STATE AGENCY ACTION REPORT

ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Wellington Regional Medical Center, Inc./CON #9811

2623 Jetton Avenue
Tampa, Florida 33629

Authorized Representative: Thomas A. Davidson
(813) 251-5470

2. Service District/Subdistrict/County

District 9; Palm Beach County

B. PUBLIC HEARING

No public hearing was requested or held regarding the proposed project to establish a 15-bed Level III Neonatal Intensive Care Unit (NICU) at Wellington Regional Medical Center. The applicant submitted nine letters of support from area physicians and the community for the proposed project. Letters of support were received from: Emilio B. Torres, M.D., FACOG (certified obstetrician on staff at Wellington Regional Medical Center); three letters were received from physicians at OB/GYN Specialists of the Palm Beaches; Jeffrey Bishop, D.O. (Chairman, Board of Directors, Wellington Regional Medical Center); three letters from Wellington Regional Medical Center board members; and Thomas M. Wenham, Mayor (Villages of Wellington). Most of the letters emphasized the population growth in the area and that residents have to travel 16 miles through dense traffic to receive Level III NICU services. In addition to the letters submitted by the applicant, the Agency independently received letters of support from Josephine T. Cudnik (Wellington Women's Club) and Senator Dave Aronberg, whose letters expressed similar views of those submitted by the applicant.

C. PROJECT SUMMARY

Wellington Regional Medical Center, Inc. (CON #9811), a propriety hospital system and wholly owned subsidiary of Universal Health System, Inc., operates Wellington Regional Medical Center, a 121-bed general acute care hospital located in Palm Beach County. The applicant proposes to establish a 15-bed Level III Neonatal Intensive Care Unit (NICU) program at Wellington Regional Medical Center (District 9). Wellington is licensed to operate 111 acute care beds and 10 Level II NICU beds.

According to the applicant's *Conditions* page, it will set aside 28.9 percent of its patient days in the Level III NICU to Medicaid/Medicaid HMO and charity care patients on a combined bases.

The total project cost is estimated at $2,865,700. Renovation costs are projected at $1,581,875 and the project will involve 9,450 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, Ryan Fitch, who evaluated the financial data and the Architect, Joel Hill, who evaluated the architectural and the schematic drawings.

E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA

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

1. Fixed Need Pool

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

In Volume 30, Number 30, dated July 23, 2004 of the Florida Administrative Weekly, zero need was published for Level III NICU beds in District 9.

Amended Section 408.036(3)(k), Florida Statutes became effective July 1, 2004, to allow a hospital with a minimum of 3,500 births during the previous 12-month period to establish a 15-bed Level III NICU outside of comparative review if it could meet other criteria that are largely set forth in CON rules for comparative review and discussed below in E. 2. The applicant's facility does not meet the minimum number of births to qualify to seek CON exemption review and is applying outside of the fixed need pool, indicating 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 III neonatal intensive care services within a district shall not normally be approved unless the average occupancy rate for Level III 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.

District 9 currently has 30 licensed Level III NICU beds and 10 CON approved beds at St. Mary's Medical Center through the delicensure of eight Level III NICU beds at Good Samaritan Medical Center[1], resulting in a net approval of two Level III beds. The Level III NICU beds in District 9 experienced an average occupancy rate of 76.18 percent during the period January 2003 through December 2003.

[1] Good Samaritan's Level III NICU has been unoccupied for the past three calendar years.

Level III NICU Bed Utilization - District 9
Calendar Year (CY) 2003

Hospital	# Beds	Occupancy
Good Samaritan MC	8	0%
West Boca MC	9	86.82%
St. Mary's MC	10	114.63%
Bethesda Memorial	3	119.27%
Total	**30**	**76.18%**

Source: ***Florida Hospital Bed and Service Utilization by District,*** **July 2004 Batching Cycle**

As noted above, St. Mary's Medical Center is approved to add 10 Level III NICU beds and Good Samaritan's beds are scheduled to be delicensed.

c. **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 applicant's 111 acute beds experienced an occupancy rate of 74.69 percent for CY 2003. The planning horizon for this cycle is January 2007 and the applicant forecasts that the hospital's acute care patient days will exceed 75 percent during the 12-month period ending December 31, 2006. Hence, the applicant is not proposing to convert any acute care beds. The applicant presented the following tables to illustrate its historical and projected acute care utilization:

Historical Acute Care Patient Days at Wellington
and Corresponding Occupancy Rates

Factor	1998	1999	2000	2001	2002	2003
Patient Days	16,725	18,917	21,245	23,582	25,999	29,273
Annual Growth		13.1%	12.3%	11.0%	10.2%	12.6%
Licensed Beds	104	104	104	104	104	107
Occupancy	44.1%	49.8%	56.0%	62.1%	68.5%	74.7%

Source: CON #9811 Application, Exhibit 19.

Projected Acute Care Patient Days at Wellington and Corresponding Occupancy Rates

PROJECTED				
2003 Adult Population of Palm Beach County	1,012,018			
2006 Adult Population of Palm Beach County	1,064,508			
Service Area Pop. Growth Rate/Year	1.7%			
	2003	**2004**	**2005**	**2006**
Patient Days	29,273	29,771	30,277	30,791
ADC		82	83	84
Licensed Beds		111	111	111
Occupancy		73.5%	74.7%	76.0%

Source: CON #9811 Application, Exhibit 19.
Note: Methodology based on projection of 2003 patient days forward on the basis of projected service area population growth.

d. Other Special Circumstances:

Wellington Regional Medical Center does not have an existing Level III NICU. The applicant contends that the need for establishing a Level III NICU program is justified based on the following special (not normal) circumstances:

- Under-utilization of Level III NICU services in District 9
- High utilization of operational Level III NICU beds in District 9
- Geographic maldistribution of Level III NICU providers
- Absence of competition in District 9 for Level III services
- Area population growth
- Increased utilization of Wellington's Level II NICU
- Growth of OB programs in the area

The applicant maintains that the continued reflection of eight inactive beds at Good Samaritan Hospital distorts the utilization data for Level III NICU services in District 9, and has resulted in capacity constraints among the district's existing Level III NICU providers. As noted above, St. Mary's Medical Center has a CON approved to implement beds not in use at its sister facility. The applicant states that this suppresses the projected need for additional beds and exaggerates the extent of available program resources. The first table below illustrates the three-year occupancy of the existing Level III providers. The second table below demonstrates what the occupancy rate would have been if the inactive beds at Good Samaritan were not configured into the calculations.

Occupancy of District 9's Existing Level III NICU Providers
CY 2001-CY 2003

Facility	# of Beds	Jan. 2003-Dec. 2003	# of Beds	Jan. 2002-Dec. 2002	# of Beds	Jan. 2001-Dec. 2001
Good Samaritan	8	0.00%	8	0.00%	8	0.00%
West Boca Medical Center	9	86.82%	9	63.37%	5	83.01%
St. Mary's Medical Center	10	114.63%	10	134.30%	10	125.56%
Bethesda Memorial	3	119.27%	3	134.34%	3	55.89%
District Total	**30**	**76.18%**	**30**	**77.37%**	**26**	**70.71%**

Source: AHCA's publication, *Florida Hospital Beds and Service Utilization by District* for the periods shows.

Occupancy of District 9's Active Level III NICU Providers Only
CY 2001-CY 2003

Facility	# of Beds	Jan. 2003-Dec. 2003	# of Beds	Jan. 2002-Dec. 2002	# of Beds	Jan. 2001-Dec. 2001
West Boca Medical Center	9	86.82%	9	63.37%	5	83.01%
St. Mary's Medical Center	10	114.63%	10	134.30%	10	125.56%
Bethesda Memorial	3	119.27%	3	134.34%	3	55.89%
District Total	**22**	**103.88%**	**22**	**105.94%**	**18**	**102.13%**

Source: AHCA's publication, *Florida Hospital Beds and Service Utilization by District* for the periods shows.

As illustrated in the second table, the utilization rate for District 9's Level III NICUs would have been extremely high had the inactive beds for Good Samaritan been omitted from the calculations. Once St. Mary's Medical Center implements the 10 CON approved beds, however, this utilization is expected to remain below 80 percent, the occupancy standard for NICU services. In its CON Application #9516, St. Mary's showed that it might be able to achieve occupancy of 76 percent in the 10 requested Level III beds by 2004. The planning horizon for this batching cycle for Level III NICU beds is January 2007. Therefore, contrary to the applicant's claims that both low and high utilization are issues supporting special circumstance approval of its project, it appears that once CON approved beds are brought on-line and unused beds are delicensed, these utilization issues will be resolved. Additionally, under amended CON laws, Bethesda can add Level III NICU beds without CON review to alleviate its current over-utilization problem.

The applicant presented information that indicates its belief that neonates in the district are not receiving needed services. While utilization is high in District 9's operational Level III NICU providers, the applicant does not demonstrate that neonates needing services are being denied. Letters of support from physicians do not support this contention either. Rather, letters generally indicate that travel times are difficult for residents who must travel at least 16 miles, with no time estimate or average given, to obtain services. This suggests that patients are being served. For example, many letters indicate that infants are being transferred to St. Mary's and that writers would prefer that these services be closer to Wellington's patient population. None of the letters indicate that neonates needing care cannot be admitted to St. Mary's because of high occupancy. Neonatal intensive care services are defined

as tertiary care services and the travel standard, as discussed below under E. 3. e. below, is that services be available within two hours ground travel time under normal traffic conditions for 90 percent of the population in the service district. The applicant presented no information suggesting this standard was not being met.

The applicant suggests that the geographic location of the growing population in the district presents a special circumstance. The applicant states that Palm Beach County is the largest of the five counties in District 9 with respect to population and live births. Data on the Department of Health's website indicates that Palm Beach County accounted for 14,659 of the district's 20,032 total live resident births. The applicant contends that none of the other counties in the district, with the possible exception of St. Lucie County, generated enough OB volume to support a Level III program. The applicant maintains that there were more live births at Wellington in 2003 than were reported in all of Indian River County, all of Martin County, or all of Okeechobee County. Following is a chart showing data available on the Department of Health's website (FloridaCHARTS.com - Florida Health Statistics and Community Health Data) regarding live resident births in District 9.

District 9 Total Resident Live Births 2003	
County	**Total Resident Live Births**
Indian River	1,213
Okeechobee	537
Martin	1,175
Palm Beach	14,659
St. Lucie	2,448
Total District 9	20,032
Total State	212,243
Source: Department of Health's website	

As the table above illustrates, Palm Beach County's 2003 live resident births represent 73.18 percent of the live resident births in the district. It is again noted that St. Mary's has approval to add 10 Level III NICU beds and is located in Palm Beach County.

The applicant feels that since there is a significant and growing population in the western sector of Palm Beach County, clinical and planning reasons justify the development of a Level III NICU in the service area. The applicant provided a table in Exhibit 7 of the application to illustrate growth trends in the volume of births at western county facilities. Population projections indicate that the western sections are expected to contain an increasingly large percentage of the county's total population of women of childbearing ages. The applicant perceives that this shift in obstetrical volume to western county facilities

can be expected to continue into the future. The applicant argues that that this demonstrates that there is a significant population in western Palm Beach County that does not enjoy easy access to Level III NICU services.

The following map of the District 9 area illustrates where Wellington is located in relation to existing Level II and Level III NICU providers and the number of all births occurring at those facilities is shown in the proceeding table.

CY 2003 District 9's Level II & Level III NICU Facilities Births for DRG 370-375 and 385-391

NICU Level II Facilities		
County	**Facility**	**Births**
Martin	Martin Memorial Medical Center	3,268
Palm Beach	Boca Raton Community Hospital	3,494
Palm Beach	Palm Beach Gardens Medical Center	937
Palm Beach	Wellington Regional Medical Center	3,068
Saint Lucie	Lawnwood Regional Medical Center	1,869
NICU Level III Facilities		
County	**Facility**	**Births**
Palm Beach	Bethesda Memorial Hospital	5,936
Palm Beach	Good Samaritan Medical Center	1,628
Palm Beach	St Mary's Hospital	7,479
Palm Beach	West Boca Medical Center	4,791

Source: The State Center for Health Statistics.

The map does support the applicant's contention that Level III NICU services are geographically mal-distributed in District 9 and Palm Beach County. All of the district's Level III beds are housed in facilities located along the eastern section of Palm Beach County. Development of a Level III NICU program at Wellington would improve access to Level III NICU services among residents of the western sections of the district. Wellington indicates that improved access to NICU services will enhance the service area's continuum of maternal and child health services because it will reduce travel hardships on infants and parents who require NICU services. However, existing Level III NICU providers are all accessible within the time frame of 120 minutes noted in the Rule.

Neonates requiring Level III NICU services are usually transferred from the hospital of birth to a Level III facility in the area. The applicant feels that this practice results in sub-optimal outcomes and higher neonatal mortality rates. The applicant cited a study that was published in an October 2, 1996 article in *The Journal of the American Medical Association*. The purpose of the study was to examine the effect on neonatal mortality of the level of neonatal services available at the hospital of birth. Among other findings in the study, the author noted: "Risk-adjusted mortality was lower for infants born in larger (average NICU census >15 patients per day) tertiary centers." The results of the study also showed that "most of the mortality difference between hospitals with large Level III NICUs and other hospitals persisted when neonatal transports were considered. Thus, maternal referrals or antenatal transfers of the mother, yields lower mortality compared with subsequent neonatal transport."[2] The applicant also cited findings from a study published in the May 5, 2002 edition of "*Pediatrics*" which states "Risk adjusted mortality remains significantly lower when high-risk

[2] Ciran Phibbs, Janet Bronstein, et.al, "The Effects of Patient Volume and Level of Care at the Hospital of Birth on Neonatal Mortality". *JAMA*, Vol. 276, Number 13. October 2, 1996, pages 1054-1059.

infants are born at a hospital with large regional NICUs (an ADC > 15). We also show that the level of care that is available at the hospital of birth is much more important to survival that is the level of care ultimately received."[3] The article offered the following explanation for why transferred neonates do not enjoy the same survival benefits from Level III care as neonates born in facilities with Level III services: "For very low birth weight infants, a great many of those infants who die do so in the first day of life. As a result, many of the sickest infants, who might potentially benefit from care at a higher level NICU, die before they can be transported". Although there is also support in the literature for fewer NICU units in an area because of quality of care issues, the applicant's analysis of need based on a maldistribution of beds and existing beds being utilized at over 100 percent for the past three years in relationship to transport issues is noted.

The applicant maintains that the existing Level III NICU programs in District 9 are overwhelmingly owned and operated by hospitals that belong to a single multi-hospital system. The applicant specifically refers to Tenet owned hospitals, which account for 29 of the district's 32 licensed or approved Level III NICU beds. The applicant referenced Section 408.035 (9) Florida Statutes, which indicates that applications for CON determinations will be reviewed in context with the extent to which its proposal would foster competition that promotes quality and cost-effectiveness. The applicant contends that the development of a competitive Level III NICU program will advance this criterion. The applicant proposes that its project will foster competition by offering managed care providers additional contracting options, which will impact the cost to consumers accessing care, and by offering choices to consumers and referring physicians. This criterion is addressed below under E. 4. g. The financial reviewer for this project determined that the level of managed care should have some positive impact on competition.

The following table illustrates the number of births by zip code for the hospital's primary service area and it also shows the population estimates of females age 15-44.

[3] Cifuentes, Javier, M.D., et. al., "Mortality in Low Birth Weight Infants According to the Level of Neonatal Care at Hospital of Birth". *Pediatrics*, Vol. 109, Number 5, May 2002, pages 745-751.

Wellington Regional Medical Center Population Growth Trends
OB Primary Service Area

Zip Code	Births 1/03-12/03	% of Births	Cumulative %	Age 15-44 Female Pop. 2004	Age 15-44 Female Pop. 2009	Percent Increase 2004-2009	Annual Rate of Increase
33411 West Palm Bch.	212	13.9%	13.9%	10,969	13,257	20.9%	3.9%
33414 West Palm Bch.	173	11.4%	25.3%	9,986	11,923	19.4%	3.6%
33463 Lake Worth	145	9.5%	34.8%	9,262	10,328	11.5%	2.2%
33415 West Palm Bch.	144	9.5%	44.3%	8,450	8,268	-2.2%	-0.4%
33467 Lake Worth	143	9.4%	53.7%	6,748	7,816	15.8%	3.0%
33461 Lake Worth	83	5.5%	59.2%	7,540	7,293	-1.9%	-0.4%
33470 Loxahatchee	59	3.9%	63.1%	5,901	2,704	23.6%	4.3%
33413 West Palm Bch.	53	3.5%	66.5%	2,392	4,557	13.0%	2.5%
33417 West Palm Bch.	53	3.5%	70.0%	4,639	5,195	-1.8%	-0.4%
33406 West Palm Bch.	50	3.3%	73.3%	4,881	4,668	-4.4%	-0.9%
33409 West Palm Bch.	49	3.2%	76.5%	5,620	5,996	6.7%	1.3%
33436 Boynton Bch.	45	3.0%	79.5%	7,690	9,131	18.7%	3.5%
33437 Boynton Bch.	44	2.9%	82.4%	5,740	6,510	13.4%	2.5%
33462 Lake Worth	36	2.4%	84.7%	5,483	5,755	5.0%	1.0%
33460 Lake Worth	32	2.1%	86.9%	6,730	6,640	-1.3%	-0.3%
Subtotal-Wellington OB Primary Service Area	**1,321**	**86.9%**	**86.9%**	**102,031**	**112,242**	**10.0%**	**1.9%**
Other Areas	200	13.1%	100.00%	117,351	121,323	3.4%	0.7%
Palm Beach Co. Total	**1,521**	**100.00%**		**219,382**	**233,565**	**6.5%**	**1.3%**

Source: CON #9811 Application (Exhibits 8and 9); Data from Information Management Systems, Inc. and Claritas.

According to the applicant, the zip codes in Wellington's OB primary service area are expected to experience a significant population growth over the next five years in females of childbearing age. Using zip code population projections for females age 15-44, the applicant shows the 2004 population for its primary service area at 102,031 and 2009 projections at 112,242 representing a 10.0 percent increase in this population. The applicant contends that the population projection indicates that the growth in OB utilization in the western sector of Palm Beach County can be expected to grow more rapidly than in other sections in the county over the next five years.

The applicant claims that the birth volume at Wellington Regional increased from 913 births in the 12-month period ending December 31, 1998 to 1,541 for the 12-month period ending December 31, 2003. Agency records indicate that Wellington actually experienced 1,533 births at its facility, which exceeds the birth volume requirement of 1,500 live births to establish a Level III NICU as promulgated in the Rule, assuming that need is demonstrated if no fixed need pool is published.

As stated earlier, St. Mary's Medical Center has received a 10-bed approval for additional Level III NICU beds. The applicant did not demonstrate that patients in need of care could not obtain it. Rather, the applicant has stated, through letters of support from physicians on its staff, that neonates needing care are transferred to other Level III NICU providers in the county.

Need for the project is not evidenced by the availability, accessibility, and extent of utilization of existing health care facilities and health services in the applicant's service area as is discussed in E.3. below. Nevertheless, there is evidence that Level III NICU services are geographically mal-distributed in the district. Development of a Level III NICU program at Wellington would improve access to Level III NICU services among residents living in the western sections of District 9.

2. Agency Rule Preferences

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.

As stated above, the applicant will set aside 28.9 percent of its patient days in the Level III NICU to Medicaid/Medicaid HMO and charity care patients on a combined basis.

The applicant projects the following payor mix for each of the first two years of operations for its proposed Level III NICU program.

Payor	Percent
Medicaid	26.3%
Medicaid HMO	1.9%
HMO/PPO/Commercial/Other	69.9%
Self-Pay/Charity	1.9%
TOTAL	100.0%

Source: CON #9811 Application, page 39.

Refer to E.4.g. below for further discussion. The applicant is not a Regional Perinatal Intensive Care Center Program.

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) The establishment of Level III neonatal intensive care services shall not normally be approved unless the hospital also provides Level II neonatal intensive care services.

The applicant states that Wellington Regional Medical Center currently operates four Level II NICU beds, which will be expanded to a 10-bed unit following construction of the new space. Yet according to Agency licensure records, the applicant was licensed to operate 10 Level II NICU beds on January 13, 2004.

(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 it will provide developmental follow-up through referrals to St. Mary's child development center. Staff at Wellington will assess patients prior to discharge who may require developmental follow-up and make the necessary referrals to St. Mary's program. Information concerning St. Mary's child development center appears in Appendix B of the application.

c. Ch. 59C-1.042(5), Florida Administrative Code - Minimum Unit Size. Hospitals proposing the establish of new Level III neonatal intensive care services shall propose a Level III neonatal intensive care unit of at least 15 beds, and should have 15 or more Level II neonatal intensive care unit beds. A provider shall not normally be approved for Level III neonatal intensive care services only.

The applicant is proposing to establish a 15-bed Level III NICU. However, its Level II NICU does not meet the minimum unit size of 15 beds as specified in this rule preference. It is noted however, that the addition of NICU beds to existing units no longer requires CON review and may be added through notification to the CON program at any time.

d. **Ch. 59C-1.042(6) - Minimum Birth Volume Requirement. Hospitals applying for Level III neonatal intensive care services shall not normally be approved unless the hospital has a minimum service volume of 1,500 live births for the most recent 12-month period ending six months prior to the beginning date of the quarter of the publication of the fixed bed need pool. Specialty children's hospitals are exempt from these requirements.**

For the period January 2003 through December 2003, the applicant reports 1,541 births at Wellington Regional Medical Center. Agency records indicate that Wellington actually experienced 1,533 births, exceeding the minimum service volume of 1,500 live births as 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 9.

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

(1) **Physician Staffing: Level III neonatal intensive care services shall be directed by a neonatologist or a group of neonatologists who are on active staff of the hospital with unlimited privileges and provide 24-hour coverage, and who are either board-certified or board-eligible in neonatal-perinatal medicine. In addition, facilities with Level III neonatal intensive care services shall be required to maintain a fetal medical specialist on active staff of the hospital with unlimited staff privileges. Specialty children's hospital are exempt from this provisions**

The applicant states that the medical director of the Level III NICU will be Dr. Janet Wingkun. Dr. Wingkun is board-certified in pediatrics and neonatal perinatal medicine by the American Board of Pediatrics. Dr. Shawn G. Lencki will serve as the maternal-fetal specialist for the NICU program. Dr. Lencki is board-certified by the American Board of Obstetrics and Gynecology in obstetrics and maternal fetal medicine. Their curricula vitas appear in Appendix C.

Schedule 6 does not reflect any physician staffing.

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

The applicant states that the clinical director of nursing for the proposed Level III NICU will be Barbara Nash-Glassman, RN, who is currently serving in this same capacity for the facility's existing Level II NICU. While the applicant states that Heather McCreary, RN currently serves as Wellington's Level II NICU night charge nurse, it does not indicate if she will serve in this same capacity for the proposed Level III NICU. Their curricula vitas are provided in Appendix E of the application. The applicant contends that all of the proposed nursing staff for the project will be registered nurses.

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

The applicant indicates that all nurses assigned to the Level III NICU will be trained and certified in the skills listed above. The applicant also states that its existing Level II nursing staff is already trained in the above listed skills.

(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 it has at least one certified respiratory care practitioner therapist trained in the care of neonates available at all times. The applicant states that it will maintain a ratio of at least one respiratory therapist for every four infants receiving assisted ventilation. Curricula vitas for the facility's current respiratory therapy staff appear in Appendix F of the application. Schedule 6A does not state how many FTEs are designated for respiratory staff.

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

The applicant states that it currently provides blood gas determination on a 24-hour basis for its existing acute care facility, and there will be a blood gas analyzer located within the proposed NICU complex.

(6) 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, on a 24-hour basis, x-ray, obstetric ultrasound, and clinical laboratory services with the ability to perform microstudies. According to the applicant, anesthesia is available in-house 24 hours a day via an on-call system within 30 minutes, which ensures coverage during off hours.

(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.

Wellington has a dietitian or nutritionist to provide information on patient dietary needs and to provide the patient's family instruction or counseling regarding the appropriate nutritional and dietary needs of the patient after discharge. Appendix F of the application provides a copy of the resume of Melanie Cagle, RD, LDN, who will be responsible for clinical nutritional assessments and design of dietary regimens for patients of the proposed Level III NICU.

(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 maintains a social service department to assist a patient's family in their supportive needs, including identification and referral to needed resources in the community. The applicant also indicates that it participates in the Healthy Start Visiting Program, which provides nursing visits to prenatal clients and postnatal infants. The applicant also participates in Healthy Mothers, Healthy Babies; which provides an informational hotline on prenatal and early infant care. In addition, the applicant states that it assists clients in accessing prenatal care.

(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 will provide in-hospital intervention services for infants identified as being high risk for developmental disabilities to include developmental assessment, intervention, and parental support and education.

(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.

The applicant states that it has an interdisciplinary discharge planning process. The personnel responsible for planning a NICU patient's discharge includes: neonatologist, NICU nurses, case managers, and a representative from the hearing screening program. Patients with developmental follow-up needs are referred to the early intervention program located on the campus of St.

Mary's Medical Center. A copy of the applicant's NICU discharge planning policies and procedures appear in Appendix G of the application.

g. Ch. 59C-1.042(10) - Level III Neonatal Intensive Care Unit Standards: The following standards shall apply to Level III neonatal intensive care services:

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

The applicant states that Dr. Harry Bayron, who is a board-certified pediatric cardiologist, will provide pediatric cardiology consultation services.

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

The applicant states that it will maintain a nurse to neonate ratio in excess of 1:2 in its proposed Level III NICU at all times. All nurses assigned to the NICU will be registered nurses. However, the applicant prepared its own version of the CON application's Schedule 6A, which does not reflect the number of registered nurses.

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

a. Eighty square feet per infant;
b. Two wall mounted suction outlets preferably equipped with an alarm to signal loss of vacuum;
c. Twelve electrical outlets;
d. Two oxygen outlets and an equal number of compressed air outlets with adequate provisions for mixing these gases;
e. An incubator and 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 non-invasive blood pressure monitoring device for every three beds;
k. At least one portable suction device; and
l. Availability of devices capable of measuring continuous arterial oxygenation in the patient.

The applicant indicates that its proposed Level III NICU will comply with all of the above requirements. Refer to the architectural review below in E.4.f.

(4) Equipment Required to be Available to Each Level III Neonatal Intensive Care Unit. Each Level III Neonatal Intensive Care Unit shall be equipped with:

a. An EKG machine with print-out capacity;
b. Portable Suction equipment; and
c. Not less that one ventilator for every three beds.

The applicant indicates it will have all of the required equipment above available.

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

(1) Provision of Emergency Transportation. Hospitals providing Level II or Level III neonatal intensive care services must operate a 24-hour emergency transportation system directly, or contract for this service, or participate through a written financial or non-financial agreement with a provider of emergency transportation services.
(2) Requirements for Emergency Transportation System. Emergency transportation system, as defined in paragraph (11)(a), shall conform to section 64E-2.003, Florida Administrative Code.

The applicant currently participates in Palm Beach County's emergency transportation system for its Level II and Level III NICU patients, and will continue to do so following approval of this project. A copy of the transfer agreement with American Medical Response was included in Appendix H of the application, as well as its neonatal transportation policies and procedures.

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

Wellington Regional Medical Center currently maintains a transfer agreement with St. Mary's Medical Center; a copy of the agreement is included in Appendix I of the application. The applicant maintains that it would not unreasonable withhold consent for transfer arrangements with other area hospitals if its Level III NICU is approved.

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

The applicant 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, 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) and 408.035(7), Florida Statutes.

The applicant maintains that there is need for an additional Level III NICU program in the district, as discussed above in E. 1.d. There is evidence to support the applicant's contention that Level III NICU services are geographically mal-distributed in District 9 and Palm Beach County. All of the district's Level III beds are housed in facilities located along the eastern section of Palm Beach County. Development of a Level III NICU program at Wellington would improve access to Level III NICU services among residents of the western sections of the district.

Need for the project is not 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. However, given where Level III NICU facilities are located and where population is growing, there is evidence to support the applicant's contention that Level III NICU services are geographically mal-distributed in District 9 and Palm Beach County. All of the district's Level III beds are housed in facilities located along the eastern section of Palm Beach County. Development of a Level III NICU program at Wellington would improve access to Level III NICU services among residents living in the western sections of the district.

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.

Wellington Regional Medical Center is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. A copy of the medical center performance report from the latest JCAHO visit was included in Appendix J. The applicant also states that its current performance improvement plan will be applied to the proposed NICU program. A review of agency records indicates the applicant had six confirmed complaints (three without deficiencies) during the past three years. One of the confirmed complaints was related to the physical plant, three were billing related, one was related to medical records/charting, and one complaint was for emergency access violation. It should be noted that the emergency access violation was not related to the NICU.

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

The audited financial statements for the periods ending December 31, 2003 and 2002 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:

WELLINGTON REGIONAL MEDICAL CENTER, INC.

	12/31/2003	12/31/2002
Current Assets	$ 14,045,000	$ 12,290,000
Cash and Current Investment	$ 288,000	$ 167,000
Assets Restricted for Capital Projects	$ -	$ -
Total Assets	$ 61,030,000	$ 49,873,000
Current Liabilities	$ 8,837,000	$ 8,057,000
Total Liabilities	$ 67,767,000	$ 61,059,000
Net Assets	$ (6,737,000)	$ (11,186,000)
Total Revenues	$ 84,501,000	$ 66,494,000
Interest Expense	$ -	$ -
Excess of Revenues over Expenses	$ 7,229,000	$ 3,230,000
Cash Flow from Operations	$ 10,118,000	$ 4,999,000
Working Capital	$ 5,208,000	$ 4,233,000
Current Ratio (CA/CL)	1.6	1.5
Cash Flow to Current Liabilities (CFO/CL)	1.1	0.6
Long-Term Debt to Net Assets (TL-CL/NA)	-8.7	-4.7
Net Assets to Total Assets (TE/TA)	-11.0%	-22.4%
Total Margin (ER/TR)	8.6%	4.9%
Return on Assets (ER/TA)	11.8%	6.5%
Operating Cash Flow to Assets (CFO/TA)	16.6%	10.0%

It should be noted that Wellington Regional Medical Center, Inc. (Wellington) is a wholly owned subsidiary of Universal Health Services, Inc. According to the audit, substantially all of the cash generated from or used by Wellington is transferred to and from Universal Health Services, Inc. (Parent). Also, the Parent Company provides general and administrative services to Wellington. The Parent allocated management fees and other cost allocations to Wellington in the amounts of $1,353,000 in 2003 and $113,000 in 2002. According to the notes to the audited financial statements, since the Parent Company can exercise its discretion when determining the management fee and other cost to allocate to Wellington, the financial position and operating results presented in the audit may not necessarily be indicative of those that would be obtained had Wellington operated autonomously.

Short-term position:
The applicant's current ratio of 1.6 indicates current assets are approximately one and a half times short-term liabilities, an adequate position. The working capital (current assets less current liabilities) of $5.2 million is a measure of excess liquidity that could be used to fund capital projects. The most recent year had an operating profit of $7.2 million resulting in a margin of 8.6 percent. The ratio of cash flow to current liabilities of 1.1 is good. The applicant has a good short-term position. (Note: these ratios include the effect of a net transfer of cash from the Parent Company of $4.6 million)

Long-term position:
The long-term debt to equity ratio of a negative 8.7 means long-term debt is in excess of the net assets of the applicant, a weak position. The cash flow to assets ratio of 16.6 percent is above average. Total equity is negative $6.7 million with equity to assets ratio of negative 11 percent, which is well below average and a weak position. The applicant has a weak long-term position. (Note: these ratios include a long-term liability due to the Parent Company in the amount of 54.9 million. This liability has no interest rate or repayment terms).

Capital requirements:
Schedule 2 indicates the applicant had $26.6 million in capital projects planned or underway. The audited financial statements disclosed that on September 5, 2004, Wellington incurred significant structural damages from Hurricane Frances. Wellington believes that the majority of damages will be covered by insurance; however, Wellington's insurance deductible is listed as $3.3 million, which was not included in Schedule 2.

Available capital:
The applicant provided a copy of a letter dated October 5, 2004, from its Parent Company indicating that the Parent will fund all projects that are in process, planned, or pending from the Parent's current cash balances or the Parent's revolving line of credit. The applicant provided the audited financial statements of its Parent Company. The audited financials of the Parent showed cash and equivalents of $34.8 million, total assets of $2.8 billion and equity of $1.1 billion. The parent reported earnings from operations of $317 million on net revenues of $3.6 billion. Cash flows from operations totaled $376.8 million. As of December 31, 2003, the Parent company had access to $157 million on a $400 million line of credit.

Conclusion:
Based on the information provided, it appears that the applicant will likely have access to capital as needed to complete this project.

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

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

Comparative data were derived from hospitals in peer groups that reported data in 2002; the applicant will be compared to the hospitals in peer group 4. Per diem rates are projected to increase by an average of 3.5 percent per year. Inflation adjustments were based on the new CMS Market Basket, 2nd Quarter, 2004.

Gross revenues, net revenues, and costs were obtained from Schedules 7 and 8 in the financial section of the application. These were compared to the control group as a calculated amount per adjusted patient day. The adjustment is made to factor out the outpatient revenues in the per patient day computation.

Net revenues per adjusted patient day (NRAPD) of $1,570 in year one and $1,620 in year two are between the control group highest and median values of $2,314 and $1,445 in year one and $2,388 and $1,491 in year two. The highest level is generally viewed as the practical upper limit on economies of operation. With net revenues falling between the median and highest level, the facility is expected to consume health care resources in proportion to the services provided. (See Comparative

Table). The applicant's NRAPD in calendar year 2003 was reported as $1,378. The difference in the NRAPD reported in 2003 and the projected NRAPD of $1,620 results in an average compound annual increase of approximately 3.2 percent. This level of increase is not materially different than the inflation percentage outlined in the CMS Market Basket, 2nd Quarter, 2004, index. Therefore, projected revenues appear reasonable.

Anticipated costs per adjusted patient day (CAPD) of $1,371 in year one and $1,415 in year two approximate the group median values of $1,364 in year one and $1,408. Projections that approximate the median balance the opposing forces of feasibility and efficiency. (See Comparative Table). The applicant's CAPD in calendar year 2003 was reported as $1,230. The difference in the CAPD reported in 2003 and the projected CAPD of $1,415 results in an average compound annual increase of approximately 2.8 percent. This level of increase is below the inflation percentage outlined in the CMS Market Basket, 2nd Quarter, 2004, index. Therefore, projected expenses may be understated.

The year two operating profit for the hospital of $12.7 million computes to an operating margin per adjusted patient day of $205 which is between the peer group median and highest value of $81 and $256. The operating margin computes to 12.7 percent, which indicates net revenues are in excess of costs. The projected operating margin is greater than the applicant's operating margin reported in 2003 of $7.8 million or 10.8 percent. As discussed above, the projected operating expenses appear to be understated; therefore, the projected operating margin may be overstated. This project is estimated to add approximately $93,652 to net profit from operations in year two.

With the noted exceptions above, overall the projections appear to be reasonable when compared to the control group. Therefore, this project is likely to be financially feasible.

COMPARATIVE TABLE

WELLINGTON REGIONAL MEDICAL CENTER, INC.

CON # 9811 **2003 DATA Peer Group 4**	Jan. 2009 YEAR 2 ACTIVITY	YEAR 2 ACTIVITY PER DAY	VALUES ADJUSTED FOR INFLATION Highest	Median	Lowest
ROUTINE SERVICES	210,937,950	3,405	1,091	619	340
INPATIENT AMBULATORY	0	0	285	107	27
INPATIENT SURGERY	0	0	0	0	0
INPATIENT ANCILLARY SERVICES	0	0	4,934	2,472	1,401
OUTPATIENT SERVICES	156,755,626	2,530	2,911	1,918	1,249
TOTAL PATIENT SERVICES REV.	367,693,576	5,935	7,787	5,476	3,701
OTHER OPERATING REVENUE	529,099	9	30	8	1
TOTAL REVENUE	368,222,675	5,944	7,788	5,480	3,716
DEDUCTIONS FROM REVENUE	267,871,412	4,324	0	0	0
NET REVENUES	100,351,263	1,620	2,388	1,491	1,082
EXPENSES					
ROUTINE	17,129,746	277	331	228	146
ANCILLARY	35,014,142	565	696	466	362
AMBULATORY	4,598,488	74	0	0	0
TOTAL PATIENT CARE COST	56,742,376	916	0	0	0
ADMIN. AND OVERHEAD	27,246,550	440	1,229	614	474
PROPERTY	3,638,721	59	0	0	0
TOTAL HOSPITAL EXPENSE	30,885,271	499	0	0	0
OTHER OPERATING EXPENSE	0	0	0	0	0
TOTAL EXPENSES	87,627,647	1,415	2,151	1,408	1,096
OPERATING INCOME	12,723,616	205	256	81	-158
		12.7%			
PATIENT DAYS	35,488				
ADJUSTED PATIENT DAYS	61,949				
TOTAL BED DAYS AVAILABLE	56,940		VALUES NOT ADJUSTED FOR INFLATION		
ADJ. FACTOR	0.5729				
TOTAL NUMBER OF BEDS	156		Highest	Median	Lowest
PERCENT OCCUPANCY	62.33%		83.8%	57.7%	25.2%
PAYER TYPE	PATIENT DAYS	% TOTAL			
SELF PAY	1,502	4.2%			
MEDICAID	3,757	10.6%	33.9%	8.6%	1.6%
MEDICAID HMO	690	1.9%			
MEDICARE	8,536	24.1%	81.5%	60.7%	22.3%
MEDICARE HMO	6,541	18.4%			
INSURANCE	85	0.2%			
HMO/PPO	13,427	37.8%	56.1%	34.3%	8.5%
OTHER	950	2.7%			
TOTAL	35,488	100%			

e. 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 58.2 percent of its patient days. This level of managed care exceeds the highest value in the group of 56.1 percent. The proposed NICU III project was compared to all other hospitals in the state with approved NICU III programs. Schedule 7's total gross revenue for the project only is estimated at $8,052,777 for year two. With 1,384 patient days anticipated, the gross revenue (gross charges) per patient day computes to $5,818. This amount is between the median and highest values of $3,862 and $7,579 respectively. With the level of managed care exceeding the highest value in the group and the NICU III charges between the median and highest values, if realized, the hospital will likely encourage competition in the local market.

f. Are the proposed costs and methods of construction reasonable? Do they comply with statutory and rule requirements? ss. 408.035(10), Florida Statutes; Ch. 59A-3 or 59A-4, Florida Administrative Code.

The applicant proposes to add 15 new Level III NICU beds to an existing Level II NICU at Wellington Regional Medical Center.

The plan is particularly well done and almost every required space or function listed in The Guidelines, Section 7.3.E, has been provided, and is well placed within the unit or in adjacent spaces.

Two items are not specifically shown on the enclosed floor plan:

- The physicians' sleeping room does not appear to have access to a shower. Possibly, there is one in the adjacent staff lounge/lockers/toilet room.

- The parents' room does not show direct private access to a sink or toilet as required.

The code references are essentially correct and the costs and schedule are most likely realistic if only relatively minor demolition/renovation is required. No extent of demolition is identified.

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.

g. Does the applicant have a history of providing health services to Medicaid patients and the medically indigent? Does the applicant propose to provide health services to Medicaid patients and the medically indigent? ss. 408.035(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) 2003 actual data prepared by AHCA.

Medicaid and Charity Care Commitment
For Wellington Regional Medical Center
Compared to the District

	FY 2003 Conventional Medicaid Days	FY 2003 Gross Charity Days Percentage
Wellington Regional	11.9%	0.7%
District 9 Average	12.0%	1.9%

Source: FY 2003 Actual Data/AHCA

Wellington's provision of both Medicaid and charity care is below the district average. The applicant proposes to condition 28.9 percent of its patient days in the Level III NICU to Medicaid/Medicaid HMO and charity care patients on a combined basis.

F. SUMMARY

Wellington Regional Medical Center, Inc. proposes to establish a 15-bed Level III NICU to be located at Wellington Regional Medical Center (District 9).

The total project cost is estimated at $2,865,700. Renovation costs are projected at $1,581,875 and the project will involve 9,450 gross square feet (GSF) of renovated space.

Need:

A fixed need pool of zero was published for Level III NICU services in District 9. The applicant is applying outside of the fixed need pool and indicates it is applying under special (not normal) circumstances. Evidence was presented to support the applicant's contention that Level III NICU services are geographically mal-distributed in District 9 and Palm Beach County. Special circumstances exist in the district to warrant additional services.

Access:
The applicant does not show that there is a problem in the district accessing Level III NICU services. However, because of the mal-distribution of Level III NICU beds in the district, this project would improve access to Level III NICU services among residents living in the western section of the district.

Quality of Care:

The applicant is JCAHO accredited and a quality care provider.

Medicaid/Indigent Care:

According to the applicant's *Conditions* page, it will set aside at least 28.9 percent of its patient days in the Level III NICU to Medicaid/Medicaid HMO and charity care patients on a combined bases. Although the applicant is willing to condition award to serve the medically indigent population, there is concern that the project will negatively impact an existing RIPCC provider currently serving this same medically indigent population. However, since there is a mal-distribution of Level III NICU beds in the district, this project is likely to increase access to care to the medically indigent population, especially for residents in the western portion of the district.

Financial/Cost:

The applicant has a good short-term position and a weak long-term position. This project is likely to be financially feasible and the applicant will likely have access to capital as needed to complete this project. This project will most likely encourage competition in the local market.

Architectural:

There are no significant architectural concerns involved with the proposed project. Almost every required space or function lines has been provided in the plans and is well placed within the unit or in adjacent spaces. Required access to a shower in the physicians sleeping room and direct private access to a sink or toilet in the parents' room is not specifically shown in the plans. The code references are essentially correct. The extent of demolition required is not identified; however, if only relatively minor demolition/renovation is required, then the costs and schedule are most likely realistic.

G. RECOMMENDATION:

Approve CON #9811 to establish a 15-bed Level III Neonatal Intensive Care Unit (NICU) at Wellington Regional Medical Center. The project involves $1,581,875 in renovation costs and 9,450 GSF of space. Project costs total $2,865,700.

CONDITION: A minimum of 28.9 percent of the Level III NICU total patient days shall be provided to Medicaid/Medicaid HMO/ and charity care patients on a combined basis.

CON Action Number: 9811

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: ______________________

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Karen Rivera
Health Services and Facilities Consultant Supervisor
Certificate of Need

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Jeffrey N. Gregg
Chief, Bureau of Health Facility Regulation