to expand its existing 10-bed Level III Neonatal Intensive Care Unit by 10 beds and reduce its acute care beds by 10. In addition eight Level III beds will be delicensed at Good Samaritan Hospital. The proposal will result in an increase of two additional Level III NICU beds in the district. The applicant has proposed to condition the application for 45 percent Medicaid/charity patients, continue as a RPICC provider and delicense Good Samaritan Medical Center's eight Level III beds.

The proposed project cost is projected to be \$1,478,503 and will involve 1,782 GSF of renovation and \$355,698 in construction costs.

Need/Special Circumstances:

Tenet St. Mary's Inc., meets the "special circumstances" defined in rule with a Level III NICU occupancy rate of above 100 percent for the period specified in rule. The excess occupancy is somewhat attributed to the closing of Good Samaritan Hospital's NICU Level III in 1999. The applicant states that the proposed project will provide a reallocation of the licensed beds from underutilized acute care beds to over-utilized Level III NICU beds and more appropriately meet the needs of the patients, physicians and staff. The applicant is proposing to delicense the eight-bed Level III unit at Good Samaritan, therefore, only adding two beds to the district's Level III inventory. The services proposed are reasonably priced in comparison to other providers and should have a positive impact on competition to promote quality assurance and cost-effectiveness.

Quality of Care:

The applicant is JCAHO accredited with commendation and a quality care provider.

Medicaid/Indigent Care:

The applicant has a history of providing health services to Medicaid patients, according to AHCA 1999 actual data, the hospital provided 21.9 percent of its patient days to Medicaid and 6.4 percent to charity. The applicant commits to 45 percent Medicaid/charity and is a RPICC provider.

Financial:

The strong financial position of the ultimate parent, Tenet Healthcare Corporation, along with its commitment to provide funding for the applicant provide adequate proof of the availability of funding for the capital projects list. The project is financially feasible.

Architectural:

The plan sent with this CON has significant architectural concerns. Chapter 59A-3 of the Florida Administrative Code requires 8' clear from the foot of one isolette to the foot of another. Neither the nurseries labeled "New" or "Expanded" have this required clearance. There were no large scale drawings of the areas in question, but from scaling the 1/8" plans, it is possible that the beds in the "new " nursery may have almost enough clearance and they could possibly be separated a few more inches and be in compliance with the code. Without further information, the plans submitted cannot be recommended for approval unless this clearance requirement is waived.

G. RECOMMENDATION

Deny CON #9516.

AUTHORIZATION 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: _____

Karen Rivera
Health Services and Facilities Consultant Supervisor
Certificate of Need

Jeffrey N. Gregg
Chief, Bureau of Health Facility Regulation