

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Punta Gorda H.M.A., Inc./CON #9550
d/b/a Charlotte Regional Medical Center
809 East Marion Avenue
Punta Gorda, Florida 33950-3898

Authorized Representative: Joshua Putter, Executive Director
(941) 639-3131

2. Service District/Subdistrict

District 8/Subdistrict 1 (Charlotte County)

B. PUBLIC HEARING

No public hearing was requested on the proposed project. However, the applicant includes 16 letters of support for its project. Senator Lisa Carlton, State Senator, 24th District, indicates that Charlotte Regional helps to make the community viable as a retirement destination and excellent place to live and has earned high health care ratings, which is confirmed by its market share and patient loyalty. Senator Carlton concludes by stating that the new hospital will benefit the well being of her constituents. Senator Tom Rossin, State Senator, 35th District indicates that Charlotte Regional plays a vital part in the delivery of medical care for the people of Charlotte County and the hospital's continued growth continues to parallel the growth of the communities of Punta Gorda/Port Charlotte and all of the Charlotte County area. Senator Rossin concludes that it is his hope that AHCA approves this application. Representative Jerry Paul, Florida House of Representatives, District 71, cites the many services community programs (approximately 52 such services/programs) the hospital is involved in his letter of support. State Representative Lindsay M. Harrington, District 72, indicates that the new hospital will alleviate diversion issues and

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enhance the quality of care for the district's residents. Representative Harrington believes that Charlotte Regional is uniquely qualified for this certificate (CON) because of its extreme importance to the community.

Wayne P. Sallade', FPEM, Director of Charlotte County Office of Emergency Management states that last September floodwaters of Tropical Storm Gabrielle surrounded the existing facility for several hours during high tide. Mr. Sallade indicates that the new facility's proposed location outside of the immediate floodplain will help solve a multitude of problems should a major storm or flood event threaten the community. He also states that the alleviation of diversion issues and the access by ambulances has been a continual problem. Chief Dennis R. DiDio of the Charlotte County Fire & Emergency Medical Services Department, indicates his Department has been experiencing diversions from all three local hospitals for the last few weeks and this has been a tremendous strain on the Fire/EMS system. He indicates that the new facility will eliminate the need for patient transport outside the county. He also indicates it will address problems with rescue access to the emergency room, the running of units outside which allows carbon monoxide fumes to seep into Charlotte Regional's ER and storage space problems for fire/EMS equipment left after calls.

Gunvantkumar O. Desai, M.D., Chief of Staff at Charlotte Regional Medical Center indicates that Charlotte Regional's physical plant is not able to be expanded due to code restrictions and lack of space and presents a list of the problems the existing hospital presently has which can be alleviated by the proposed project. These include capacity constraints during the "season", the ER often being overcrowded, the need for more private patient rooms and new/expanded services such as specialized care for neurosurgery, insufficient classroom space, extremely limited storage space and inadequate parking facilities, and operating rooms that are small and old making it difficult for the hospital to compete with other hospitals in the community.

Bob Carpenter, Executive Director of the Punta Gorda Business and Community Alliance, a not-for-profit organization with 462 members; indicates that the Charlotte County population has increased from 58,461 in 1980 to 149,278 in 2002, an increase of 90,817 residents. Charlotte County's median age is the highest of any county in the entire continental United States at 52.9 compared to Florida's 37.3, and its population over 65 accounts for 34.7 percent of the total population. Mr. Carpenter also cites Health Management Associates' community service, expansion of hospital services, addition of state of the art equipment and recruiting many physician specialists. Since HMA took over, the hospital has earned Top-100 Status for both cardiac and stroke services provided, according to Mr. Carpenter.

Punta Gorda Police Wilfred Daniel Libby, indicates that while Charlotte Regional's reputation for providing quality care is outstanding and the public has a high degree of confidence in the care they receive, the current facility is totally inadequate to meet the needs of the growing community. The current facility does not have enough space and is not designed with the capacity to efficiently provide new or expanded services. Chief Libby also states that patients are kept in the ER for extended periods of time until there is space available for them. He concludes that added staff, specialized care programs and larger critical care capacity will simply make the City of Punta Gorda a better place to work and raise our families.

The applicant also included general letters of support which echo some of the above comments from Lane Diedrick, President of the Charlotte County Chamber of Commerce, Betty H. Williams, Greater Charlotte Harbor and the Gulf Islands Economic Development Manager, Jack L. Price, Executive Director of the Charlotte County Foundation, Inc., Paula F. McQueen, C.P.A. with Webb, Lorah & Company, P.L. and Charlotte Regional Medical Center board members Leo Wotitzky, Esquire, Vernon Peeples, and Robert F. Wenzel, who is also moderator of the hospital's board and President of Peace River Distributing, Inc.

C. PROJECT SUMMARY

Punta Gorda H.M.A., Inc. (CON #9550) operates Charlotte Regional Medical Center (CMRC), a 208-bed facility with a bed complement of 156 acute care, 26 adult psychiatric and 26 adult substance abuse beds. The applicant presently has an exemption (#0000240) to add 10 adult psychiatric beds and delicense 10 of its adult substance abuse beds. Punta Gorda H.M.A., Inc. is requesting to construct a new 75 acute care bed hospital through the transfer of 75 beds from Charlotte Regional Medical Center. This will leave 81 acute care beds and the adult psychiatric and substance abuse beds at the Charlotte Regional Medical Center campus.

Charlotte Regional Medical Center's 156 acute care beds averaged 60.33 percent occupancy during the 12-month reporting period ending June 30, 2001. The applicant proposes on its *Conditions* page, to a location of within two to five miles from the existing facility and on the (same) south side of the Peace River and the same admission policies and procedures for both facilities. No other conditions are proposed. The applicant does not have a condition on its existing acute care beds.

The proposed project consists of new construction of 180,000 GSF at a construction cost of \$34,378,507. The project involves a total cost of \$65,883,443.

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, James B. McLemore analyzed the application in its entirety with consultation from the Financial Analyst, Doug Pierce who evaluated the financial data, and the Architect, Joel Hill who evaluated the architectural and the schematic drawings as part of the application.

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, 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? Or does the project proposed seek beds or services in excess of the fixed need pool? Ch. 59C-1.008(2), Florida Administrative Code.

On January 25, 2002, AHCA published a fixed need pool (FNP) in Volume 28, Number 4, Florida Administrative Weekly (F.A.W.) of zero (0) for additional hospital acute care beds in District 8, Subdistrict 1 for the January 2002 review cycle.

District 8, Subdistrict 1 had a total of 544 licensed beds that experienced an occupancy rate of 56.23 percent for the reporting period July 2000 though June 2001. As of January 25, 2002, Subdistrict 1 has 25 acute care beds approved under exemption #0100029 via conversion of 25 hospital-based skilled nursing beds at Fawcett Memorial Regional Hospital. The applicant's project would not increase the subdistrict's bed count but is a transfer of acute care beds from its existing facility in order to establish a new facility. Therefore, the fixed need pool is not applicable to this project.

b. Other Special Circumstances:

The applicant contends that the following special circumstances support the need for its project:

- The present site is at maximum capacity and no expansion on the site is possible. The site is landlocked and located in the flood plain.
- Parking is a significant problem.
- Building additional stories is not possible because of building code restrictions. Current codes for the location require elevation of new structures at least four to six feet.
- Eleven acres is not sufficient to build a modern facility with today's square footage requirements and associated support and ancillary services.

The applicant states that since it took over the hospital, HMA has done major renovations to nearly every area of the hospital. However, there remains a need for more private patient rooms and new/expanded services such as specialized care for neurosurgery. There is insufficient classroom space, the facility has extremely limited storage space, inadequate parking facilities and operating rooms that are small and old, which make it difficult for the hospital to compete with other hospitals in the community.

The review of the project will focus on the applicant's discussion of how the transfer of beds will benefit subdistrict residents in the following areas: efficiency and cost-effectiveness, resident access to health care services including access to the medically indigent, and quality of care.

Efficiency: The applicant indicates that efficiencies in overall operations will be provided as areas in the existing hospital will be renovated¹. These include the ER, the change to all private patient rooms, additional parking facilities, operating rooms and an elevator (at present, according to the applicant, there is only one for patients, staff, physicians, visitors and maintenance). The applicant states that as the existing hospital's infrastructure is a valuable existing resource, it can be streamlined to maximize and enhance its strengths. With this project, diagnostic services can be more efficiently located for optimal service delivery, additional and larger operating rooms can be constructed, outpatient services can be streamlined, and administrative offices can be moved back to the hospital from an outbuilding. Although the applicant

¹ It is noted that the applicant did not submit plans for renovations at the existing hospital, so these were not reviewed. Refer to E. 4. h.

contends that the new facility will benefit, achieving cost efficiencies, from the sharing of human resources, risk management, medical staff office, accounting, materials management, marketing, safety and loss control, infection control/employee health, education, information systems, business office, administration and performance improvement and that corporate purchasing power and achieved savings are documented, a review of information presented in financial pro formas does not appear to support this contention. The AHCA financial reviewer concludes that the applicant's pro formas indicate revenues and profits that are high compared to the existing operation, resulting in excessive profits that are expected to generate an excessive level of patient charges to area patients. The financial reviewer further states that for a non-tertiary hospital, this hospital will be expensive to operate. Economies of scale do not appear to be present. The project is deemed to be a costly and a financially inefficient use of health care resources to provide the same level of services to the local community.

In reference to resident access to health care services, the applicant contends and letters from State Representative Lindsay M. Harrington, District 72, Dennis R. DiDio, Fire Chief, Charlotte County, Wayne P. Sallade', FPEM, Director of Charlotte County Office of Emergency Management, and other community leaders support the contention that the addition of a fourth emergency room in Charlotte County will greatly enhance access to emergency care. It will be appropriately sized to handle projected utilization for the population. Patient diversions during the winter season from Charlotte County to other hospitals can be alleviated by the proposed project. However, while there are letters of support indicating Charlotte County hospitals have been experiencing diversions in the winter season and statements by the applicant as to the need to avoid ER diversion, the number of times and hours Charlotte County facilities were on diversion is not provided.

Additionally, the applicant indicates that the project will enhance more direct access for Charlotte County residents and south outmigrating patients who now travel on I-75 to Lee County. The applicant states that CRMC East's location will virtually eliminate any interior road travel for some residents.

The applicant does not indicate that the project is designed to ensure access to the medically indigent and does not propose to condition approval to the CON on services to these patients. However, CRMC indicates that it has a history of the provision of services to the medically indigent and Medicaid patients and will continue to do so at both locations. Fiscal year 2000 actual data prepared by AHCA indicates the applicant provided 4.0 percent of its total patient days to Medicaid

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patients and 0.7 percent to charity care patients. Schedule 7A indicates that traditional Medicaid will account for 4.3 percent of the new facility's total patient days. No Medicaid HMO patient days are shown in this schedule. Notes to the schedule indicate that indigent care will account for 1.5 percent of net revenues (less bad debt) for all operating periods.

In reference to quality of care, Punta Gorda H.M.A., Inc. indicates that Charlotte Regional Medical Center has a history of providing quality care since 1947. The hospital is JCAHO accredited and has had no confirmed quality of care complaints during the three previous years. The applicant documents the ability to provide quality care.

Next, the applicant discusses projected Charlotte County population growth, and indicates that since CY 1996, persons age 65+ have consistently accounted for over 34 percent of the Charlotte County population. The following chart documents this.

Charlotte County 65+ Population as Percent of Total Population Calendar Years 1996, 2000, and 2001				
Year	65+ Pop.	Total Pop.	% 65+ to Total Pop.	Statewide % 65 pop. to total
1996	45,486	131,458	34.60%	17.73%
2000	49,169	142,401	34.53%	17.48%
2001	49,735	145,306	34.23%	17.49%

Source: CON #9550 from "AHCA Population Estimates" published December 2001 for July of each year.

The applicant indicates that CMRC East will serve essentially the same population CRMC has traditionally served and the age 65 and over age group has consistently represented 71 percent of CMRCs discharges. AHCA hospital discharge data for the 12 months ending June 30, 2001, indicates age 65 and over patients accounted for 70 percent of Charlotte Regional's total discharges. Older patients represent higher utilization of health care facilities and longer length of stay overall. Florida Executive Office of the Governor Population Estimates published by the Agency in December of 2001, indicates Charlotte County will have approximately 160,140 residents by January 2006 and 52,496 or 32.78 percent of the population will be 65 and over. Charlotte County is projected to have 163,335 residents by January 2007 (year two) and 53,335 or 32.65 percent of the population will be 65 and over. Therefore, the percentage of persons age 65 and over is projected at approximately two percent lower than the applicant projects.

Regardless, this project is not driven by overall county population growth, as there will be no additional beds in the county as a result of this project and the applicant indicates that it will not increase its overall market share as the two facilities will be located within two to five miles of each other on the same side of the Peace River. The applicant further contends that CRMC East admissions projections are based only on conservative increases in CRMC's discharges per thousand population at seven percent annually for years 2002 - 2006. The applicant indicates this is reasonable based on its increase of 15.8 percent of the Charlotte County discharges in FYE September 30, 2000 and 10.7 percent in FYE September 30, 2001.

The reviewer examined the hospital's market share for the 12-month periods ending June 30, 1999 through June 30, 2001. For the period ending June 30, 1999, Charlotte Regional Medical Center had 25,738 (or 28.11 percent) of the Charlotte County facilities total of 91,570 patient days. During the period ending June 30, 2000, Charlotte Regional Medical Center had 32,511 (or 31.10 percent) of the Charlotte County facilities total of 104,544 patient days. During the period ending June 30, 2001, Charlotte Regional Medical Center had 34,351 (or 30.77 percent) of the Charlotte County facilities total of 111,654 patient days. Therefore, the applicant's market share in terms of patient days has not demonstrated a seven percent increase, in fact the hospital lost patient day market share from period ending June 30, 2000 to the reporting period ending June 30, 2001.

The applicant's projected occupancy as a result of the project for FY 2005 and 2006 is contained in the chart below.

**Charlotte Regional Medical Center East
Projected Patient Days**

Fiscal Year	Projected Discharges (Total 156 Beds)	Percent Discharges to CRMC East	Total Discharges CRMC East	ALOS @ CRMC East	Projected Patient Days @ CRMC East
2005	10,767	38%	4,091	4.7	19,230
2006	11,756	38%	4,467	4.7	20,996

Source: CON #9550, page 48.

The applicant indicates that the next step in the projection was to analyze the hospital's FY 2001 utilization by service in order to determine the patient volume at CRMC East. This resulted in CRMC East projected to have 80 percent of the existing hospital's volume in the following Medical Diagnostic Codes (MDC): nervous system, digestive, musculoskeletal, skin/subcutaneous/breast, male reproductive system, female reproductive system, infectious/parasitic disease and an "other" MDCs. The applicant indicates that 50 percent of the service area's total

discharges at CRMC East will be from the following MDC categories: respiratory, circulatory, hepatobiliary system/pancreas, endocrine, nutritional/metabolic, kidney/urinary, blood/blood forming organs, myeloproliferative disease, and injury/poisoning. The applicant indicates that the satellite facility will treat patients in these categories whose condition is not one of high acuity and does not require tertiary care, therefore it allocates only 903 of the 3,924 projected total to CRMC East.

The applicant next presents the projected occupancy for CRMC East during the first two fiscal years of operation.

**Occupancy Projections for CRMC East
In 75 Acute Care Beds**

Fiscal Year	Bed Days	Patient Days	Occupancy
2005	27,375	19,230	70.25%
2006	27,375	20,996	76.70%

Source: CON #9550, page 49.

The applicant indicates that it believes these projected occupancies are realistic and conservative. Charlotte County's projected population growth was also reviewed and the county grew from by the 145,306 persons in 2001, to 160,140 by January 1, 2006 or approximately 10 percent. This translates to an annual growth rate of approximately two percent. The growth rate from January 1, 2006 (160,140) to January 1, 2007 (163,335) is 2.0 percent. This along with the hospital's actual growth rate in total patient days as discussed above, indicates the projections might be a little high. Otherwise, the applicant will actually impact another facility's market share if projections are correct.

In summary, the applicant's strongest arguments supporting this project follow: it would allow for renovation of the existing facility and the addition of a state of the art facility above the flood plain and more beds and an ER would be available during peak season. The applicant's contention that it will not negatively impact existing providers is supported by its projections; any impact appears minimal. None of the subdistrict hospitals are Medicaid Disproportionate Share providers, so there are no concerns about this project negatively impacting a Medicaid Disproportionate Share provider. However, while the project should improve the applicant's profits it would not improve the subdistrict's overall efficiency in the delivery of health care services because of the excessive profits generated by the project.

2. Local Health Plan Preferences

Is need for the project proposed supported by the applicable district plan? ss. 408.035(1); 408.037(1), Florida Statutes.

The October 2000 District 8 CON Allocation Factors Report lists the following preferences relevant to acute care beds:

- a. Preference shall be given to applications for the addition of general acute care beds, including obstetrical and pediatric beds, that contain a provision to accept all persons in need, especially the medically underserved and the indigent**

Charlotte Regional Medical Center does not propose to add beds as it will relocate 75 beds with this project. The project does not involve the provision of obstetric and pediatric services. While the applicant indicates it accepts all patients regardless of ability to pay, the hospital is not a disproportionate share Medicaid provider. Schedule 7A shows the applicant projects Medicaid to account for 4.3 percent of the project's total patient days in year two to Medicaid patients and notes to this schedule indicate charity care is calculated at 1.5 percent of net revenues (less bad debt). However, the applicant does not propose any Medicaid or charity care conditions on this project.

- b. Preference shall be given to applications based on shared services and transfer arrangements that mutually increase existing resource efficiency.**

The applicant indicates that the proposed project does not meet the definition of shared services and transfer arrangements between different providers.

- c. Preference shall be given to applications for the transfer of beds within a subdistrict if the applicant can demonstrate a more cost-efficient method than the renovation and/or expansion of the existing facility.**

The applicant contends that construction of CRMC East and the relocating of beds allows the existing facility the space it requires, thus increasing the useful life of the physical plant and making it more effective for patient care delivery. The project will cost less than a total replacement facility, which would result in abandoning the existing facility. However, the applicant's pro formas indicate revenues and profits that are high compared to the existing operation and the project is expected to generate an excessive level

of patient charges to area patients. The project is deemed to be a costly and financially inefficient use of health care resources to provide the same level of services to the local community.

- d. **Preference shall be given to applications for the transfer of beds within a Subdistrict if the applicant is able to improve the physical plant of an existing facility as the result of the bed transfer.**

The applicant indicates that the following areas will be improved as a result of its project: CRMC's emergency room, the facility's patient rooms will be changed to all private rooms, parking facilities, operating rooms and the elevator. At present there is only one elevator for patients, staff, physicians, visitors and maintenance.

- e. **Preference shall be given to applications for the addition of general acute care beds, including obstetrical and pediatric beds, when equal to existing levels in the subdistrict. The application shall demonstrate acceptance of all persons in need, especially the medically undeserved, including Medicaid and charity patients. "Uncompensated care" includes charity and the difference between average payments and average costs for Medicaid and Medicare patients.**

The following table provides the percentage of Medicaid and charity provided by each of the subdistrict's acute care facilities.

District 8 Subdistrict 1 Medicaid & Charity Care % Patient Days - FY 2000		
Facility	% Medicaid	% Charity Care
Charlotte Regional Medical Center	4.0%	0.7%
Fawcett Memorial Hospital	1.5%	0.1%
Bon Secours - St. Joseph Hospital	7.3%	2.3%
Subdistrict 1 Average	4.3%	1.0%
District 8 Average	7.3%	1.9%

Source: AHCA Hospital Financial Data FY 2000.

The table above shows that Charlotte Regional Medical Center is second in provision of Medicaid and charity care to subdistrict patients. Schedule 7A indicates that the applicant projects Medicaid patient days (Medicaid HMO is shown at zero) will account for 4.3 percent of the project's acute care patient days. This exceeds the facility's FY 2000 utilization; however, the facility did provide 5.4 percent of its total patient days to Medicaid patients during FY 1999. The applicant indicates charity care

provided during FYE September 30, 2001 and September 30, 2000 was \$5,489,860 and \$4,939,742 and the applicant's proposed charity care for this project would be 1.5 percent of net revenue (less bad debt). The applicant does not propose any charity care or Medicaid conditions for this project.

- f. Preference shall be given to applications that demonstrate renovation is more economical than new construction or vice versa.**

The applicant proposes to construct a new facility; however, the project is deemed to be a costly and financially inefficient use of health care resources to provide the same level of services to the local community.

- g. Preference shall be given to licensed hospitals that exceed a 90 percent occupancy level during the period of January through March on an annual basis, and in the event of multiple locations under one license any individual location applies. (During the months January through March, the district's population increases significantly due to the influx of tourists and part-time residents. This seasonal increase in population results in increased demands for inpatient services that can exceed available bed capacity).**

Charlotte Regional Medical Center Acute Care Patient Days & Occupancy Levels January - March (1st Quarter) Calendar Years 1999-2001		
	Patient Days	% Occupancy
1999	8,200	58.40%
2000	11,198	78.88%
2001	10,232	72.88%

Source: AHCA Hospital Bed Need Projections January 2002 - 2000 Batching Cycles.

Note: The facility's acute care bed count has remained at 156 beds during these reporting periods.

The chart above demonstrates that the applicant's utilization of the facility's acute care beds during the peak season of each year has fluctuated. CRMC contends that because of operational requirements such as male/female bed capacity, isolation, intensive and critical care bed all combine to make higher occupancy impossible.

3. **Agency Rule Criteria**

Does the project respond to preferences stated in agency rules? Indicate how each applicable criteria for the type of service proposed is met. Ch. 59C-1.038(6) (a) & (b), Florida Administrative Code.

- a. **Priority consideration for initiation of new acute care services or capital expenditures shall be given to applicants with a documented history of providing services to medically indigent patients or a commitment to do so.**

The applicant cites its history of provision of care to Medicaid and charity care patients and indicates that it will continue to do so. For a discussion on the comparison of the applicant's Medicaid and charity care provision, see 2.e. above.

- b. **When there are competing applications within a subdistrict, priority consideration shall be given to the applications, which meet the need for additional acute care beds in a particular service through the conversion of existing underutilized beds.**

There are no competing applications for additional acute care beds in District 8, Subdistrict 1. The applicant is proposing the transfer of underutilized beds at Charlotte Regional Medical Center to establish Charlotte Regional Medical Center, East. The applicant's existing facility reported the highest utilization of the three hospitals in the subdistrict at 60.33 percent occupancy during the reporting period ending June 30, 2002.

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.**

In reference to availability, the applicant discusses how the new hospital, CRMC East will ease capacity constraints at CRMC, via a more accessible location for some of the population because of the proximity to I-75. Punta Gorda, H.M.A., Inc., indicates that the new facility will provide another 24-hour emergency room and sharing of inpatient and outpatient areas will provide more flexibility and operational efficiencies found in new facilities. Charlotte Regional has the highest acute care utilization (60.33 percent) in the subdistrict. This compares to the

subdistrict's 56.23 percent average occupancy rate during the 12-month reporting period ending June 30, 2001. The new beds would be available to handle the emergency diversions during the tourist season.

Subdistrict 1 facilities averaged 69.54 percent utilization during the 1st quarter of 2001, second highest of the six subdistricts in District 8.

The applicant did not question the quality of care provided by other hospitals in the subdistrict. See item 4.c. for a discussion of the applicant's quality of care.

In respect to efficiency, the applicant indicates that the new facility will benefit from the sharing of human resources, risk management, medical staff office, accounting, materials management, marketing, safety and loss control, infection control/employee health, education, information systems, business office, administration and performance improvement. Corporate purchasing power and achieved savings are documented according to the applicant. The applicant indicates that efficiencies in overall operations will be provided as areas in the existing hospital will be renovated. These include the ER, change to all private patient rooms, parking facilities, operating rooms and the elevator, at present there is only one for patients, staff, physicians, visitors and maintenance. However, the applicant's pro formas indicate revenues and profits that are high compared to the existing operation, resulting in overly excessive profits. The project is expected to generate an excessive level of patient charges to area patients and for a non-tertiary hospital, will be expensive to operate, as economies of scale do not appear to be present. The project is deemed to be a costly and financially inefficient use of health care resources to provide the same level of services to the local community.

Access should be improved as the new beds would be available to handle the subdistrict's emergency diversions. The project should have a positive impact on the quality of care, but the applicant's projections could not be relied upon to assess the impact on competition in the subdistrict. As previously stated, the applicant indicates that its project would not result in an increased market share.

District 8, Subdistrict 1 is comprised of three acute care hospitals in one county with a total of 544 beds. The average occupancy in the acute care beds in District 8, Subdistrict 1 was 56.23 percent during the July 2000 through June 2001 reporting period.

The following table shows the number of acute care beds and occupancy rates for District 8, Subdistrict 5.

District 8 Subdistrict 1 Occupancy Rates July 2000 through June 2001		
Hospital	# of Acute Care Beds	Percent Occupancy
Fawcett Memorial Hospital	196	53.59%
Charlotte Regional Medical Center	156	60.33%
Bon Secours- St. Joseph Hospital	192	55.60%
TOTALS	544	56.23%

Source: Florida Hospital Bed and Service Utilization by District, Vol. II, January 2002.

Need for the project is not evidenced by the utilization of like and existing services in the service area. However, it appears that the project would improve the applicant's ability to serve the subdistrict as well as access to acute care beds. The applicant contends that the project will not increase its overall market share, one of the reasons being the Peace River division of the market area, and should this be correct, there would be minimal impact on the occupancy of the other two hospitals in the subdistrict.

- b. Does the applicant have a history of and demonstrate the ability to provide quality care? ss. 408.035(3), 408.035(12), Florida Statutes.**

Punta Gorda H.M.A., Inc. indicates that Charlotte Regional Medical Center has a history of providing quality care since 1947. The hospital is JCAHO accredited and is the only hospital on the southwest coast of Florida to rank in the "Top 100 Heart Hospital" (in 1999 and 2000) in the U.S. and in CY 2001, the "100 Top Stroke Hospitals Award" as determined by the HCIA-Sachs. HCIA-Sachs ranks hospitals nationwide based on quality of care, efficiency of operations and sustainability of overall performance. The applicant also provides a description of its performance improvement and quality management programs. Attachment M contained a copy of Charlotte Regional Medical Center's performance improvement plan, which includes all three hospitals. The hospital participates in the Medicaid and Medicare programs and is in compliance with the conditions of participation for these programs. The hospital has had no confirmed quality of care complaints during the three previous years.

- 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, which are not accessible in adjacent districts.

- d. **Is the 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 applicant indicates that CRMC East will provide an additional trading source and educational opportunities for medical students, interns, residents and physicians. The new hospital will also provide a clinical training site for local college and university programs in nursing and technical health professional programs. However, the proposed project will not be located in a teaching hospital, nor is the project's primary purpose research or physician education.

- e. **What resources, including health manpower, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? ss. 408.037(6), Florida Statutes.**

Punta Gorda H.M.A., Inc. presents a brief discussion of the parent company's management system and a description of operational resources. The applicant indicates that Charlotte Regional Medical Center does not have difficulty regularly attracting staff. The applicant presents a description of its retention and recruitment procedures. CRMC has a Retention and Recruitment Committee, which it states has been in operation for approximately 1-1/2 year with demonstrated success. The committee has partnered with hospitals in five other counties to form a Southwest Florida Nurses Recruitment Task Force where educators and administrators plan community activities that promote nursing as a viable profession. Activities include job shadowing and work with area clubs and organizations in the health field. The applicant indicates that it has newsletter, an endowment program and mentoring program for nurses. The applicant indicates that it recruits nurses from all over the country and CMRC and HMA have a well established and tested program. A good description of nurse recruiting and benefits is provided.

Schedule 6A indicates that 369.25 FTEs will be added by the end of year two (December 31, 2006). These include 107.5 FTE RNs/specialty clinicians, 18 LPNs/EMTs, and 64.25 technicians/PCA/nurse assistants. The applicant does not indicate that any of these FTEs will be filled by employees who will transfer from the existing hospital. However, the applicant indicates that it is fully staffed to provide the necessary support for the development and operation of the proposed project and indicates administrative staff will provide ongoing support in areas including but not limited to, finance, accounting, reimbursement, development and quality management. Since the application is a bed

transfer, it follows that some of the nursing/care giver personnel would transfer from the existing facility. Therefore, it is probable that the applicant's Schedule 6A does not give the actual number of the applicant's new employees but only the number of positions at the new facility.

Punta Gorda H.M.A, Inc.'s audited financial statements for the periods ending September 30, 2001 and 2000 were analyzed for the purpose of evaluating the applicant's ability to provide the capital and operational funding necessary to implement the project. The following is a list of accounts and ratios used in the analysis:

FINANCIAL INDICATORS AND RATIOS

TABLE ONE

	09/30/2001	09/30/2000
Current Assets	\$ 16,201,401	\$ 15,187,757
Cash and Current Investment	\$ 451,740	\$ 320,227
Assets Restricted for Capital Funding	\$ 0	\$ 0
Total Assets	\$ 60,029,581	\$ 59,386,681
Current Liabilities	\$ 7,556,739	\$ 6,437,613
Total Liabilities	\$ 25,586,837	\$ 31,229,170
Total Equity	\$ 34,442,744	\$ 28,157,511
Net Operating Revenues	\$ 99,506,149	\$ 87,502,147
Interest Expense	\$ 74,265	\$ 22,991
Net Profit - Operations	\$ 10,346,063	\$ 7,897,562
Net Income	\$ 6,285,233	\$ 4,797,769
Cash Flow Provided by Operating Activities	\$ 12,003,208	\$ 7,749,318
Working Capital	\$ 8,644,662	\$ 8,750,144
Current Ratio (CA/CL)	2.1	2.4
Long-Term Debt to Equity (TL-CL/TE)	0.5	0.9
Operating Cash Flow (CFO/CL)	1.6	1.2
Equity to Total Assets (TE/TA)	57.4%	47.4%
Operating Margin (NPO/NOR)	10.4%	9.0%
Total Margin (NI/NOR)	6.3%	5.5%
Return on Assets (NI/TA)	10.5%	8.1%
Operating Cash Flow to Assets (CFO/TA)	20.0%	13.0%

Short-term position:

The applicant's current ratio of 2.1 indicates current assets are over two times that of short-term liabilities, a strong position. The working capital (current assets less current liabilities) of \$8.6 million is adequate in relation to the entity's size. The ratio of operating cash flow of 1.6 is above the average for Florida acute care hospitals of 0.7. The applicant has a strong short-term position.

Long-term position:

The long-term debt to equity ratio of 0.5 is strong, due to the fact that the hospital has no long-term debt. However, in 2001 the applicant reported \$19.9 million as “Due to Parent Company”. The cash flow to assets of 20.0 percent is satisfactory. The most recent year had an operating profit of \$10.3 million, which resulted in a margin of 10.4 percent. The previous year had an operating profit of \$7.9 million. The total equity of \$34.4 million with the equity to assets of 57.4 percent is adequate. Because of the significant earnings and cash flows the applicant has a satisfactory long-term position.

Capital requirements:

Schedule 2 indicates total capital projects of \$81.1 million. All long-term debt is due to the parent company, with no specific maturities. The schedule indicates funding for these projects will come from the parent, Health Management Associates, Inc.

Available capital:

The audited balance sheet shows \$8.6 million in working capital and over \$12 million in annual cash flows from operations to provide continued funding for operations. A letter from the parent, Health Management Associates, Inc. states it will fund the entire project cost for the replacement hospital as well as guaranteeing funding for all capital projects. The audited financial statements from the parent are contained in the 10-K report, which is included in the application. These statements disclose \$70.3 million cash on hand, \$1.9 billion in assets, \$1.3 billion in equity, \$321 million operating profits and \$290 million cash flows. The parent is a large and financially strong entity, capable of providing the funding needed.

Conclusion:

Based on the cash flows of the applicant and the financial commitment from the parent, funding for this and all other capital projects will be available as needed.

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 management proficiency 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.

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 outpatient revenues into the per patient day computation.

Comparative data were derived from hospitals in peer groups that reported data in 2000. Based on the projected range of services, data were obtained by utilizing the detailed patient information reported by the applicant and excluding obstetric, psychiatric, and tertiary services to calculate a case mix index for the satellite of 1.4325. This case mix compares the satellite to the hospitals in group seven. Per diem rates are projected to increase by an average of 3.3 percent per year. Inflation adjustments were based on the most current Florida Hospital Input Price Index.

Net revenue per adjusted patient day (NRAPD) of \$1,987 in year one and \$2,045 in year two is above the control group highest values of \$1,699 in year one and \$1,750 in year two. The highest level is generally viewed as the practical upper limit on both economy of operation and financial feasibility. With net revenues falling above the highest level, the facility is expected to consume health care resources in a significantly greater proportion to the services provided. (See Financial Comparison Table).

In order to further evaluate the reasonableness of the revenue projections, we compared the need revenues per day of the satellite to those of the Charlotte main campus. The 2000 actual NRAPD for Charlotte Regional Medical Center was \$1,494, which was then adjusted for inflation to 2006. The inflation adjusted NRAPD for the Charlotte main campus is \$1,791.

The satellite projections exceed the inflation adjusted NRAPD of the main campus. This result is not logical, as the satellite facility will not be providing tertiary services that are typically reimbursed at a higher rate.

Projected cost per adjusted patient day of \$1,704 in year one and \$1,675 in year two is above the control group highest value of \$1,633 in year one and is slightly below the highest value of \$1,682 in year two. (See Financial Comparison Table). Compared to the control group, these costs describe high levels of expenditures that are required by very few of the peer facilities.

In order to further evaluate the reasonableness of the projected expenses, we compared the expenses of the satellite to those of the Charlotte main campus. The 2000 actual CAPD for Charlotte Regional Medical Center was \$1,367, which was then adjusted for inflation to 2006. The inflation adjusted CAPD for the Charlotte main campus is \$1,639

The projected expenses of the satellite facility exceeded those of the main campus when adjusted for inflation. When adjusting for the additional capital costs associated with the new construction, the operating expenses per adjusted patient day are equivalent between the satellite hospital and the main campus. Considering that the satellite facility will not be providing any tertiary services, operating expenses excluding capital costs should be materially less than those of the main campus. Operating expenses for the satellite hospital are very high and are only marginally cost-efficient.

The year two operating profit for the satellite hospital of \$9.7 million computes to an operating margin per adjusted patient day of \$370 which falls above the peer group highest value of \$351. The operating margin ratio computes to 18.1 percent. In 2001, the main campus hospital had an operating profit of \$10.3 million, which computes to an operating margin per adjusted patient day of \$127. The operating margin ratio for the Charlotte main campus computes to 10.4 percent.

The reasons given for establishing the satellite facility at the new location are better access and a more efficient layout. However, compared to the group data it appears these projections show revenues and costs that are high, resulting in excessive profits. The applicant's ability to implement this project is not in question, however the project is expected to generate an excessive level of charges to area patients and, for a non-tertiary hospital, will be expensive to operate, as economies of scale do not appear to be present. This project represents a costly and financially inefficient use of health care resources to provide the same level of services to the local community.

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Punta Gorda H.M.A., Inc. CON: 9550

FINANCIAL COMPARISON TABLE

PEER GROUP 7

	2006 YEAR 2 ACTIVITY	YEAR 2 ACTIVITY PER DAY	INFLATION ADJ. VALUES		
			Highest	Median	Lowest
ROUTINE SERVICES	14,538,800	552	792	599	377
INPATIENT AMBULATORY	0	0	101	40	30
INPATIENT SURGERY	0	0	0	0	0
INPATIENT ANCILLARY SERVICES	91,583,265	3,475	3,355	2,488	1,555
OUTPATIENT SERVICES	26,705,462	1,013	1,640	1,252	748
TOTAL PATIENT SERVICES REV.	132,827,527	5,039	5,365	4,456	3,414
OTHER OPERATING REVENUE	397,342	15	40	11	5
TOTAL REVENUE	133,224,869	5,054	5,405	4,467	3,419
DEDUCTIONS FROM REVENUE	79,314,384	3,009	*	*	*
NET REVENUES	53,910,485	2,045	1,750	1,537	1,304
EXPENSES					
ROUTINE	9,406,152	357	344	216	171
ANCILLARY	12,347,979	468	611	502	427
AMBULATORY	2,086,986	79	0	0	0
TOTAL PATIENT CARE COST	23,841,117	905	955	718	598
ADMINISTRATIVE & OVERHEAD	13,274,352	680	803	634	535
PROPERTY	4,640,368	*	*	*	*
TOTAL HOSPITAL EXPENSE	41,755,837	1,584	1,682	1,401	1,247
OTHER OPERATING EXPENSE	2,390,515	0	0	0	0
TOTAL EXPENSE	44,146,352	1,675	1,682	1,401	1,247
OPERATING INCOME (MARGIN)	9,764,133	370	351	73	-97
PERCENT OPERATING MARGIN	18.1%				

**PERCENTAGES NOT INFLATION
ADJUSTED**

PATIENT DAYS	20,996				
ADJUSTED PATIENT DAYS	26,358				
TOTAL BED DAYS AVAILABLE	27,375				
ADJ. FACTOR	0.7966				
TOTAL NUMBER OF BEDS	75				
PERCENT OCCUPANCY	76.7%		75.3%	52.6%	30.7%

PAYER CLASS

	PATIENT DAYS	PERCENT OF TOTAL			
SELF-PAY	177	0.8%	3.9%	1.4%	0.1%
MEDICAID	902	4.3%	23.5%	7.5%	1.1%
MEDICAID HMO	0	0.0%			
MEDICARE	15,777	75.1%	76.8%	56.4%	20.1%
MEDICARE HMO	0	0.0%			
INSURANCE	0	0.0%			
HMO/PPO	3,973	18.9%	60.6%	26.0%	9.7%
TOTAL	20,996	100.0%			

g. Will the proposed project foster competition to promote quality and cost-effectiveness? ss.408.035(9), Florida Statutes.

The applicant projects managed care to represent 18.9 percent of its patient days. This is below the control group median of 26.0 percent and is significantly above the hospital's own 2000 managed care level of 5.9 percent of patient days. Given the statement that the satellite is expected to serve essentially the same population, the projections appear to present an unrealistic level of expected managed care activity. It is felt that these projections cannot be relied upon to indicate the competitive impact in this area.

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.

The applicant proposes to relocate 75 of Charlotte Regional Medical Center's 156 acute care beds to a new satellite facility several miles from the existing hospital. The CON does not address what will become of the space that will be made available in the existing building when these beds are removed. This architectural review is based only on the plans submitted for the proposed new facility. The applicant should be aware that should this CON be approved and the new hospital be submitted to the AHCA Office of Plans and Construction, the disposition of the vacated spaces in the existing hospital will need to be addressed and reviewed.

Although plans for renovation of the existing facility were not provided, it is noted that on page 11 of the application, H.M.A. indicates that this project will allow it to streamline the existing facility to maximize and enhance its strengths. These include locating diagnostic services more efficiently for optimal patient service delivery, constructing additional and larger operating rooms, streamlining outpatient services and moving administrative offices from an outbuilding back to the main hospital. The applicant also indicates and shows that patient rooms at the existing and new facilities will all be private.

The site had not been selected at the time the CON Application was submitted. Because of this, it cannot be determined if the final location will meet the Disaster Preparedness requirements of the Florida Building Code, Section 419.4.56 regarding the flood plain elevation and the Category 3 Surge Inundation. It is critical that the site and design of the hospital meet these code provisions.

The application includes plans of all three floors as well as large-scale plans of typical patient rooms and a plan of the energy plant. The patient rooms themselves appear to meet codes. However, Section 11-6 of the Florida Building Code states that “At least 10 percent of patient bedrooms and toilets and all public use and common use areas are required to be designed and constructed to be accessible”. Also, Section 11-4.33 toilet rooms, requires the 5’ diameter turning space within an accessible toilet room as defined in paragraph 11-4.2.3. It does not appear that any of these toilet rooms are accessible. Enlarging the toilet rooms to be accessible could be a major change, possibly rippling thru the whole building design. The plans were prepared by a design professional with extensive health care experience, but by scaling the toilet rooms, there does not appear to be enough room for the turning circle. It is possible that there might be another typical accessible room, which is not shown, but this does not seem likely since the typical patient room plan is the one that is too small. Oddly, this typical plan also includes what looks like a wheelchair-accessible shower. Perhaps the design professional is not aware of the requirements for a single toilet room’s accessibility. This is a critical deficiency of the proposed design.

In addition to the patient room toilets, there are public and staff toilets where the turning space circle is not indicated. An example of this is the toilet adjacent to the waiting room in the 2nd floor ICU. Some of these toilet rooms appear to be and may actually be accessible, but there is no turning circle shown whereas other toilet rooms have the circle. The implication is that the ones without the circle are not accessible. Some toilet rooms are actually labeled H/C, but they have the circle drawn in them. It is possible that the issues regarding accessible toilets are merely the result of inconsistent drafting standards, but there are obviously questions that need to be addressed.

More information about the body holding room would have been helpful. If autopsies are performed in the hospital, then this space will need to be expanded to include the required ancillary spaces.

There is a partial list of applicable codes on the drawings, but it needs to be expanded when the project progresses.

The front of the hospital has the visitor drop-off, the patient drop-off and the public ER entry on what appears to be the same traffic loop. There is a long wide canopy over these three entries. It is not shown whether vehicles actually drive under the canopy, but it could be assumed that this is the case. It is possible that there might be some congestion with these three functions so close to each other, particularly since cars will be stopping at all three points to let passengers out. Although the

entrances are labeled “drop-off”, they are most likely “pick-up” points also. This would increase the possibility of congestion. The designers may have some explanation as to how this adjacency is workable, but this area might benefit from further study.

- 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.**

Punta Gorda H.M.A., Inc. d/b/a Charlotte Regional Medical Center is not a disproportionate share Medicaid provider. However, the applicant indicates that it has a history of the provision of services to the medically indigent and Medicaid patients and will continue to do so at both locations. Fiscal year (FY) 2000 actual data prepared by AHCA indicates the applicant provided 4.0 percent of its total patient days to Medicaid patients and 0.7 percent to charity care patients.

Charlotte Regional Medical Center’s open heart surgery program is conditioned to 2.59 percent of the total procedures being provided to Medicaid patients and 1.2 percent to charity care patients. During CY 1996 through CY 2000, the applicant complied with these conditions.

Schedule 7A indicates that traditional Medicaid will account for 4.3 percent of the new facility’s total patient days. No Medicaid HMO patient days are shown in this schedule. Notes to the schedule indicate that indigent care will account for 1.5 percent of net revenues (less bad debt) for all operating periods.

F. SUMMARY

Punta Gorda H.M.A., Inc. d/b/a Charlotte Regional Medical Center (CON #9550) proposes to construct a new 75-bed hospital in District 8, Subdistrict 1, through the transfer of 75 beds from the existing facility. This project will not increase the total number of acute care beds in the subdistrict.

After weighing and balancing all applicable review criteria, the following relevant factors are listed with regard to the hospital project in District 8, subdistrict 1, Punta Gorda H.M.A., Inc. d/b/a Charlotte Regional Medical Center.

Need/Other Special Circumstance:

The Agency published no need for acute care beds in District 8, Subdistrict 1.

The applicant does not apply under the fixed need pool, but applies under special circumstances. However, although the applicant claims the project will offer efficiencies in its overall operations, pro formas indicate revenues and profits are high compared to the existing operation, resulting in excessive profits that are expected to generate an excessive level of patient charges.

The project should not improve the efficient delivery of services in the subdistrict, as this is offset by the applicant's projected high costs and revenues. Need for the project was not demonstrated.

Quality of Care:

The applicant has demonstrated that it is a quality of care provider.

Medicaid/charity care:

The applicant is not a disproportionate share Medicaid provider. Schedule 7A indicates that the applicant projects Medicaid and Medicaid HMO patient days will account for 4.3 percent of the project's acute care patient days. Charity care is projected to amount to 1.5 of net revenues (less bad debt). During FY 2000, Charlotte Regional provided 4.0 percent of its total patient days to Medicaid patients and 0.7 percent to charity care patients. The applicant does not propose any charity care or Medicaid conditions for this project.

Financial Feasibility:

The financial review of the applicant indicates that its project is financially feasible. Capital requirements for all projects is available, as the parent is funding these and the parent is a large and financially strong entity.

Compared to the existing operation and hospital group data, the project is expected to generate an excessive level of charges to area residents and to be expensive to operate.

The financial reviewer concludes that the project is a costly and financially inefficient use of health care resources to provide the same level of services to the local community.

Architectural Analysis:

The site had not been selected at the time the CON Application was submitted and it cannot be determined if the final location will meet the Disaster Preparedness requirements of the Florida Building Code, Section 419.4.56 regarding the flood plain elevation and the Category 3 Surge Inundation.

Patient rooms themselves appear to meet codes. However, no five foot' turning space circle is indicated on any of the large scale plans showing patient toilet rooms and it does not appear that any of these toilet rooms are accessible. This is a critical deficiency of the proposed design.

In addition to the patient room toilets, there are public and staff toilets where the turning space circle is not indicated. While some of these toilet rooms appear to be and may actually be accessible, there is no turning circle shown whereas other toilet rooms have the circle. The implication is that the ones without the circle are not accessible. Some toilet rooms are actually labeled H/C, but they have the circle drawn in them. It is possible that the issues regarding accessible toilets are merely the result of inconsistent drafting standards, but there are obviously questions that need to be addressed.

G. RECOMMENDATION

Deny CON #9550.

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