

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 #9616
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 included 16 letters of support for its project to establish a new 75-bed acute care hospital to be located between two and five miles from its existing facility, through the delicensure of 75 acute care beds at that facility, Charlotte Regional Medical Center in Punta Gorda. 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 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

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services/programs) the hospital is involved with in his letter of support. State Representative Lindsay M. Harrington, District 72, indicates that the new hospital will alleviate diversion issues and 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, FPED, 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 experienced diversions from all three local hospitals, which places a strain on the fire/EMS system. He also indicates that this project will address problems with rescue access to the hospital's 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. *(Note: According to AHCA Population data for July 1, 2002, the over 65 population accounts for 33.87 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 Chief 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 #9616) 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 52 psychiatric and substance abuse beds are located in a separate facility known as Riverside Behavioral Center. 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 delicensure and 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. It is the applicant's intent to operate as a single, integrated facility with two campuses (CRMC and CRMC East) and to eventually relocate all 156 acute care beds to the new site.

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 retaining the same admission policies and procedures for both facilities. The applicant further conditions the project to relocate the remaining 81 beds to the new location once the CRMC East location has been licensed and operational for five years. The applicant does not have a condition on its existing acute care beds.

The proposed project consists of new construction of 162,398 GSF at a construction cost of \$33,308,016. The project involves a total cost of \$58,875,198.

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, M. Riley Gibson analyzed the application in its entirety with consultation from the Financial Analyst, Roger Bell 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 July 26, 2002, AHCA published a fixed need pool (FNP) in Volume 28, Number 30, Florida Administrative Weekly (F.A.W.) of zero (0) for additional hospital acute care beds in District 8, Subdistrict 1 for the July 2002 review cycle.

As of July 26, 2002, District 8, Subdistrict 1 had a total of 566 licensed beds. During calendar year (CY) 2001, the subdistrict had a total of 541 licensed acute care beds that experienced an occupancy rate of 58.89 percent for the reporting period January 2001 through December 2001. The most recent acute care addition in the subdistrict involved a conversion through exemption of 25 hospital-based skilled nursing beds at Fawcett Memorial Regional Hospital to 25 acute care beds, effective February 1, 2002. The applicant's project will 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 while alternatives have been considered, the proposed project represents the most feasible option to ensure that CRMC can meet the increasing demand for inpatient, emergency and outpatient services. The applicant further contends that the age of portions of the existing facility and poor planning of additions and renovations, in earlier years by previous owners, have resulted in a physical plant that is inadequate to meet present day operational-space demands, with 156 acute care beds. However, since acquiring the facility in 1994, the applicant states that it has invested considerably in renovations to the physical plant and equipment. In view of this, the applicant contends that the existing hospital is a \$30 million asset,

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which it cannot feasibly abandon at the present time. This would appear to present a dilemma for the applicant since the architectural review of the project (Reference Item 4-f) concludes that the partial replacement facility will duplicate current services and functions for a minimum of five years and does not appear to be cost-efficient.

The following are some of the "significant" issues that the applicant states exist with the facility:

- Previous renovations that created inadvertent separations among diagnostic services and direct care, support and ancillary services, and loss of overall space due to the requirements of meeting modern day codes at each renovation.
- In view of space constraints, the following departments have been relocated outside the hospital: administration, business office, marketing, medical records, central stores, human resources, and conference rooms.
- Patient rooms and bathrooms are adequate but undersized compared to modern facilities. Many rooms share bathrooms and private rooms are limited.
- There are only two elevators for all hospital staff, physicians, visitors and patient transport.
- The emergency room is undersized for the population base served.
- Construction of additional floors is not possible. Building code restrictions and elevation requirements are significant because of the location of CRMC in the designated flood plain. Storm water systems in the area are inadequate to handle drainage during major storms. There is no room on the current site to expand. The 11 acres on which the hospital is sited is landlocked.
- Influx of seasonal population, increasing patient populations, and a larger than average 65 and over population in the area (33 percent of the Charlotte County population is 65 plus compared to 18 percent statewide).

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In view of the above issues that exist with the current facility and the architectural review of the project that suggests that splitting current bed capacity in half will result in an apparent duplication of services that does not prove to be cost-efficient, the proposed partial replacement of the facility rather than total replacement does not appear to represent the best use of resources.

The applicant contends that the 75-bed relocation and the relocation of a majority of outpatient services to CRMC East will allow streamlining of the existing facility to maximize and enhance its strengths. The facility will have more private patient rooms; the facility will gain space for needed storage; undersized nursing stations can spread into vacated and otherwise relocated space, the ICU beds at CRMC East will take pressure off ICU beds at CRMC and medical/surgical patients won't have to be placed in CCU beds when the existing ICU is full; holding and observation areas can be established for emergency, outpatient and diagnostic services and for special procedures staging; and parking problems will be alleviated. The applicant further states that the emergency room at CRMC East will augment the capacity of the emergency room at CRMC, which will enhance access in Charlotte County to emergency care. The applicant states that patient diversions to other hospitals are signs of a critical access issue. The applicant states that these diversions occur regularly during the winter season and that a new emergency room at CRMC East should alleviate emergency room crowding and delays. However, the applicant did not document the number of times and hours Charlotte County facilities were on diversion. Refer to the letter of support from Wayne P. Sallade, FPED, Director of Charlotte County Office of Emergency Management discussed earlier.

It is the intent of the applicant to offer basically the same services at both locations with the exception of open heart surgery, angioplasty, and cardiac catheterization. These services will remain consolidated at CRMC due to what the applicant contends is the most efficient and cost effective option since there have been recent infrastructure improvements to these facilities at CRMC. However, based on Mr. Sallade's comments regarding problems in accessing CRMC's emergency department, it is assumed that cardiology patients admitted through the emergency department at the new hospital will be transported to CRMC's main campus for services. This would appear to be a less than optimal option and contradicts the applicant's contention that the project promotes efficiency and cost-effectiveness.

Because this project does not involve the addition of acute care beds to the subdistrict, the review will focus on the applicant's discussion of how the transfer of beds will benefit subdistrict residents in the following

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areas: efficiency and cost-effectiveness, resident access to health care services including access to the medically indigent, and quality of care.

With regard to efficiency, the applicant 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 will occur. These cost-efficiencies and savings were not specifically documented. However, those are efficiencies often obtained by hospitals operating a satellite hospital several miles away. It is more likely that services will be duplicated resulting in more inefficiencies than efficiencies. Refer to architectural review below under E.4.h. The applicant has agreed to condition award of the CON upon locating within five miles of the existing facility and upon relocating all of its beds to the new hospital within five years. This is essentially a partial replacement hospital proposal and therefore, appears to propose a duplication of services rather than achieve efficiencies through the sharing of resources.

In reference to resident access to health care services, the applicant cites the consistent demand created by the age 65 and over population in Charlotte County. The applicant cites AHCA population figures to show that the 65 and over population in Charlotte County currently represents approximately 33 percent of the total county population in comparison to the state average percentage of 17-18 percent. These percentages are not expected to vary significantly during the next several years. However, the applicant states that the county's population does increase 30-50 percent during the winter season and represents a significant factor for Charlotte County health care providers.

The following chart documents the 65 and over population growth in the county:

Charlotte County 65+ Population as Percent of Total Population Calendar Years 1996, 2000, 2001, and 2002				
Year	65+ Pop.	Total Pop.	% 65+ to Total Pop.	Statewide % 65 pop. to total
1996	45,486	131,458	34.60%	17.73%
2000	49,096	142,370	34.48%	17.48%
2001	49,514	145,290	34.08%	17.47%
2002	49,862	148,093	33.67%	17.46%

Source: "AHCA Population Estimates" published December 2001 for July of each year.

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The applicant indicates that CMRC East will serve essentially the same population CRMC has traditionally served. Based on hospital internal records, the applicant presented a chart to show that the 65 plus discharges represents 70.6 percent of total hospital discharges for 2002. *(Note: Statewide, the 65 and over group accounts for 45 percent of total statewide patient discharges).* Additionally, the applicant indicates that the project will enhance more direct access for Charlotte County residents and south out migrating 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. As previously noted, the two facilities, CRMC East and CRMC, will serve essentially the same market and offer the same services (with the exception of open heart surgery, angioplasty, and cardiac catheterization). 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 three hospitals primarily serving Charlotte County individually maintained a relatively consistent market share within a few percentage points annual variation. While the applicant is projecting growth, this is not inconsistent with the historical performance of the hospital. Based on AHCA Public Information Data Tapes presented by the applicant, CRMC experienced a 12.68 percent increase in total inpatient discharges between July 1996 and June 2001, while St. Joseph Hospital increased by 7.82 percent and Fawcett Memorial remained relatively flat at 1.17 percent.

The applicant does not indicate that the project is designed to ensure access to the medically indigent and does not propose to condition approval of 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 patients and 0.7 percent to charity care patients. Schedule 7A indicates that traditional Medicaid will account for 2.89 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 CRMC has a history of providing quality care since 1947. The hospital is JCAHO accredited. According to the most recent hospital complaint summary report, CRMC and has had five confirmed complaints out of 42

allegations between December 1997 and June 2002. The applicant reasonably documents the ability to provide quality care. Improvement in access, particularly emergency access, is an indicator that the quality of care in the subdistrict could be improved with this proposal. However, this is only partially true with this proposal as the entire facility will not be replaced. Under this proposal, the applicant will operate two emergency rooms, one of which, according to Wayne P. Sallade, FPED, Director of Charlotte County Office of Emergency Management, is inaccessible at times. Although transporting emergency cardiac patients from the new hospital to the old hospital is not a quality of care issue, it is less than optimal for a hospital that considers itself a premier provider of cardiac services in the state and, apart from duplicating services and staff, limits improvement to the quality of care currently being provided in the subdistrict.

It is clear that the proposed location will better serve the same patient population and assuming it is above the flood plain, will address some of the shortcomings and failings of the hospital's existing location. It is also clear that there are limitations at the present site including being land-locked with no room for expanding parking lots and other areas for a growing elderly population. Although not demonstrating cost savings between renovating at the existing site and building a replacement hospital, the applicant has clearly demonstrated reasons for replacing the hospital. However, the applicant has not demonstrated that the overall proposal is cost effective or offers any efficiencies. Rather, it appears to duplicate services and offer some noteworthy inefficiencies such as emergency transport from its new emergency room to the old hospital, especially for cardiac patients. This would be particularly true in the untimely event of a hurricane or other flooding problem at the existing facility. The proposal will not increase access to the medically needy population, as the applicant expects to serve the same patient population and has not agreed to condition the CON upon serving any percentage of this population.

The architectural review of the project (Reference Item 4-h) indicates that the degree of duplication of services and functions proposed for a period of at least five years does not appear to be cost-efficient.

It appears that need for relocating the 156-bed facility has been demonstrated. However, need for relocating 75 acute care beds to serve the same patient population and duplicate services currently being provided at a sister hospital located within five miles of the proposed new hospital has not been demonstrated.

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 initially 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 2.89 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 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 architectural review of the project states that the degree of duplication of services and functions for at least five years does not appear to be cost efficient.

In addition, the architectural review reveals that the proposed cost per square foot (\$231.00) appears quite high for new construction.

- 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 relocation of beds and a majority of outpatient services will allow streamlining of the existing facility to maximize and enhance its strengths. This will result in more private patient rooms, space for needed storage, undersized nursing stations can spread into vacated and relocated space, less pressure on ICU beds, establishment of holding and observation areas, and alleviation of parking problems. As previously shown, the applicant reasonably demonstrates reasons for replacing the total hospital. However, the applicant has not demonstrated that the proposal to construct a partial hospital is cost-effective or offers any efficiencies. Rather, it appears to duplicate services and offer some noteworthy inefficiencies such emergency transport from its new emergency room to the old hospital, especially for cardiac patients

- 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	5.2%	1.9%
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 2.89 percent of the project's acute care patient days. This is less than the facility's FY 2000 Medicaid utilization. The applicant indicates charity care provided during FY 2002 was \$6,351,700, an increase from the FY 2001 total of \$5,489,860. 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 reasonably addressed the various alternatives to the construction of a new facility. It was determined that it is cost-prohibitive to renovate or replace the facility on the existing site. Two of the prohibitive factors include the fact that the current site is flood prone and new construction must be elevated four feet or higher, and the facility is basically landlocked.

- 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 (1 st 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. Actually, the hospital experienced a higher utilization for 2001 during the October through December 2001 reported quarter with 78.67 percent.

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 and Item 4-i.

- 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 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 65.31 percent occupancy during the reporting period ending December 31, 2001.

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. 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. However, as noted earlier, because the applicant is proposing to only replace a portion of the existing facility, there appears to be more of a duplication of services than efficiencies achieved in this proposal. Charlotte Regional has the highest acute care utilization (65.31 percent) in the subdistrict. This compares to the subdistrict's 58.89 percent average occupancy rate during the 12-month reporting period ending December 31, 2001. The new beds would be available to handle the emergency diversions during the tourist season, which should improve access. However, as noted earlier, this would only be true when the ER at the existing facility is accessible, which according to Wayne P. Sallade, FPED, Director of Charlotte County Office of Emergency Management, is not always the case. When the ER is not accessible, patients needing cardiac services provided solely at the old facility, will need to be transported from the new ER to the old facility. Subdistrict 1 facilities averaged the second highest average utilization of the six subdistricts that comprise District 8. In FY 2002, CRMC had 17,665 emergency room visits, an increase from the 16,285 visits in 2001. This represents an 8.4 percent increase in emergency room visits in the most recent year. Since 1998, emergency room visits have increased 39.8 percent.

The applicant did not question the quality of care provided by other hospitals in the subdistrict. As indicated in item 1 above, had the applicant proposed to replace the 156-bed facility, it is most likely that the quality of care in the subdistrict would have improved. However, with this partial replacement proposed, that is not entirely the case. See item 4.c. for a discussion of the applicant's quality of care.

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In respect to efficiency, the applicant indicates that the new facility will form the essential core of the CRMC future replacement facility. CRMC and CRMC East will operate as a single, integrated facility with two campuses, on an interim basis until the remaining 81 beds are relocated to join the facility once again. The applicant expects to 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. Although the applicant states that corporate purchasing power and achieved savings are documented, these savings are not specifically identified by 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, and operating rooms. However, as noted earlier, those are efficiencies often obtained by hospitals operating a satellite hospital several miles away and serving a different patient population. This project proposes to do neither. The applicant has agreed to condition award of the CON upon locating within five miles of the existing facility and upon relocating all of its beds to the new hospital within five years. This is essentially a partial replacement hospital proposal and therefore, appears to propose a duplication of services rather than achieve efficiencies through the sharing of resources.

District 8, Subdistrict 1 is comprised of three acute care hospitals in one county with a total of 566 acute care beds as of July 26, 2002. The average occupancy in the 541 licensed acute care beds in District 8, Subdistrict 1 was 58.89 percent for the calendar year 2001 reporting period. Acute care beds were added at Fawcett Memorial between the reporting period and the July 26, 2002 bed inventory published for this review cycle.

The following table shows the number of acute care beds and occupancy rates for District 8, Subdistrict 1.

District 8 Subdistrict 1 Occupancy Rates January 2001 through December 2001		
Hospital	# of Acute Care Beds	Percent Occupancy
Fawcett Memorial Hospital	193	54.56%
Charlotte Regional Medical Center	156	65.31%
Bon Secours- St. Joseph Hospital	192	58.08%
TOTALS	541	58.89%

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

Need for the project is not evidenced by the utilization of like and existing services in the service area. 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. As concluded in the architectural review of the project (Item 4-f), the degree of duplication of services and functions at the proposed facility for a period of at least five years does not appear to cost-efficient and the cost per square foot to construct the facility appears high for new construction.

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. purports 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 CRMC's performance improvement plan. The hospital participates in the Medicaid and Medicare programs and is in compliance with the conditions of participation for these programs.

According to the most recent Complaint Summary report dated October 1, 2002 provided by the Office of Quality Assurance-Hospital Section, Charlotte Regional has had 42 allegations since 1997 with 12 confirmed violations involving patient rights, medicine errors, patient care, and restraints.

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 training 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.**

The 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

	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 minimal long-term debt. The long-term debt consists of \$17 million "Due to Parent Company". The cash flow to assets of 20.0 percent is very strong. 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 good. Because of the significant earnings and cash flows the applicant has a very good long-term position.

Capital requirements:

Schedule 2 indicates total capital projects of \$141.8 million, which includes the previous application for this same project. If only the larger of the two projects were included the total would be \$83 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. The audited financial statements from the parent for the year ended September 30, 2001 are contained in the 10-K report 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.

Staffing:

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 376.77 FTEs will be employed at the new hospital by the end of year two (September 30, 2007). These include 107.5 FTE RNs/specialty clinicians, 18 LPNs/EMTs, and 61.5 technicians/PCA/nurse assistants. The applicant indicates that the vast majority of staff for the new facility is currently employed by the existing facility. The additional staff required will be hired primarily to satisfy the overall census growth, and accompanying demand for existing services, projected over the next five years. However, because some services are duplicated, it is expected that some portion of the staff will be duplicated as well.

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; the applicant will be compared to the hospitals in group 6. Per diem rates are projected to increase by an average of 3.2 percent per year. Inflation adjustments were based on the most current Florida Hospital Input Price Index.

Net revenue per adjusted patient day (NRAPD) of \$1,859 in year one and \$1,927 in year two is between the control group median and highest values of \$1,723 and \$2,295 in year one and \$1,775 and \$2,365 in year two. The facility is expected to consume health care resources in proportion to the services provided. (See Comparative Table).

In order to further evaluate the reasonableness of the revenue projections, staff compared the net revenues per day of the new facility to those of Charlotte Regional Medical Center. The 2001 actual NRAPD for Charlotte Regional Medical Center was \$1,553.91, which was then adjusted for inflation to 2007. The inflation adjusted NRAPD for Charlotte Regional is \$1,851.

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Projected cost per adjusted patient day of \$1,824 in year one and \$1,800 in year two is between the control group median and highest values of \$1,582 and \$2,283 in year one and \$1,630 and \$2,352 in year two. (See Comparative Table). Compared to the control group, these costs are in proportion to the services provided.

In order to further evaluate the reasonableness of the projected expenses, staff compared the expenses of the new facility to those of Charlotte Regional Medical Center. The 2001 actual CAPD for Charlotte Regional was \$1,398.56, which was then adjusted for inflation to 2007. The inflation adjusted CAPD for the Charlotte main campus is \$1,666.

The projected expenses of the new facility exceeded those of the main campus when adjusted for inflation. Operating expenses for the new hospital seem high and only marginally cost-efficient.

The year two operating profit for the new hospital of \$3.7 million computes to an operating margin per adjusted patient day of \$127 which falls between the peer group median and highest values of \$77 and \$383. The operating margin ratio computes to 6.6 percent. In 2001, Charlotte Regional 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.

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CON # 9616					
Punta Gorda 2000 DATA Peer Group 6	2007	YEAR 2	<u>INFLATION ADJ. VALUES</u>		
	ACTIVITY	ACTIVITY	Highest	Median	Lowest
		PER DAY			
ROUTINE SERVICES	126,998,610	4,399	940	646	380
INPATIENT AMBULATORY	0	0	107	52	19
INPATIENT ANCILLARY SERVICES	0	0	4,794	3,162	1,892
OUTPATIENT SERVICES	41,562,994	1,440	1,978	1,358	992
OTHER OPERATING REVENUE	411,766	14	234	13	1
TOTAL REVENUE	168,973,370	5,853	6,853	5,538	3,394
DEDUCTIONS FROM REVENUE	113,344,456	3,926	*	*	*
NET REVENUES	55,628,914	1,927	2,365	1,775	1,517
EXPENSES					
ROUTINE	10,005,396	347	350	259	209
ANCILLARY	12,284,427	425	1,002	630	515
AMBULATORY	2,220,118				
OVERHEAD	24,243,351	840	976	688	456
OTHER	3,220,503	112			
TOTAL EXPENSES	51,973,795	1,800	2,352	1,630	1,353
OPERATING INCOME	3,655,119	127	383	77	-101
		6.6%			
PATIENT DAYS	21,699		NOT INFLATION ADJUSTED		
ADJUSTED PATIENT DAYS	28,871				
TOTAL BED DAYS AVAILABLE	27,375				
ADJ. FACTOR	0.7516				
TOTAL NUMBER OF BEDS	75				
PERCENT OCCUPANCY	79.3%		82.5%	60.6%	34.0%
<u>PAYER TYPE</u>	<u>PATIENT</u>	<u>% TOTAL</u>			
	<u>DAYS</u>				
MEDICARE	16,529	76.2%	75.2%	58.4%	35.3%
COMMERCIAL	1,444	0.0%			
MEDICAID	628	2.9%	15.1%	4.1%	1.3%
PRIVATE	357	1.6%			
HMO/PPO	2,741	12.6%	49.2%	30.6%	5.9%
OTHER	0	0.0%			
TOTAL	21,699	100.0%			

The reasons given for establishing the new facility are to begin replacement of the existing hospital and to relieve crowding problems in the interim. When compared to the group the new facility is financially feasible. Net revenues and costs appear a little high when compared to the existing hospital but not to the extent to preclude financial feasibility.

Although the financial analyst concludes financial feasibility of the project as presented, the architectural review of the project indicates that the project will duplicate current services and functions, is costly to construct and does not appear to be cost efficient (Reference Item 4-f).

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 12.6 percent of its patient days. This is below the control group median of 30.6 percent and is above the hospital's own 2001 managed care level of 7.5 percent of patient days. Given the statement that the new facility is expected to serve the same market area, the projections appear to present an optimistic level of expected managed care activity. It is felt that these projections, if met, will have relatively minor positive impact on competition to promote quality 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.

Charlotte Regional Medical Center Hospital proposes to relocate 75 of its 156 acute care beds to a new "partial replacement" facility on a site approximately two to five miles from the existing hospital. A subsequent CON application to enlarge this new building and to move the remaining 81 acute care beds to the resulting replacement facility will not be submitted to AHCA until the new facility has been licensed and operational for five years. This results in some duplication of services and spaces for several years.

The application proposes to split the patient beds capacity into two almost equal portions. Since there are quite a few services and functions that a building must have to be classified as a hospital, the degree of duplication of these services and functions for a period of at least five years does not appear to be cost efficient. In fact, the cost per square foot as tabulated below at \$231, is quite high for new construction.

The R.S. Means Building Construction Cost Data book and their web site indicate that the Total Project Costs of this project are higher than the "High Quartile" determined from their web site. The Means on-line resource is somewhat limited in that hospitals of the size contemplated here and in a similar part of the State cannot be accurately determined from the extensive data that Means has at its disposal. The closest data is for the Lakeland area. The High Quartile cost per square foot in Polk

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County of \$164.36 is considerably below the \$362.54 projected for the project in Charlotte County.

The current CON addresses to some extent what will become of the space that will be made available in the existing building when all the beds are removed. The applicant needs to be aware that should CON #9616 be approved and the new building submitted to the AHCA Office of Plans and Construction, the disposition of the vacated spaces in the existing hospital may need to be addressed and reviewed at that time.

The new site has not been disclosed by the applicant. Because of this, it cannot be determined if the actual location will meet the disaster preparedness requirements of Chapter 59A-3 of the Florida Administrative Code or the Florida Building Code, Section 419.4.56 regarding the flood plain elevation and the Category 3 surge inundation. It is imperative that the site and design of the new facility meet these code requirements.

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 appear to meet codes. Some 5' turning space circles for disabled patients are indicated on the large scale plans showing patient toilet rooms. It appears that rooms with accessible toilet/showers are identical to those where the turning circle is not shown, but for some reason, all are not designated as being accessible for patients with disabilities. This is acceptable as long as the facility meets the required percentages of accessible spaces.

In addition to the patient toilet rooms, 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. Most of these toilet rooms appear to be accessible, but there is no circle shown whereas other toilet rooms have the circle. Since some of the toilet rooms have the turning circle indicated and others do not, the implication is that the ones without the circle are not required to be and are not designated as 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 if and when the project progresses and is submitted to the AHCA Office of Plans and Construction.

The front of the new building 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 is 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 project designers may have some experience that this adjacency is workable, but this area might benefit from further study. This design, or a variant on it has been submitted to AHCA previously, and it might be assumed that this prototypical traffic loop has been built and has proven to be workable.

There is a reasonable correct list of applicable codes on the drawings. The information from Schedule 10 indicates that sufficient time has been allowed for construction. The projected cost for the construction, appears to be reasonable for this type of space and the extent of the construction required.

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 2001, the applicant complied with these conditions.

Schedule 7A indicates that traditional Medicaid will account for 2.89 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 #9616) proposes to construct a new 75-bed hospital in District 8, Subdistrict 1, through the delicensure and transfer of 75 beds from the existing 156 acute care bed facility. This project will not increase the total number of acute care beds in the subdistrict. The proposed facility will be sized to permit relocation of the entire facility in the future.

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.

The project should enhance the delivery of services in the subdistrict. However, the applicant did not sufficiently document the efficiencies and cost savings as a result of constructing another hospital with duplicative services. It is clear that the proposed location will better serve the same patient population and assuming it is above the flood plain, will address some of the short comings and failings of the hospital's existing location. It is also clear that there are limitations at the present site including being land-locked with no room for expanding parking lots and other areas for a growing elderly population. Although not demonstrating cost savings between renovating at the existing site and building a replacement hospital, the applicant has clearly demonstrated reasons for replacing the hospital. However, the applicant has not demonstrated that the overall proposal is cost-effective or offers any efficiencies. Rather, it appears to duplicate services and offer some noteworthy inefficiencies such emergency transport from its new emergency room to the old hospital, especially for cardiac patients. The proposal will not increase access to the medically needy population, as the applicant expects to serve the same patient population and has not agreed to condition the CON upon serving any percentage of this population. Additionally, the architectural review of the project reveals that the duplication of services and functions does not appear to be cost-efficient.

Quality of Care:

The applicant has demonstrated that it is a quality of care provider and that improvement in access, particularly emergency access, is an indicator that the quality of care in the subdistrict could be improved with this proposal. However, this is only partially true with this proposal as the entire facility will not be replaced. Under this proposal, the applicant will operate two emergency rooms as well as duplicate other hospital services and functions. Although transporting emergency cardiac patients from the new hospital to the old hospital is not a quality of care issue, it is less than optimal and, apart from duplicating services and staff, limits improvement to the quality of care currently being provided in the subdistrict.

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 2.89 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. This project will not improve access to the medically indigent.

Financial Feasibility:

The financial review of the applicant indicates a strong short term and long term financial position. Capital requirements for all projects is available, as the parent is funding these and the parent is a large and financially strong entity.

When compared to the control group, the new facility is financially feasible. Net revenues and costs appear high when compared to the existing hospital but not to the extent to preclude financial feasibility.

The applicant's projected managed care is below the control group median but above the hospital's own managed care level. The financial review determined that the project will have relatively minor positive impact on competition to promote quality and cost-effectiveness.

Architectural Analysis:

The site has not been disclosed by the applicant and therefore, 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 imperative that the site and design of the new facility meet these code requirements.

The architectural review concludes that the proposed project will create a certain degree of duplication of services and functions for a minimum of five years and does appear to be cost-efficient.

The applicant addresses to some extent the disposition of the space to be vacated in the existing facility.

Patient rooms appear to meet codes. However, there is some confusion regarding the designation of handicapped toilet rooms for patients as well as the public and staff toilets. The facility must meet the required percentages of accessible spaces.

There is also some confusion regarding the "traffic loop" in the front of the proposed building. It is unclear if this is both a drop off and pick up point for patients. The concern regards potential congestion problems.

The architectural review concludes that sufficient time has been allowed for construction and that the projected cost for construction appears to be reasonable.

G. RECOMMENDATION

Deny CON #9616.

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