

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Osceola Regional Hospital, Inc./CON #9763

d/b/a Osceola Regional Medical Center

P.O. Box 422589

Kissimmee, Florida 34742-2589

Authorized Representative: Randy Gross
(407) 518-3606

2. Service District/County

District 7 (Osceola County)

B. PUBLIC HEARING

No public hearing was requested or held regarding the proposed project. The applicant submitted three letters of support. The letters of support were submitted by Maria Grulich, Director of Osceola County Economic Development; Raymond Plummer, M.P.H., Administrator of Osceola County Health Department; and Silvia C. Zapico, ED.D., Moderator of the Board of Trustees for the Osceola Regional Medical Center. The letters indicate that due to the area's population growth and increasing number of deliveries, additional beds were needed to avoid out-migration to hospitals in other counties for NICU services.

C. PROJECT SUMMARY

Osceola Regional Hospital, Inc. (CON #9763) operates Osceola Regional Medical Center (Osceola Regional), a 171-bed facility in Kissimmee, Florida consisting of 165 acute care and six Level II NICU beds. The applicant also has CON approval to for 40 acute care beds. The applicant proposes to add four Level II NICU beds with this project.

According to the applicant's *Certificate of Need Predicated on Conditions* page, since Osceola Regional has the sole contract with the Osceola County Health Department to provide obstetrical services for low-income and indigent women, Medicaid is the largest payer of neonatal intensive care for the hospital. Given its level of involvement with the County Health Unit, the applicant contends that conditions are not warranted.

The total project cost is estimated at \$287,576. Renovation costs are projected at \$5,000 and the project will involve 250 gross square feet (GSF) of renovated space.

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, Jennifer Benghuzzi, analyzed the application in its entirety with consultation from the Financial Analyst, John Williamson, who evaluated the financial data, and the Architect, Joel Hill, who evaluated the architectural and the schematic drawings.

E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA

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

1. Fixed Need Pool

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

The fixed need bed pool published in Volume 30, Number 4 of the Florida Administrative Weekly dated January 23, 2004, shows a need for zero Level II NICU beds for District 7.

As of January 23, 2004, District 7 had 93 licensed Level II NICU beds and 34 approved Level II NICU beds (CON #9614). The Level II NICU beds in District 7 experienced an occupancy rate of 91.81 percent during the period July 2002 through June 2003. The proposed project is not submitted in response to the fixed need pool. The applicant is applying outside of the fixed need pool and indicates it is applying under special (not normal) circumstances.

b. Regardless of whether bed need is shown under the need formula, the establishment of new Level II neonatal intensive care unit beds within a district shall not normally be approved unless the average occupancy rate for Level II beds in the district equals or exceeds 80 percent for the most recent 12-month period ending six months prior to the beginning date of the quarter of the publication of the fixed need pool. Ch. 59C-1.042(3)(d), Florida Administrative Code.

As stated above, the 93 Level II NICU beds in District 7 experienced an occupancy rate of 91.81 percent for the most recent reporting period. The following table reflects the utilization data for Level II NICU beds in District 7 for the most recent reporting period, July 2002 through June 2003:

District 7 Level II NICU Occupancy July 2002- June 2003

Hospital	Level II Beds	Level II Patient Days	Occupancy
Holmes Regional Medical Center	10	826	22.63%
Florida Hospital-Orlando	28	7,448	72.88%
Arnold Palmer Hospital	34	18,844	151.85%
Winter Park Memorial Hospital	5	1,519	83.23%
Osceola Regional Medical Center	6	1,383	63.15%
Wuesthoff Memorial Hospital	10	1,145	31.37%
Total	93	26,865	91.81%

Source: Florida Hospital Bed and Service Utilization by District, January 2004 Batching Cycle.

The 34 CON approved Level II NICU beds for the district are approved to be located at Arnold Palmer Hospital, with occupancy in this last reporting period of 151.85 percent.

- c. Special Circumstances for the Approval of Additional Neonatal Intensive Care Unit Beds at Existing Providers, Ch. 59C-1.042(3)(g), Florida Administrative Code - Need for additional Level II neonatal intensive care beds at hospitals with Level II neonatal intensive care services seeking additional Level II beds is demonstrated in the absence of need shown under the formula specified in paragraph (3)(c) of this rule if the occupancy rate for their Level II beds exceeded an average of 90 percent as computed by the agency for the same time period specified in subparagraph (3)(e)(2).**

Although the published need in the district is for zero Level II NICU beds, the applicant is requesting four beds. The occupancy rate for Osceola Regional's Level II NICU beds for the 12 months ending June 30, 2003, was 63.15 percent. The applicant does not meet the "special circumstances" defined in Rule.

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

The occupancy for the applicant's 165 acute care beds was 72.47 percent from July 2002 through June 2003. The applicant was approved for CON #9545 to add 40 acute care beds to its existing 165 acute care beds.

As the applicant has unimplemented acute care beds it received due to anticipated high utilization, it is not proposing to convert acute beds with this proposal.

Other Special Circumstances:

Given the absence of a published need for Level II NICU beds in District 7, the applicant contends that “not normal” circumstances exist. The proposed addition of four Level II NICU beds at Osceola Regional would increase the number of currently licensed and approved Level II NICU beds in District 7. The applicant states that Osceola Regional is the sole provider of neonatal intensive care services in Osceola County and its existing six-bed Level II NICU experiences high fluctuations in occupancy rates, often at or above 100 percent. According to the applicant, Osceola Regional’s NICU exceeded 100 percent occupancy a total of 78 days during CY 2003, and 18 days during January 2004 through February 2004. The applicant indicates that Osceola Regional’s NICU is often full, creating a need to divert patients to other counties within the district. The applicant’s six Level II NICU beds highest quarterly period of utilization during the July 2002 to June 2003 reporting period was 73.19 percent, which occurred in the 2nd quarter of CY 2002. In looking at more recent data this quarter was still the highest quarter as utilization dropped from 73.19 percent to 54.44 percent in the 1st quarter of 2003, and 63.37 percent in the 2nd quarter of 2003. Therefore, Level II NICU beds have been generally available at the facility and occupancy appears to be dropping.

The applicant reports that District 7’s Level II NICU utilization has grown in the last three years. The following table shows District 7’s Level II NICU patient days by hospital and county for the last four years.

**District 7 Level II NICU Patient Days By Hospital and County
CY 2000 through CY 2003**

Hospital	CY 2000	CY 2001	CY 2002	CY 2003	Growth
Holmes Regional Medical Center	525	810	880	667	27.05%
Wuesthoff Memorial Hospital	902	1,076	1,388	1,623	79.93%
Brevard County Total	1,427	1,886	2,268	2,290	60.48%
Brevard Annual Growth		32.17%	20.25%	.97%	
Florida Hospital-Orlando	7,278	7,103	6,771	8,222	12.97%
Florida Hospital-Winter Park	544	605	1,604	1,495	174.82%
ORHS-Arnold Palmer	15,972	16,319	16,634	19,606	22.75%
Orange County Total	23,794	24,027	25,009	29,323	23.24%
Orange Annual Growth		0.98%	4.09%	17.25%	
Osceola Regional Medical Center	553	950	1,204	1,423	157.32%
Osceola County	553	950	1,204	1,423	157.32%
Osceola Annual Growth		71.79%	26.74%	18.19%	
District 7 Total	25,774	26,863	28,481	33,036	28.18%
District 7 Annual Growth		4.23%	6.02%	16.0%	

Source: Florida Hospital Bed and Service Utilization for periods shown. Health Council of East Central Florida for the period of 07/01/2003-12/31/2003.

The table above demonstrates that utilization of Level II NICU providers within District 7 has grown, with an average growth rate of 28.18 percent. Over the last three years, Osceola Regional has experienced 157.32 percent average growth rate in its Level II NICU utilization, as well as a 60.48 percent average growth rate in Brevard County and an average growth rate of 23.24 percent for Orange County. The applicant maintains that given the population growth and increase in births for District 7, this increase in Level II NICU services is expected to grow. However, since this NICU was established October 7, 1999 and has not been operational for very long, it is unreasonable for the applicant to expect its NICU to have the continued growth experienced during the initial onset of its NICU services.

With respect to birth trends, the applicant supplied the following table to show the total resident and recorded live births by county for District 7 between 1999 and 2002.

**Resident and Recorded Live Births by County for District 7, 1999-2002
And the most Recent Three-Year Average Resident and Recorded Birth Rates**

County	Females 15-44			Residents Births					Birth Rate
	2000	2001	2002	1999	2000	2001	2002	Growth	
Brevard	89,126	90,089	90,876	4,741	5,014	4,789	4,807	1.39%	54.09
Orange	216,461	221,981	226,042	13,176	14,070	14,242	14,144	7.35%	63.89
Osceola	38,721	39,589	40,325	2,355	2,615	2,704	2,895	22.93%	69.24
Seminole	82,442	84,427	85,779	4,445	4,583	4,510	4,526	1.82%	53.91
Dist. 7	426,750	436,086	443,022	24,717	26,282	26,245	26,372	6.70%	60.42
County	Recorded Births					Birth Rate			
	1999	2000	2001	2002	Growth				
Brevard	4,550	4,868	4,645	4,677	2.79%	52.54			
Orange	16,018	16,912	17,008	17,176	7.23%	76.90			
Osceola	2,524	2,852	3,033	3,237	28.25%	76.89			
Seminole	3,664	3,788	3,816	3,678	0.38%	44.66			
District 7	26,756	28,420	28,502	28,768	7.52%	65.62			

Source: CON #9763, Pg. 6. Data from Vital Statistics Annual Report, 1999-2002; AHCA's Population Estimates, June 2003.

The applicant notes that the number of births over the past three years indicates a strong growth rate for Osceola County, with resident births increasing by 23 percent and recorded births within the county growing by 28 percent. With 2,895 live resident births in Osceola County for 2002, the majority of the births (76 percent) are occurring at Osceola Regional Medical Center according to the applicant. Furthermore, the applicant states that Osceola County also has the highest birth rate for the female population aged 15 to 44 when compared to other counties in District 7. The three-year resident birth rate for Osceola was 69.24 births per 1000 females age 15-44 for the period between 2000 and 2002, while the district's average was 60.42. It is the applicant's contention that the high birth rate and continued growth in the number of births indicate a strong demand for obstetrical and neonatal services. It is noted that neonatal services are defined in statute as tertiary care services and the service area is the district, not the county.

The applicant maintains that the population of Osceola County is growing at a faster rate than other counties in District 7 and furthermore, the female population aged 15 to 44 of Osceola County has the highest fertility rate of all the counties in District 7. The applicant states that the population in District 7 and Osceola County has experienced a high growth rate over the past five years, which is expected to continue over the next five years. The applicant provided Table 1-4 on page 8 of its application that was based on data derived from AHCA's *Population Estimates* published in June 2003. The applicant's table showed that the previous five years growth rate was over 22 percent for the total population in Osceola and almost 14 percent for the female population aged 15 to 44. The table further showed that Osceola County's population would grow by approximately 15 percent over the next five years, exceeding the growth rate of other counties within the district, with the female population aged 15 to 44 growing by at least 5.5 percent. However, updated data from AHCA's *Population Estimates* published in March 2004 clearly indicates the population growth and growth of females of childbearing age is slowing down in Osceola County and District 7, as shown in the table below:

**Total Population and Female population aged 15 to 44 for District 7 by County
January 1999, January 2004, and January 2009**

County	Jan. 1999 Population		Jan. 2004 Population		Population Growth	
	Females 15-44	Total	Females 15-44	Total	Females 15-44	Total
Brevard	87,675	465,382	92,499	512,902	5.50%	10.21%
Orange	203,874	847,088	229,150	998,286	12.40%	17.84%
Osceola	35,740	160,157	45,102	214,691	26.19%	34.10%
Seminole	79,964	352,804	86,391	400,332	8.04%	13.47%
Dist. 7	407,253	1,825,431	453,142	2,216,211	11.28%	21.40%
County	Jan. 2004 Population		Jan. 2009 Population		Population Growth	
	Females 15-44	Total	Females 15-44	Total	Females 15-44	Total
Brevard	92,499	512,902	93,301	539,825	.86%	5.25%
Orange	229,150	998,286	242,633	1,106,072	5.88%	10.80%
Osceola	45,102	214,691	45,571	236,535	1.04%	10.17%
Seminole	86,391	400,332	91,128	440,200	5.48%	9.96%
District 7	453,142	2,216,211	472,633	2,322,632	4.30%	4.80%

Source: Data from AHCA's Population Estimates, March 2004.

As the table above shows, Osceola County's previous five-year growth was over 34 percent for the total population in Osceola and over 26 percent for the female population aged 15 to 44. The table further shows that Osceola County's total population is projected to increase by 10.17 percent and females aged 15-44 by only 1.04 percent over the next five years. District 7's total population is projected to increase by 4.80 percent and females aged 15-44 by only 4.30 percent. It is apparent that the population growth and growth rate of females of childbearing age in District 7 and Osceola County will slow down over the next five years.

It is the applicant's contention that this project will improve access to neonatal intensive care services to Osceola County residents. The applicant states that with its existing six-bed Level II NICU operating at 80 percent occupancy 50 percent of the time, and reaching 100 percent occupancy 30 percent of the time, Level II NICU beds are sometimes not available at its facility. When this occurs, neonates must be transferred out of the county. As the only facility providing Level II NICU services in Osceola County, as well as the facility contracted by the Osceola County Public Health Unit to provide obstetrical services, the applicant feels that a sufficient bed supply must be available to meet the demands of local residents. The applicant claims that higher paying patients with health care coverage are diverted to Orange County more often than Medicaid patients. This in turn impacts Osceola Regional to provide a disproportionate share of Medicaid than other NICU providers within the District, adding to the cost of care. Refer to E.4.i. for discussion of the applicant's provision health services to Medicaid patients and the medically indigent. However, as noted above, NICU services are defined in statute as tertiary care services and the service area is the district.

Section 408.036 (17), Florida Statutes contains the following definition:

***“Tertiary health service”** means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, specialty burn units, **neonatal intensive care units**, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service...”*

The applicant states that its number of live births has grown 20 percent over the last three years, but based upon patient origin data for MDC 15, only 52.3 percent of the patient days associated with Osceola resident births, received care at one of the two obstetrical hospitals within the county. Over 46 percent of these residents traveled to Orange County to give birth according to the applicant. The applicant contends that the table demonstrates that 74.4 percent of the NICU Level II and III patient days generated from Osceola County residents are served in Orange County, compared to 41 percent for Brevard County residents, where Level II beds are more available. However, the applicant is licensed to provide Level II services only and many of the facilities in Orange County are licensed to provide both Level II and Level III services. It is unclear what percentage of the 74.4 percent of Osceola County’s NICU resident patient days served in Orange County were for Level II services.

Facility specific need projections calculated by the applicant show that average annual occupancy is expected to reach 120.24 percent in calendar year 2005 if no beds are added. Given that the annual occupancy for the 12-month period ending June 2003 was 63.15 percent, the applicant expects occupancy to almost double in one and a half years. Even if none of the applicant’s level II neonates are transferred, and based on what does not appear to be a reasonable historical rate of increase, this projection is not reasonable.

By increasing the number of Level II NICU beds at its facility, the applicant contends that availability and accessibility of these services to Osceola County residents would be improved. However, as noted earlier, NICU beds provide a tertiary service, which means access should be available within the district. With Arnold Palmer approved to add 34 Level II NICU beds, there is no evidence of potential access problems and the applicant did not demonstrate that residents were unable to access these services from other Level II area providers.

2. Local Health Plan Preferences

Is need for the project supported by the applicable district plan? ss. 408.035(1) and 408.037(1), Florida Statutes, and Ch. 59C-1.030(2)(c), Florida Administrative Code.

The District 7 July 2003 CON Allocation Factors Report provides the following generic preferences in the review of all CON applications:

- 1. Preference shall be given to applicants who demonstrate that they can alleviate a current or potential geographic access problem. Applicants must provide specific evidence of lack of access in a geographic area.**

The applicant contends that its proposed project will alleviate a current geographic access problem. As previously discussed in E. 1.d., Osceola Regional operates the only NICU in the county. The applicant claims that unlike Level III NICU care that is accessed regionally, Level II NICU care is primarily accessed locally, within about a 15-mile radius of the hospital. However, as also discussed above in E. 1.d., NICU beds are defined in statute as tertiary beds and the service area for both Level II and III, by definition, is the district, not the county. This is a generic preference, not specific to NICU services. The applicant has not demonstrated a geographic access problem. It has shown that patients are being appropriately transferred for this tertiary care service.

- 2. Preference shall be given to applicants who demonstrate that new or expanded bed capacity and/or a new or expanded service will not have a significant negative impact on similar facilities in the service area. Applicants are encouraged to include letters of support from similar facilities indicating that the project will not negatively impact their programs and services.**

As noted above, Arnold Palmer has CON approval to add 34 Level II NICU beds. Although that facility is experiencing high occupancy, the applicant acknowledged that it is transferring many of its Level II and Level III neonates to Orange County. Additionally, Florida Hospital Orlando, another large tertiary care center's occupancy shows that it has capacity in its Level II NICU. For the applicant to meet expected occupancy levels in the proposed beds, it must at least capture all Osceola County residents. However, as noted above, the applicant's projections were not reasonable and therefore, it is likely that it will either not reach expected occupancy levels or capture a broader market. So, while it claims

that the expansion of its NICU services will not have a significant impact on similar facilities in the service area, this was not demonstrated.

- 3. Preference shall be given to applicants who formally commit to a program of Medicaid and/or charity care, and specify the annual amount of Medicaid and/or charity care they provide in their CON application. Applicants are encouraged to document their involvement in local activities geared to increasing access to care for the medically indigent.**

The applicant states that it provides a significantly higher percentage of Medicaid patient days in relation to certain other neonatal intensive care providers in District 7. The applicant states that for the period of October 1, 2002 through September 30, 2003, it provided 57.1 percent of its NICU patient days to Medicaid recipients compared to the district average of 52.5 percent. Since Osceola Regional has the sole contract with the Osceola County Health Department to provide obstetrical services for low-income and indigent women, Medicaid is the largest payer of neonatal intensive care for the hospital. Given the level of involvement with the County Health Unit, the applicant contends that a formal commitment to Medicaid recipients and other low-income individuals already exists and will continue with the implementation of this project. Therefore, the applicant indicates on its *Certificate of Need Predicated on Conditions* page that it does not wish to accept any conditions upon approval of this project. The applicant states that Osceola Regional has not reported any charity care neonates for its existing Level II due to most patients of low-income families qualifying for Medicaid or other government programs. See Section E.4.i. for additional discussion.

- 4. Preference shall be given to applicants who propose to locate beds or services in an area that will improve access to Medicaid and medically indigent patients.**

As previously discussed in E.2. (3) above, the applicant is providing a proportionately higher percentage of Medicaid than the district average. Because Medicaid patients are already accessing this service at the hospital, the applicant believes access will be improved as more beds become available according to the applicant. However, there is no evidence that access to this population is denied and the applicant has not agreed to a formal commitment to this population. Additionally, Arnold Palmer, a high provider of care to Medicaid recipients, received certificate of need approval (CON #9614) to add 34 Level II NICU beds at its facility. The applicant has not shown that it meets this preference.

- 5. Preference shall be given to applicants who demonstrate their commitment to meeting the needs of culturally diverse populations. Applicants should provide evidence of the availability of translation and interpretation services for diverse populations. Applicants should document in the application any cultural competency training and continuing education to be received by employees who will staff the project.**

To ensure access to hospital services, information, and educational material, brochures are printed in both English and Spanish. Translation and interpretation services are provided under contract with Language Line Services, Inc. and American Sign Services, Inc. The applicant provided copies of its translation service agreements and an overview of the services provided in Exhibit 2-3 of the application. The applicant did not document any cultural competency training and continuing education to be received by employees who will staff the project.

- 6. Preference shall be given to applicants who commit in their application to provide beds and/or services for HIV/AIDS infected persons. Applicants should document in the application the estimated number and percent of HIV/AIDS patients to obtain services. Applicants are encouraged to discuss their involvement in local activities focused on increasing access to care for persons living with HIV/AIDS.**

The applicant provided the following table to show Osceola Regional's historical utilization for patients treated under MDC 25, human immunodeficiency virus infection, for the past three calendar years.

**Osceola Regional Medical Center
MDC 25 Discharges and Patient Days**

Annual Period	Patients	Days
October 2000-September 2001	28	192
October 2001-September 2002	15	141
October 2002-September 2003	36	350

Source: CON #9763, Pg. 2-8. Data from AHCA's Hospital Patient Discharge Data Files for the years shown.

As demonstrated by the number of cases reported under MDC 25, the applicant does have a history of providing care to patients with HIV/AIDS and states that it will continue to do so with implementation of this project. The applicant states that it is impossible to predict any neonates that may be infected with HIV/AIDS at birth since all services provided in the NICU are normally coded under MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period.

7. Preference shall be given to applicants who commit to providing prevention and education activities to the general public and to their patients. Applicants should include a description of prevention/education programs and services that will be available to patients and the public.

The applicant maintains its commitment to providing preventative and educational activities for patients and the community by offering classes and seminars on a variety of health and wellness topics throughout the year, such as:

- Take Control of Diabetes
- Quit Smoking Now
- Save a Life-CPR Training
- Better Breathers
- Add Years to Your Life by Losing Weight
- Prepared Childbirth Classes
- Breastfeeding Classes

Other specialty programs such as “Ask a Nurse”, reach out to the public to enhance early detection or prevention of diseases. In addition, the applicant provides a website to apprise the community about up-to-date information. The applicant collaborates with the Osceola County Health Department, the Department of Children and Families, the Children’s Home Society, and others to provide classes and educational information on parenting and caring for children with special needs.

8. Preference shall be given to applicants who have demonstrated quality of care standards by achieving exemplary survey/accreditation results. This preference only applies to existing facilities.

The applicant is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and has a long history of providing quality of care. Please refer to E.4.b, below regarding quality of care discussion.

The District 7 July 2003 CON Allocation Factors Report provides the following preferences in the review of applications pertaining to neonatal intensive care services:

- 1. Preference shall be given to applicants who propose to close or convert existing licensed unused beds.**

The applicant is not proposing to close or convert any existing licensed unused beds.

- 2. Preference shall be given to applicants who commit to conduct Healthy Start screens on all infants born in the facility.**

The applicant indicates that Osceola Regional conducts Healthy Start screens on all infants born in its facility.

- 3. Agency Rule Criteria**

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

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

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

Osceola Regional hospital was not listed as a disproportionate share provider for State Fiscal Year 2003-2004 as of March 31, 2004, nor is it a Regional Perinatal Intensive Care Center Program. As stated above, the applicant is not proposing any conditions for

the proposed project. Osceola Regional has the sole contract with the Osceola County Health Department to provide obstetrical services for low-income and indigent women. The applicant is also contracted by the county to provide inpatient and outpatient care for inmates detained in the Osceola County Detention Facility.

The applicant projects its first two years of Level II NICU payor mix to be:

Payer	Percentage of Allocation
Medicaid	54.65%
HMO/PPO	43.07%
Insurance	0.00%
Self-Pay/Other*	2.28%*
TOTAL	100.0%

Source: CON #9673 application.

*The applicant notes that since most low income or charity care families qualify for Medicaid for NICU services, charity is included in the Self Pay/Other category.

Please refer to E.4.i. below for further discussion.

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

- (1) Hospitals may be approved for Level II neonatal intensive care services without providing Level III services. In a comparative review, preference for the approval of Level II beds shall be given to hospitals, which have both Level II neonatal intensive care unit beds and Level III neonatal intensive care unit beds.**

The applicant is currently licensed to operate a six-bed Level II NICU and is proposing to add four Level II NICU beds in order to establish a 10-bed Level II NICU.

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

The applicant states that the hospital's staff ensures developmental follow-up on patients discharged from its program. The applicant insists that no neonate is discharged to home care without an individualized discharge plan and appropriate referrals.

Infants requiring specialized home care will require extensive parent education to be determined by medical, respiratory, and nursing staff. The architectural plans provided with this application show that a parent sleep room is available for the family to practice supervised home care under supervision before discharging the infant (refer to E.4.h. below regarding architectural discussion). The length of time for “rooming-in” is based upon an individualized family needs. If necessary, a home care agent is involved in the discharge process.

A case management assessment is conducted on each NICU admission to determine any community services needed at discharge. If necessary, an appropriate discharge plan and follow-up appointment are arranged. Assistance and monitoring may be provided by a social worker assessment, the County Health Department, Medicaid (CMS), Health Families, or WIC. Additional appointments are made with physicians and therapist specializing in the areas targeted for developmental follow-up care before discharge.

A common referral source for graduates of Osceola Regional’s NICU requiring developmental follow-up care is the Children’s Home Society (CHS). Through the CHS Early Intervention Program (EIP), the parents of developmentally challenged infants or toddlers are provided the necessary information and education to make appropriate decisions. The CHS Family Service Coordinators provide an initial consultation to determine eligibility and needs, researching services, providers, agencies, and funding sources.

CHS also provides a free program, OPTIONS (Osceola Parent Team Intent On Nurturing Successfully), which offers emotional support, prenatal and child development information, peer group meetings, and volunteer assistance.

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

Osceola Regional is already an established Level II NICU provider. The applicant is requesting to add four beds to its existing six-bed Level II NICU, creating a 10-bed Level II NICU, which meets the minimum requirement specified in this rule preference.

- d. **Ch. 59C-1.042(6) - Minimum Birth Volume Requirement. Hospitals applying for Level II neonatal intensive care services shall not normally be approved unless the hospital has a minimum service volume of 1,000 live births for the most recent 12-month period ending six months prior to the beginning date of the quarter of the publication of the fixed bed need pool. Specialty children's hospitals are exempt from these requirements.**

The hospital experienced over 2,000 births for the reporting period of July 2000-June 2003 and therefore, exceeded the minimum service volume specified in this rule preference.

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

Currently Level II and Level III NICU services are available and accessible within the two hours ground time to 90 percent of the residents of District 7.

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

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

The applicant states that Osceola Regional's medical staff has the credentials and experience necessary to maintain a high quality neonatal intensive care program. The Chief of Staff is Muhammad K. Shaukat, M.D. Dr. Shaukat has been with Osceola Regional since 1992 and maintains affiliation with Florida Hospital Medical Center and Orlando Regional HealthCare System. He is board-certified by the American Board of Internal Medicine. The medical director of the NICU at Osceola Regional is Angelina C. Pera, M.D. Dr. Pera is board-certified by the American Board of Pediatrics and the Neonatal-Perinatal Medicine Subspecialty Board. She has been with Osceola Regional since 1997 and maintains an affiliation with Florida Hospital Medical Center and Orlando Regional HealthCare System.

The applicant provided the names of nine physicians who are on Osceola Regional's neonatal roster. All but one of these physicians is board certified in neonatology, with staff privileges at Osceola Regional. The exception is Dr. Shannon Brown, M.D., who is board-certified in pediatrics and board-eligible in neonatology. The applicant did not comment on whether these physicians had unlimited privileges or provide 24-hour coverage, as specified in preference. Refer to Exhibit 3-2 of the application for physician profiles and specialty roster.

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

According to the applicant, Ruth A. Reichard, RN, MPM, CNA, is the director of maternal child services. Ms. Reichard has 28 years of nursing experience in gynecology/obstetrics/pediatrics, and is responsible for all maternal, pediatric, and NICU nursing staff. She is responsible for developing clinical policies and protocols, and providing education and leadership for the department. The applicant also states that current and proposed nurse staffing exceeds the requirement specified in Rule of having at least one-half of its nursing personnel as registered nurses. Schedule 6 of the application indicates that the proposed 10-bed Level II NICU nursing staff will consist of 1.00 Lead RN FTE and 10.00 RN FTEs by year 2 of the project.

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

The applicant states that the nurses in Osceola Regional NICU are trained in the foregoing requirements.

- (4) Respiratory Therapy Technician Staffing: At least one certified respiratory care practitioner therapist with expertise in the care of neonates shall be available in the hospitals with Level II or Level III neonatal intensive care services at all times. There shall be at least one respiratory therapist technician for every four infants receiving assisted ventilation.**

The applicant states that the respiratory care department is operated and staffed 24 hours, seven days a week. Lisa A. Livingston, CRT, RRT is the director of respiratory care and rehabilitation, and has been employed by Osceola Regional since 1988. She is a certified respiratory therapist, a registered respiratory therapist of the National Board For Respiratory Care; and is a member of the American Association For Respiratory Care, Florida Society For Respiratory Therapist, and the American Heart Association. The applicant states that its NICU meets the staffing requirements as delineated in the rule. Ms. Livingston's resume appears in Exhibit 3-3 of the application along with the resumes of the 13 other staffed respiratory therapists that provide services to the NICU. According to the applicant, each respiratory therapist is certified and supplemented by continuing education. The applicant contends that current and proposed staffing for this project assures that there will be at least one respiratory therapist technician for every four infants receiving assisted ventilation. Schedule 6 shows a total 6.0 FTE respiratory therapists in the proposed 10-bed Level II NICU.

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

The applicant states that its facility has blood gas determinations available on a 24-hour basis.

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

The applicant provides on site x-ray, obstetric ultrasound, and clinical laboratory services with the ability to perform microstudies 24 hours a day, seven days a week. In addition, anesthesia is available within 30 minutes, 24 hours a day.

- (7) **Nutritional Services: Each hospital with Level II or Level III neonatal intensive care services shall have a dietician or nutritionist to provide information on patient dietary needs while in the hospital and to provide the patient's family instruction or counseling regarding the appropriate nutritional and dietary needs of the patient after discharge.**

The clinical nutritional manager for Osceola Regional is Jenny Vaughn, RD, LD/N. She is responsible for the overall management of clinical, patient service operations, and performance improvement activities of the department. This includes providing in-service training, establishing nutritional care policies and procedures, developing patient educational materials, and providing nutritional assessments and patient education. A copy of her resume is included in Exhibit 3-3 of the application. No FTE's are reflect in Schedule 6 for dietary services.

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

The applicant indicates that it employs clinical social workers who are members of an interdisciplinary team, responsible for assessing and intervening with families of acute and chronically ill newborns; crisis and bereavement counseling; drug counseling and education; networking with Department of Children and Families and community resources; and medically complex discharge planning.

The director of case management for Osceola Regional is Trudy L. Jackson, RN, MBA, CAN, LHRM. Under the title of Director of Quality and Risk, she is responsible for the management of hospital-wide Performance Improvement and Risk Management. The supervisor of case management is Cheryl Bearup, RN. She provides oversight to the hospital's clinical social workers, including those assigned to the NICU. Other social workers that assist with the NICU patients and families include Judith Mitchell and Marielle Asencio. The resumes for the above individuals appear in Exhibit 3-3 of the application.

Schedule 6 of the application indicates an additional 1.0 FTE for social workers.

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

The applicant indicates the nurse case manager or social worker refers patients identified as being at risk for developmental disabilities to the Children's Medical Service Department in Orange County. In addition, the infant will be referred to agencies related to the specific diagnosis. The case manager will make referrals and arrange for these programs to ease the transition into the home and facilitate the parents' ability to access these services.

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

According to the applicant, infants in the NICU are discharged or transferred from the unit only upon written orders of the attending neonatologist. The discharge plan requires that the nursing staff demonstrate to the family how to provide the required care and service in response to the neonate's needs at the time of discharge. In addition to the basic discharge demonstrations, aftercare services are reviewed that appear in the discharge plan. These aftercare services include clinical services as well as other social services with other agencies, such as Children's Medical Services or Developmental Services. Any appointments made for the neonate or family will be reviewed, with written instructions.

- i. Ch. 59C-1.042(9) - Level II Neonatal Intensive Care Unit Standards: The following standards shall apply to Level II neonatal intensive care services:**

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

The applicant states NICU is staffed at a nurse to patient ratio of at least 1:4 at all times. The applicant also states that 50 percent of

the nurses assigned to the NICU are RNs. Schedule 6 of the application indicates that the 10-bed Level II NICU will consist of 10.0 FTE RNs.

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

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

The applicant indicates that it currently meets or exceeds all of the requirements above and will continue to meet or exceed these requirements following implementation of the proposed project. Refer to the architectural review below in Section E.4.h.

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

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

The applicant indicates it currently has all of the required equipment above available. Refer to the architectural review below in E.4.h.

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

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

(2) Requirements for Emergency Transportation System. Emergency transportation systems, as defined in paragraph (11)(a), shall conform to Section 64E-2.006, Florida Administrative Code.

The applicant states that it provides emergency transportation for neonate intensive care services through an agreement with Orlando Regional HealthCare System. The emergency transportation system conforms to federal, state, and local rules and regulations according to the applicant.

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

See response to 3.j. above. A copy of the applicant's transfer policies and procedures is included in the application.

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

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

4. **Statutory Review Criteria**

- a. **Is need for the project evidenced by the availability, efficiency, quality of care, accessibility, and extent of utilization of existing health care facilities and health services in the applicant's service area? ss. 408.035(2)and 408.035(7), Florida Statutes.**

As noted above, District 7's Level II NICUs experienced an average annual occupancy rate for the appropriate reporting period of 91.81 percent and need for additional Level II NICU beds were not published by the Agency. The occupancy rate for Osceola Regional's Level II NICU beds for the 12 months ending June 30, 2003, was 63.15 percent. Refer to E. 1 above for the applicant's discussion of hospital-specific need for an addition four Level II beds, which found that need was not demonstrated.

Because it is the only NICU provider in Osceola County and is under contract with the Osceola County Health Department to provide obstetric services to Medicaid patients, the applicant maintains that sufficient capacity in the NICU must be available. Therefore, the applicant contends that increasing the capacity of its Level II NICU will improve access to Medicaid recipients within the county. The applicant provided letters of support from the Osceola County Economic Development Department and the Osceola County Health Department that echoed this same sentiment. Refer to E.4.i for discussion of applicant's provision of Medicaid. However, there is no evidence that access to Level II NICU services will be improved to this population if this application is approved. Orlando Regional Healthcare System, which operates several facilities in the district including Arnold Palmer Hospital, provided 20.1 percent of its patient care to Medicaid patients in 2002. In addition, there are 34 CON approved Level II NICU beds at Arnold Palmer Hospital.

The applicant is proposing to add four Level II NICU beds at Osceola Regional, which will add additional beds to the planning area. Given the growth in population and Level II NICU utilization over the past few years, which the applicant states is expected to continue, additional Level II NICU beds are needed. However, as discussed above in E.4.d., more recent utilization data shows that fewer, rather than more, Level II services are being provided by the facility.

According to the financial analysis, this project may foster positive competition to promote quality and cost-effectiveness.

Please refer to E.4.b, below regarding quality.

Need for the project is not evidenced by the availability, efficiency, quality of care, accessibility, and extent of utilization of existing health care facilities and health services in the applicant's service area.

b. Does the applicant have a history of providing quality of care? Has the applicant demonstrated the ability of providing quality care? ss. 408.035(3), Florida Statutes.

The applicant is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A copy of the JCAHO accreditation is included in the application. The application also includes a detailed outline of the applicant's Performance Improvement Plan 2003-2004. The applicant also utilizes patient and family care to provide guidelines for improving the patient's outcome.

Osceola Regional was the 2003 recipient in the "Best Run Hospital" (up to 250 beds) category the *14th Annual Medical Business Awards* and received a Certificate of Recognition as a 2002 finalist in the "*Business of the Year*" Award, presented by the Chamber of Commerce Kissimmee/Osceola County.

According to AHCA data, the applicant had four confirmed complaints during the last three years. All of the confirmed complaints concerned patient care.

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 health care services that are not reasonably or economically accessible in adjacent districts.

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

The applicant did not specifically address this review criterion. Nevertheless, it appears that Osceola Regional is not a designated statutory teaching hospital nor is the proposed project's primary purpose research or physician education. The applicant notes that the hospital is affiliated with TECO (Technical Education Center Osceola), Valencia Community College, Polk Community College, and University of Central Florida to promote the development and education of health professionals. However, the applicant did not provide a copy of its affiliation agreements with these schools.

- e. What resources, including health manpower, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? ss. 408.035(6), Florida Statutes.**

The audited financial statements of Osceola Regional Hospital, Inc. for the periods ending December 31, 2002 and 2001 were analyzed for the purpose of evaluating the applicant's ability to provide the capital and operational funding necessary to implement the project.

Osceola Regional Hospital, Inc.		
	12/31/2002	12/31/2001
Current Assets	\$ 20,369,287	\$ 17,996,206
Cash and Current Investment	\$ -	\$ 22,156
Board Designated Investments	\$ -	\$ -
Total Assets	\$ 71,015,824	\$ 68,032,231
Current Liabilities	\$ 9,360,299	\$ 9,064,296
Total Liabilities	\$ 54,632,906	\$ 54,949,693
Equity of Parent	\$ 16,382,918	\$ 13,082,538
Total Operating Revenues	\$ 130,731,689	\$ 107,726,518
Interest Expense	\$ 4,218,027	\$ 4,474,284
Income from Operations (Before Income Tax)	\$ 5,423,301	\$ 3,208,532
Net Income	\$ 3,300,380	\$ 1,726,283
Cash Flow from Operations	\$ 6,386,206	\$ 9,082,904
Working Capital	\$ 11,008,988	\$ 8,931,910
Current Ratio (CA/CL)	2.2	2.0
Cash Flow to Current Liabilities (CFO/CL)	0.7	1.0
Long-Term Debt to Equity (TL-CL/TA)	2.8	3.5
Times Interest Earned (NPO+Int/Int)	2.3	1.7
Equity to Total Assets (NA/TA)	23.1%	19.2%
Operating Margin (NPO/NOR)	4.1%	3.0%
Total Margin (NI/NOR)	2.5%	1.6%
Return on Assets (NI/TA)	4.6%	2.5%
Operating Cash Flow to Assets (CFO/TA)	9.0%	13.4%

Osceola Regional Hospital, Inc. is an indirect wholly owned subsidiary of HCA Inc. HCA Inc. is a holding company whose affiliates own and operate hospitals and related health care entities. HCA uses a centralized cash management system and does not carry significant cash balances on the books of its subsidiaries. Long-term debt consists of intercompany balances, which represent the net excess of funds transferred to or paid on behalf of the medical center over funds transferred to a cash management account of an HCA affiliate.

Short-term position:

The applicant's current ratio of 2.2 is at the median for Florida hospitals, an adequate position. The working capital (current assets less current liabilities) of \$11.0 million is a measure of excess liquidity that could be used to fund capital projects. The ratio of cash flow to current liabilities of 0.7 is slightly below the 50th percentile for Florida hospitals, but an adequate position. The short-term position of Osceola Regional Hospital, Inc. is effected by the practice of not carrying cash on their books. If cash were booked, their short-term position would appear stronger. Overall, the applicant has an average short-term position.

Long-term position:

The ratio of long-term debt to equity of 2.8 is above the 50th percentile, a highly leveraged position. The ratio of cash flows to assets of 9.0 percent is about average. The most recent year had net income \$3.3 million, resulting in a margin ratio of 2.5 percent, which is below the 50th percentile for Florida hospitals. Total equity is \$16.4 million. The ratio of net equity to total assets is 23.1 percent, which is below the average level. Overall, the applicant has a below average but acceptable long-term position.

Capital requirements:

Schedule 2 indicates the applicant has capital projects totaling \$63.6 million.

Available capital:

These projects project will be funded by HCA from operations or a line of credit. A letter of commitment from HCA was provided. HCA had, according to their 10-K report for the period ended December 31, 2003, \$115 million in cash on hand and \$2.2 billion in operating cash flows.

Conclusion:

Osceola Regional Hospital, Inc., with its parent HCA, Inc., has the financial resources to fund this project and all capital projects.

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

A comparison of the applicant's estimates to the control group values provides for an objective evaluation of financial feasibility, (the likelihood that the services can be provided under the parameters and conditions contained in Schedules 7 and 8) and efficiency (the degree of economies achievable through the skill and management of the applicant). In general, projections that approximate the median are the most desirable, and balance the opposing forces of feasibility and efficiency. In other words, as estimates approach the highest in the group, it is more likely that the project is feasible, because fewer economies must be realized to

achieve the desired outcome. Conversely, as estimates approach the lowest in the group, it is less likely that the project is feasible, because a much higher level of economies must be realized to achieve the desired outcome. These relationships hold true for a constant intensity of service through the relevant range of outcomes. As these relationships go beyond the relevant range of outcomes, revenues and expenses may, either go beyond what the market will tolerate, or may decrease to levels where activities are no longer sustainable.

The applicant failed to submit Schedules 7 and 8 that included the hospital as a whole with the proposed new beds. Therefore, we are unable to compare the applicant's estimates to the control group values. However, a comparison can be made between the actual data reported for this hospital for 2002 and the other hospitals in peer group 5.

Net revenue per adjusted patient day (NRAPD) of \$1,493 reported for 2002 is between the control group highest and median values of \$1,912 and \$1,382. The highest level is generally viewed as the practical upper limit on economies of operation. With net revenues falling between the median and highest level, the facility has, in the past, used health care resources in proportion to the services provided.

Cost per adjusted patient day (CAPD) of \$1,413 reported for 2002 is between the control group highest and median values of \$1,658 and \$1,286. Compared to the control group these costs are considered efficient.

This project is expected to add a net profit of \$204,142. This project appears to be financially feasible.

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

The applicant did not provide an estimate of managed care levels including this project. The level reported by this hospital for 2002 was 36.4 percent, approximating the group median level of 34.6 percent.

The proposed NICU II project was compared to all other hospitals in the state with approved NICU II programs. Schedule 7, total gross revenue for the project only is estimated to be \$2,000,441 for year two. With 845 patient days anticipated the gross revenue (gross charges) per patient day computes to \$2,367. This amount is between the control group lowest and median values of charges of \$1,360 and \$2,430. Osceola

Hospital reported average charges per day in the existing NICU II unit of \$1,830 per day. Current charges adjusted to 2006 would be \$2,100 per day. With the NICU II charges between the lowest and median, this project may foster positive 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.

The application is for the addition of four new Level II NICU beds to augment the six existing Level II beds located on the second floor. The new beds will be located in an additional space adjacent to and open to the existing beds. This space is said to have been designed for all 10 beds, and only minor demolition is anticipated. No further details about the new area were mentioned in the application.

Even though the ancillary spaces to serve the proposed beds may have been originally planned to function for 10 beds, there have been code changes since the original construction and the new bed and ancillary space must meet the current codes.

The application states that there are two bedrooms available for family members, but only one is shown. The unit also has an on-call room and two toilets, one with a large shower. One of these may have been intended to serve as the required staff toilet. There is also an existing dictation room, a supply room, an office, and a sizable unnamed space with a vestibule.

There are several significant code issues with the plan. The guidelines require that the room for the parents have “direct, private access to sink and toilet facilities”. Neither of the two toilet rooms has this private access. Additionally, every NICU bed must be within 20 feet of a hands-free hand washing station. In fact, no handwashing stations are shown although there must be some existing in the unit.

The guidelines also require that there be 120 square feet per patient care space. The area for the additional four beds is hand-lettered on the plan as “250 sq ft” and this figure is also used on Schedule 9. This is probably incorrect since 250 square feet would only accommodate two new beds and this area seems to be in excess of 300 square feet. Since this is a unit, some of the space for the new beds may be part of the space for the existing six beds. A minimum of 1,200 square feet is required for all 10 beds with the ancillary spaces required by the guidelines.

The larger plan of the NICU is not to scale and is smaller than the ¼” = 1’-0” required. There was no detailed plan of the unit showing the actual bassinets and the required circulation aisles. The entire viability of the project is contingent on having the required space within the unit and meeting the other requirements of the guidelines, Section 7.3.E.

The application had a list of applicable building codes, and it is essentially correct and the schedule appears reasonable for the scope of the work as shown. Because of the square footage issues noted above, it is not possible to evaluate the budget if the square footage is inaccurate.

It is required that schematic drawings be submitted as part of the CON application. Although the drawings for this proposal may be more advanced than required, they have been reviewed as schematics with the expectation that they will necessarily be revised and refined during the design development (preliminary) and contract document stages. The architectural review of the application shall not be construed as an in-depth effort to determine complete compliance with all applicable codes and standards. The final responsibility for facility compliance ultimately rests with the owner.

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.

The following table provides an indication of the applicant’s commitment to charity and Medicaid, with comparison to the district, based on fiscal year (FY) 2002 actual data prepared by AHCA:

Medicaid and Charity Care of the Applicant Compared to the District for fiscal year 2002

Applicant	FY 02 Percent of Medicaid Days	FY 02 Gross Charity Percentage of Charges
Osceola Regional Med. Ctr.	14.7%	1.7%
District 7 Average	13.3%	2.7%

Source: FY 2002 Actual Data/AHCA

The applicant is not proposing any payer condition for the proposed project. As reflected in the table, Osceola Regional’s provision of Medicaid exceeds the district average but its charity care is lower than the district average.

As reflected in the table above, the applicant’s provision of Medicaid exceeded the district average but its provision of charity care was lower than the district average. As of March 31, 2004, Osceola Regional was not listed as a disproportionate share provider for State Fiscal Year 2003-2004.

The applicant projects its first two years of Level II NICU payer mix to be:

**Osceola Regional's Level II NICU
Payer Distribution
Second Year of Operation**

Payer	Percentage of Allocation
Medicaid	54.65%
HMO/PPO	43.07%
Insurance	0.00%
Self-Pay/Other*	2.28%*
TOTAL	100.0%

Source: CON #9673 application.

***The applicant notes that since most low income or charity care families qualify for Medicaid for NICU services, charity is included in the Self Pay/Other category.**

F. SUMMARY

The applicant proposes to add four Level II NICU beds to the existing six-bed Level II NICU, creating a 10-bed Level II NICU at Osceola Regional Medical Center.

The total project cost is estimated at \$287,576. Renovation costs are projected at \$5,000 and the project will involve 250 gross square feet (GSF) of renovated space.

Need/Access:

This project is not submitted in response to published need. The applicant indicates it is applying under special (not normal) circumstances for the approval of additional NICU beds at its facility. Occupancy in the applicant's Level II NICU for the 12 months ending June 30, 2003, was 63.15 percent. Although the applicant contends it is transferring neonates and will experience occupancy constraints in the future, occupancy is declining and projections do not appear reasonable. Need for additional beds was not shown.

Quality of Care:

The applicant is JCAHO accredited and a quality care provider.

Medicaid/Indigent Care:

Although the applicant is not proposing any Medicaid or indigent care condition for the proposed project, the applicant is under contract with the Osceola County Health Department to provide obstetric care to Medicaid recipients. The applicant has historically provided and projects to continue to provide a high provision of Level II NICU patient days to Medicaid patients. However, it was not demonstrated that access to this population will be improved if this project is approved.

Financial/Cost:

The applicant has an overall average short-term position and an overall below average, but acceptable long-term position. With its parent corporation, HCA, Inc., the applicant has the financial resources to fund this project and all capital projects. This project is expected to add a net profit of \$204,142 and appears to be financially feasible. This project may foster positive competition to promote quality and cost-effectiveness.

Architectural:

The application is for the addition of four new Level II NICU beds to augment the six existing Level II beds. The new beds will be located in an additional space adjacent to the existing NICU beds and only minor demolition is anticipated. There are several significant code issues with the plan. The guidelines require that the room for the parents have “direct, private access to sink and toilet facilities”. Neither of the two toilet rooms has this private access. Every NICU bed must be within 20 feet of a hands-free hand washing station yet, no hand washing stations are shown. The guidelines also require that there be 120 square feet per patient care space. The area for the additional four beds is hand-lettered on the plan as “250 sq ft”, which would only accommodate two new beds. The larger plan of the NICU is not to scale and is smaller than required. There was no detailed plan of the unit showing the actual bassinets and the required circulation aisles. The entire viability of the project is contingent on having the required space within the unit and meeting the other requirements of the guidelines. Because of the square footage issues, it is not possible to evaluate the budget.

G. RECOMMENDATION

Deny CON #9763.

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