

STATE AGENCY ACTION REPORT
CON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number:

Holmes Regional Medical Center, Inc./CON #9836

6450 US Highway 1
Rockledge, Florida 32955

Authorized Representative: Jerry Senne
(321) 434-5601

2. Service District/Subdistrict

District 7/Subdistrict 1 (Brevard County)

B. PUBLIC HEARING

No public hearing was requested.

The agency received 376 free-form letters and approximately 11,500 form letters by the April 20, 2005 deadline supporting the establishment of a new acute care facility in the Viera/Suntree area of Brevard County. These letters were received from residents, community leaders and members of the medical community, and presented variations on the following arguments: the Viera community and Brevard County are experiencing high population growth rates and increasing demands for emergency care; the proposed site will improve accessibility to health care for residents of this new community; traffic increases have exceeded road way capacities inhibiting access to care at existing facilities; the aging demographics of the area require increased available services; current driving times of 20-30 minutes to existing hospitals are unacceptable; the proposed facility would be farther inland to withstand hurricanes; there is a shortage of beds in Brevard County; seasonal populations push area occupancy rates beyond capacity.

The approximately 11,500 form letters of support were submitted in 10 bound volumes. All are identical in content and attest to the growing community and the disaster relief aspect of the site's inland location.

Fifty-seven letters of opposition were received by the omissions submission deadline, with the majority submitted by area physicians, including Health First physicians, arguing the following: no need exists for the proposed project; no accessibility problems exist in the area; the proposed facility would hurt private practices; physicians cannot add another hospital to their on-call status; staffing shortages would either prevent the applicant from appropriately staffing Viera Medical Center (VMC), or VMC would take staff from existing facilities; Holmes provides substandard care due to lack of staffing as evidenced by the understaffing of Palm Bay Community Hospital; Health First is already or is attempting to become a monopoly as evidenced by the Health First HMO, hospice and home health program; the proposed facility would hurt the Wuesthoff facilities; Health First argued no need existed in this area when Wuesthoff sought to build a Melbourne satellite.

One of these letters of opposition was submitted by the vice president of Finance and Strategic Planning for Wuesthoff Health System, making many of the same points as those of the area physicians. In addition to the above, this letter argues the following: Current expansion at Holmes should alleviate some of its overcrowding, as well as providing the applicant sufficient ability to expand in the future; beds added at Wuesthoff¹ further cancel need for an additional facility; 25 percent of the patients admitted at Holmes are patients from Palm Bay Community Hospital who have undergone a "triage and transfer" unnecessarily; VMC would likely also be a "triage and transfer" facility; less than 10 percent of Holmes admissions come from Viera/Suntree; Holmes could decompress at the underutilized Palm Bay Community Hospital, since its occupancy has hovered around 50 percent since its inception and sits on 50 acres of largely undeveloped land; VMC would not bring any new

¹ Wuesthoff-Melbourne has added 50 beds and has shelled space to add another 19, while Wuesthoff-Rockledge has recently added 22 beds and is in the process of building another floor to house another 24 beds in the next year.

programs or services to the area; all current and future residents of Viera are within 15 minutes of at least one hospital; VMC would not improve financial access for residents without insurance, leaving the burden of indigent care to Wuesthoff²; VMC could be financially devastating to Wuesthoff; VMC would reduce competition in the area and drive up health care costs.

C. PROJECT SUMMARY

Holmes Regional Medical Center, Inc. (CON #9836) is applying for a certificate of need (CON) to establish Viera Medical Center (VMC), an 84 private bed acute care satellite hospital with a full-service emergency department in Viera, District 7, Subdistrict 1 in Brevard County. The applicant operates Holmes Regional Medical Center, a Class 1 not-for-profit hospital currently licensed for 504 acute care beds and 10 Level II NICU beds, as well as Palm Bay Community Hospital with 60 acute care beds³. Health First, Inc., the parent company of the applicant, also operates the 150-bed Cape Canaveral Hospital in Cocoa Beach, Brevard County. The proposed VMC would be located west of Interstate 95 at the intersection of Lake Andrew Drive and Wickham Road on 50 acres purchased by Health First, Inc., with 20 acres allocated for the facility. The proposed VMC would be phase II of a multi-phase health care development planned for the site.

The applicant proposes the following conditions:

- The proposed facility will be located on 20 acres of a larger parcel at the southwest corner of Lake Andrew Drive and Wickham Road in Viera.
- At least three percent of inpatient cases at the proposed facility will be covered by Medicaid and/or Medicaid HMO, and at least 2.6 percent of gross revenues will be provided to charity care.
- The applicant will provide land, fully equipped and designed to support temporary staging of Disaster Medical Assistance Teams (DMAT).

² The letter writer refers to Wuesthoff as a disproportionate provider. Although Wueshtoff is not recognized by the Medicaid office as a Disproportionate Share Hospital (DSH), it provides approximately the level of Medicaid and charity care as does the subdistrict's DSH Parrish Medical Center. DSH regulates changed recently restricting DSH providers to public hospitals like Parrish.

³ The applicant anticipates adding 40 beds to Palm Bay Community Hospital, creating a 100-bed facility. With the 40 beds and this 84-bed proposal, the number of beds on the Holmes license would increase from 574 to 698.

The reported total project cost is \$104,766,044. Total construction costs are reported at \$44,950,387 and the project will involve 213,334 GSF of new construction.

D. REVIEW PROCEDURE

The evaluation process is structured by the certificate of need review criteria found in Section 408.035, Florida Statutes and rules of the State of Florida, Chapters 59C-1 and 59C-2, Florida Administrative Code. 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 evaluating the responses and data 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(s) best meet the review criteria.

Rule 59C-1.010(3)(b), Florida Administrative Code, prohibits any amendments once an application has been 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 Karen Weaver analyzed the application with consultation from the financial analyst Ryan Fitch, who reviewed the financial data, and 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 with the review criteria and application content requirements found in Sections 408.035, and 408.037, and applicable rules of the State of Florida, Chapters 59C-1 and 59C-2, Florida Administrative Code.

1. Fixed Need Pool

- a. Does the project proposed respond to need as published by a fixed need pool? Or does the project proposed seek beds or services in excess of the fixed need pool? Ch. 59C-1.008(2), Florida Administrative Code.**

In Volume 31 Number 4 of the Florida Administrative Weekly dated January 28, 2005, a fixed need pool of zero beds was published for acute care beds in all of District 7 for the January 2005 batching cycle. On April 15, 2005 in Volume 31 Number 15 of the Florida Administrative Weekly, the agency published a notice of withdrawal of the fixed need pools for acute care hospital beds that was published on January 28, 2005. As of this writing, a petition challenging this withdrawal of the fixed need pool is pending before the agency. This project is not submitted in response to published numeric need but is predicated upon arguments of special circumstance as detailed below.

District 7, Subdistrict 1 had a total of 1,207 licensed acute care beds⁴ with an occupancy rate of 67.49 percent for the July 2003 through June 2004 reporting period, and Holmes RMC saw a 79.23 percent occupancy during this same time. An additional 68 beds⁵ are approved for Wuesthoff-Rockledge in Subdistrict 1 and will bring the subdistrict's total number of licensed beds to 1,325. Also, the applicant states that it intends to expand Palm Bay Community Hospital by 40 beds.

The proposed service area covers 165 square miles and five zip codes around the Viera community: 32940, 32955, 32934, 32935 and 32904. Two facilities currently exist within these five zip codes, Wuesthoff Medical Center – Rockledge and Wuesthoff Medical Center – Melbourne. The applicant does not define a secondary service area. Four other facilities exist in the subdistrict three of which are Health First facilities⁶. Of the existing subdistrict facilities, Holmes RMC maintained the highest occupancy level for the most recently reported 12-month period:

⁴ 1,207 beds were used to compute the utilization percentage of 67.49. Since that percentage was calculated, Wuesthoff Medical Center-Melbourne added 50 beds (resulting in the bed count quoted in Florida Hospital Bed Need Projections by District Volume I) and Wuesthoff Medical Center-Rockledge added 22 beds. As of the writing of this report, the current bed count for District 7 Subdistrict 1 is 1,279.

⁵ Agency records indicate that 22 of these had become licensed as of the writing of this report.

⁶ Cape Canaveral Hospital, Holmes Regional Medical Center and Palm Bay Community Hospital

Utilization of Licensed Acute Care Beds in District 7-1 from 7/2003-6/2004

Facility	Occupancy
Cape Canaveral Hospital	54.05%
Holmes Regional Medical Center	79.23%
Palm Bay Community Hospital	52.58%
*Parrish Medical Center	45.85%
Wuesthoff Medical Center - Rockledge	73.84%
Wuesthoff Medical Center - Melbourne	70.26%
Subdistrict 1	67.49%
District 7	67.98%

* Disproportionate Share Provider

Source: Florida Hospital Bed and Service Utilization by District, Volume II, January 2005 Batching Cycle

Occupancy levels in the district range from a high at the applicant’s flagship facility, Holmes RMC, down to Parrish Medical Center, the subdistrict’s Disproportionate Share Provider⁷. Three facilities achieved occupancy levels greater than the subdistrict average during this time, those being Holmes RMC and the two Wuesthoff facilities. The other two Health First facilities in this subdistrict, Cape Canaveral Hospital and Palm Bay Community Hospital, experienced levels below that of the district and subdistrict, at 54.05 percent and 52.58 percent respectively. Occupancy levels indicate possible need for decompression at Holmes RMC, but do not necessarily indicate need for an additional facility in light of §408.036(5)(c) of the Florida Statutes, which requires only notification to the agency, not further CON approval, when a health care facility should seek to add beds to its count. For example, the applicant states that it intends to expand Palm Bay Community Hospital (Palm Bay), an underutilized 60-bed acute care hospital, to almost double in size creating a 100-bed facility without CON review.

The Holmes RMC campus is said to be at capacity, and substantiating information for this is included from *Florida Today*, letters of support and personal testimonials included in the CON application.

The applicant explores three alternatives to the proposed project:

1. Build out the eighth floor of the new north tower at Holmes RMC.
2. Not convert semi-private rooms to private rooms.
3. Build the “mirror tower.”

The applicant states that the first alternative is not feasible because this floor and other space within the existing plant have other planned purposes, including a new heart center, a new ED and trauma center. Holmes RMC is attempting to move toward all private rooms, and the first two alternatives would be contrary to this. The applicant reports there is no way to add beds to the existing facility or its new tower without compromising this private bed strategy, or expanding ancillary

⁷ As published by the agency November 23, 2004.

and support functions, which would be difficult and costly due to physical constraints. Currently, Holmes RMC has 1,192 square feet per bed, and this will increase to 1,926 once the North Tower is completed. The applicant reports that modern hospitals are typically designed to allow as much as 2,400 square feet per bed, and that Holmes RMC is thus undersized and inadequate by newer hospital standards; however, the agency architectural reviewer could not verify that either 2,400 square feet per bed is typical design or that Holmes RMC is inadequate by newer hospital standards. The applicant explains that to infringe upon this square footage per bed any further would result in cramped conditions and inefficient service. The kitchen at Holmes RMC is said to be half the recommended size for its patient load, and the existing radiology, laboratory and pathology are similarly undersized. Holmes RMC is also hoping to recapture some of the areas currently used for patient holding and convert these areas back to support functions, as all support functions non-essential to clinical operations have been moved out of the hospital⁸. The third alternative is not explained at length, but appears to be a reference to facility replacement at Holmes RMC, which would also be difficult and costly.

The applicant states there is insufficient land capacity at the existing facility to account for parking increases and any future expansion deemed necessary to accommodate population growth, and that the proposed facility would not be land-locked in such fashion. Land around the hospital is said to be largely owned by parties not affiliated with the hospital, and the applicant has previously attempted to purchase these properties with no success.

The current facility is said to be unable to structurally support a vertical expansion, and horizontal expansion is limited by streets, existing buildings and the applicant's future plans of expanding the hospital's parking, main lobby and drive through entrance. The existing campus is said to be out of compliance with current storm water retention requirements that have become effective after original construction of the facility: land area would have to be reserved for water retention areas should a major construction project ensue, and the applicant's ability to build patient bed space would be further inhibited. It is not explained why this retention area was not required with the construction of the new north tower.

The possibility of expanding across the street is also explored, but the applicant dismisses this possibility due to the impracticality of placing patients away from the hospital's clinical core.

⁸ Those support services moved out of the hospital are specifically named to be human resources, employment, employee health, safety and security, marketing, legal, medical staff support and credentialing, foundation and information technology.

It is not clear why the applicant expects VMC to be a successful run-off facility when success has not been achieved at its other facility, which is closer geographically to Holmes than the proposed facility would be. Should Palm Bay become a more viable facility, then a fourth option, not explored by the applicant, would be better utilization at Palm Bay along with the planned 40-bed expansion of that facility. Palm Bay becoming a viable option for its own patient population would help decompress the main campus.

The applicant contends that two primary circumstances warrant approval of the proposed project:

1. Rapid population growth in Viera is increasing the demand for health care services; as discussed below, it is not demonstrated that planned additions at Palm Bay and non-applicant facilities in the subdistrict will not provide adequate decompression for Holmes without benefit of the proposed project.
2. Existing community and health care infrastructures are insufficient to support population growth, impeding the availability of emergency health care; as discussed below, it is not demonstrated that planned additions at Palm Bay and non-applicant facilities in the subdistrict will not meet growing needs in this community without the proposed facility.

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In response to point one, the applicant credits the U.S. Census as counting 42,000 residents in the Viera and Suntree areas in year 2000. The 2000 U.S. Census credited the five PSA zip codes with a population of 117,697, and the applicant provides a Claritas quote of 135,798 for year 2004, which would be a 15.38 percent increase over four years. The following table is provided by the applicant and attributed to Claritas:

Viera Medical Center's 2004 to 2009 Primary Service Area Population Profile

Zip Code	2004	2009	Change	Percent Change
32940	26,835	35,941	9,106	33.9%
32955	29,072	33,956	4,884	16.8%
32904	21,313	25,381	4,068	19.1%
32934	18,039	19,743	1,704	9.4%
32935	40,539	42,314	1,775	4.4%
PSA Total	135,798	157,335	21,537	15.9%
Brevard County	509,940	552,168	42,228	8.3%

Source: CON Application #9836, attributed to Claritas

The above data, if correct, would indicate a growth rate for the PSA almost twice that of the county. Estimates published by the agency illustrate growth patterns for the county, district and state:

**Population Growth Rates for Brevard County, District 7 and the State of Florida
01/2000 - 01/2010**

Date	Total County Population	Growth %	Total District Population	Growth %	Total State Population	Growth %
1-Jan-00	473,972		1,892,654		15,883,205	
1-Jan-01	482,938	1.89%	1,957,606	3.43%	16,245,736	2.28%
1-Jan-02	491,611	1.80%	2,016,159	2.99%	16,585,793	2.09%
1-Jan-03	504,262	2.57%	2,079,905	3.16%	16,970,984	2.32%
1-Jan-04	515,640	2.26%	2,139,714	2.88%	17,342,993	2.19%
1-Jan-05	523,757	1.57%	2,192,175	2.45%	17,679,224	1.94%
1-Jan-06	532,015	1.58%	2,244,528	2.39%	18,011,798	1.88%
1-Jan-07	540,602	1.61%	2,297,267	2.35%	18,343,562	1.84%
1-Jan-08	549,107	1.57%	2,349,529	2.27%	18,671,180	1.79%
1-Jan-09	557,544	1.54%	2,401,399	2.21%	18,995,543	1.74%
1-Jan-10	565,913	1.50%	2,452,953	2.15%	19,317,436	1.69%

Source: Population Estimates, as published by the AHCA Certificate of Need Office, April 2005

As seen above, county and district populations grew from 2000-2005 and are projected to continue growing through 2010, although at a decreasing rate. While it is reasonable that the Viera area would be growing at rates equal to or exceeding that of the county, it should be noted that an area embarking on development would typically see higher growth percentages than that of an established area because each small addition makes a larger percentage difference to the smaller area than would those same small additions make to a larger area. The applicant provides evidence of growth with several examples of road widenings, housing starts and increased retail establishments, and quotes numerous articles from the *Florida Today* publication commenting on projected continued growth. The Viera Company is said to be adding an

additional 12,000 acres to the community, increasing this target area to 33 square miles. A representative of Health First expressed to the reviewer during a site visit made on March 31, 2005 (prior to deeming current batch cycle applications complete) that retail development in Viera has been denied due to road capacity limitations.

The applicant has used Claritas Zip Code data for its analysis and provided Claritas estimates for Brevard County.

**Comparison of Brevard County Population Estimate for 2004
Applicant's Claritas Number and Published Agency Number**

Claritas Estimate	Agency Estimate
509,940	519,972

Source: CON application and Population Estimates Published April 2005

As shown above, the Claritas estimate is more conservative than the Agency's published estimate for July 1, 2004.

Over-65 rates (or "elderly") in the PSA are also said to be increasing, with the following percentages offered by the applicant:

Viera Medical Center's Primary Service Area 2004 Elderly Population Distribution

Zip Code	Total	65 & >	65-74	75 and Older
32940	26,835	28.4%	14.8%	13.6%
32955	29,072	18.3%	10.3%	8.0%
32904	21,313	29.1%	13.0%	16.1%
32934	18,039	15.8%	8.9%	6.9%
32935	40,539	16.9%	9.0%	7.9%
PSA Total	135,798	21.2%	11.0%	10.2%
Brevard County	509,940	20.1%	10.7%	9.4%

Source: CON Application 9836, attributed to Claritas

The above data, if correct, would indicate a somewhat higher concentration of elderly population in Viera than that of Brevard County. The following estimates are published by the agency on elderly population growth for Brevard County, District 7 and the State of Florida:

**Elderly Population Growth Rates for Brevard County
District 7 and the State of Florida - 01/2000 - 01/2010**

Date	Elderly County Population	Growth %	Elderly District Population	Growth %	Elderly State Population	Growth %
1-Jan-00	94,232		241,500		2,796,279	
1-Jan-01	95,471	1.31%	247,521	2.49%	2,840,368	1.58%
1-Jan-02	97,200	1.81%	255,765	3.33%	2,913,502	2.57%
1-Jan-03	99,814	2.69%	264,347	3.36%	2,990,031	2.63%
1-Jan-04	101,855	2.04%	271,772	2.81%	3,057,275	2.25%
1-Jan-05	103,080	1.20%	278,533	2.49%	3,120,312	2.06%
1-Jan-06	104,507	1.38%	286,075	2.71%	3,189,721	2.22%
1-Jan-07	106,209	1.63%	294,555	2.96%	3,267,048	2.42%
1-Jan-08	108,092	1.77%	303,920	3.18%	3,351,614	2.59%
1-Jan-09	110,184	1.94%	314,261	3.40%	3,444,270	2.76%
1-Jan-10	112,512	2.11%	325,692	3.64%	3,545,772	2.95%

Source: Population Estimates, as published by the AHCA Certificate of Need Office, April 2005

As seen above, elderly growth rates in the county are consistently lower than rates for the district and state. Elderly populations are increasing, but this increase is less significant than that of the rest of the district or state.

The applicant has included several tables and charts designed to demonstrate growth, many of which cannot be verified by the reviewer. One table in particular references a growth in the numbers of patients treated and transported to a trauma center in Brevard County, which is a point brought up in letters of opposition. According to these letters, Health First uses its other facilities as “Triage and Transfer” for the purposes of increasing volume at Holmes Regional. For the applicant to illustrate a 20.8 percent growth in this type of service seems to support the contentions of the opposition. Holmes RMC trauma center annual visits are said to have increased by 55 percent from 1999 to 2005. Many of the statistics are quoted directly from the *Florida Today* newspaper publication, which does not credit its sources of information and thus cannot be verified by the reviewer.

The applicant provided an assessment of the community’s ability to support a hospital and the hospital’s projected impact on surrounding facilities. Results of this analysis are reported to be that the VMC service area’s medical/surgical discharges increased more than 38 percent from 2000 to 2004, versus the county increase of 23.0 percent. The applicant’s projections indicate sufficient volume growth projections for the area to allow all area hospitals, with the exception of Holmes Regional, to achieve volumes in excess of their 2004 volumes, even with the addition of Viera Medical Center. However, as noted earlier, Wuesthoff submitted a letter of opposition indicating that its analysis concludes that it will be negatively impacted if this hospital is

established. The following table illustrates primary market share within the primary service area:

Non-Tertiary Primary Market Share as Percent of Admissions and as a Percent of Patient Days Subdistrict 1 for Calendar Year 2004

Facility	% Admissions	% Patient Days
Holmes Regional Medical Center	49.09%	52.82%
Wuesthoff – Rockledge	23.06%	22.96%
Wuesthoff – Melbourne	17.60%	13.61%
Cape Canaveral Hospital	2.94%	2.71%
Palm Bay Community Hospital	1.22%	0.88%
*Parrish Medical Center	0.26%	0.27%

*Disproportionate Share Hospital

Source: State Center for Health Statistics

Likely impact on Wuesthoff facilities may be underestimated by the applicant, particularly since the applicant is projecting fewer patient days for the proposed facility in year two than it is currently serving at the main campus from this area⁹, as seen in section E.3.d. below.

It should be noted that while cardiovascular DRGs have been excluded from this analysis to approximate Viera Medical Center’s likely impact on area facilities, the architectural schematics submitted with this application include plans for a catheterization lab, a possible indication of future plans in this area. Should cardiac services and additional acute care beds, both exempt from CON review, be developed, the main campus might be further decompressed and existing providers further impacted.

The following table illustrates Medicaid and charity care provisions within the subdistrict:

District 7-Subdistrict 1 Medicaid and Charity Care Provision Percentages for Fiscal Year (FY) 2003

Facility	MCD	Charity Care	Total
Cape Canaveral Hospital	5.00%	1.70%	6.70%
*Holmes Regional Medical/Palm Bay	7.00%	2.60%	9.60%
**Parrish Medical Center	10.40%	2.30%	12.70%
Wuesthoff Memorial Hospital	10.90%	2.50%	13.40%
Wuesthoff Medical Center - Melbourne	9.80%	1.80%	11.60%
Subdistrict Average	8.62%	2.18%	10.80%

*Holmes Regional Medical Center and Palm Bay Community Hospital provided consolidated financial statements to the agency for fiscal year 2003, and thus their Medicaid and charity care percentages are combined.

** Disproportionate Share Hospital

Source: 2003 Hospital Financial Data, provided by the AHCA Financial Analysis Unit

During FY 2003, Wuesthoff facilities provided Medicaid and charity care at levels similar to Parrish Medical Center, the subdistrict’s

⁹ The applicant is projecting 20,492 patient days in year two for VMC. Holmes RMC is already providing 31,508 patient days for the services expected to be delivered by the satellite hospital in the primary service area.

Disproportionate Share Hospital. Health First facilities provided the lowest levels of Medicaid and charity care in the subdistrict during this time. Should the proposed project affect any non-applicant facility in this subdistrict, this impact would be felt at a facility more likely to provide Medicaid and charity care services than would the applicant.

It should be noted that data submitted within a letter of opposition from Wuesthoff Health System concluded that Holmes RMC and Palm Bay netted materially higher revenues from commercial managed care sources than did Wuesthoff facilities. The agency financial reviewer attempted to validate these conclusions. Although the level of net revenues for commercial managed care payers calculated by the agency's financial reviewer varied from the data in the opposition letter, the same conclusion was reached.

While it is not clear that population increases in the area are unusually high compared with other newly developing communities across the state, it does remain that Holmes Regional Medical Center is near capacity a relatively high percentage of the time and that even average population increases should push this percentage up over the next few years. Considering planned additions at Palm Bay and the possible decompression that represents for Holmes RMC, it is not clear that the applicant does not already have the necessary resources to decompress. Wuesthoff – Melbourne has added 50 beds and has shelled space to add another 19, while Wuesthoff – Rockledge has recently added 22 beds and is in the process of building another floor to house another 24 beds in the next year. With these planned additions, decompression may already be imminent for Subdistrict 1, without an approval of the proposed project.

Point two emphasizes that community infrastructures are insufficient to support the growth argued in point one. Again, much of the supporting argument for this point is quoted from the *Florida Today* newspaper publication, which does not credit its source and thus cannot be verified by the reviewer. The applicant does state that the nearest hospital is approximately 10 miles away from the location of the proposed facility, which does not agree with information verified by the reviewer. The following table illustrates travel distances in miles between subdistrict facilities and the proposed facility:

Travel Distances in Miles Between Existing and Proposed Subdistrict 1 Facilities

	<i>Cape Canaveral Hospital</i>	<i>Holmes Regional Medical</i>	<i>Palm Bay Community</i>	<i>*Parrish Medical Center</i>	<i>Wuesthoff - Rockledge</i>	<i>Wuesthoff - Melbourne</i>	<i>**Proposed Facility</i>
Cape Canaveral Hospital		21.2	27.7	27.4	8.5	20.0	16.7
<i>Holmes Regional Medical</i>	21.2		7.2	40.7	18.8	5.2	11.7
<i>Palm Bay Community</i>	27.7	7.2		47.2	25.3	11.3	18.3
<i>*Parrish Medical Center</i>	27.4	40.7	47.2		22.1	37.5	30.3
Wuesthoff - Rockledge	8.5	18.8	25.3	22.1		15.5	8.4
Wuesthoff - Melbourne	20.0	5.2	11.3	37.5	15.5		7.8
<i>**Proposed Facility</i>	16.7	11.7	18.3	30.3	8.4	7.8	

*Disproportionate Share Hospital

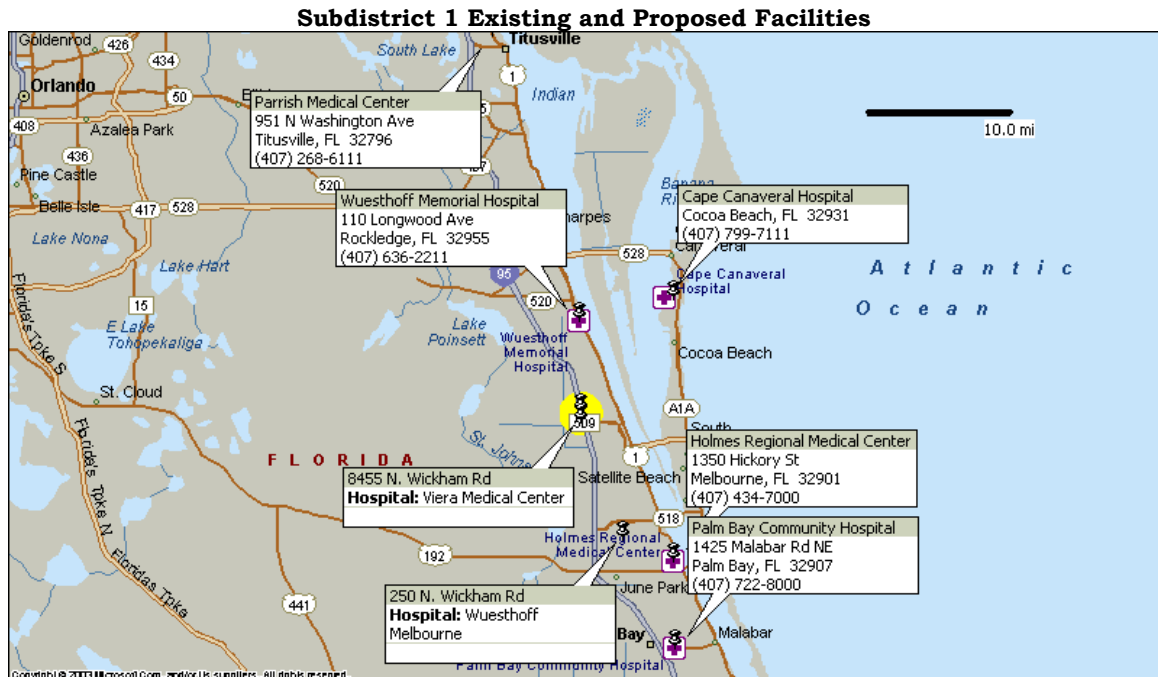
**Address used in this analysis belongs to a Super Target store on the same corner with the proposed facility. The proposed site is currently a green space and does not have a useable address.

Source: Expedia.com

As seen above, the proposed facility will be closest to Wuesthoff – Rockledge and Wuesthoff – Melbourne, both of which will be within the ten-mile figure quoted by the applicant. Travel times from Viera to nearby emergency departments are said to exceed 30 minutes, largely due to railroad tracks crossing between Wuesthoff – Rockledge and the target area. Traffic is also reported as a contributing factor to increased travel times, but information provided suggests that planning authorities are taking this into account considering the road improvements either under construction or planned for the next two years identified by the applicant on page 3 of the CON application. While these road improvements/widenings are taking place over the next two years, VMC would not have yet begun operations, so circumventing traffic doesn’t seem to be an appropriate argument for this particular application. A representative of the applicant expressed in a face-to-face interview with the reviewer that areas east of I-95 are built out and no space is available for an additional facility. The focus of new construction and meeting expanding needs is on the areas west of I-95, from which the proposed facility would be approximately one mile away.

The applicant maintains that after the hurricanes of 2004 the community requires a hospital further inland to accept patient transfers from evacuated hospitals during coastal disasters; however, the small

number of beds at the proposed facility would limit its ability to serve in this role.



As seen in the above map of the service area¹⁰, the proposed site is not much farther inland than existing facilities, and would be afforded little if any additional protection by its geography relative to other Subdistrict 1 hospitals. Holmes RMC is not significantly closer to the shore than is the proposed site of VMC, yet several buildings around Holmes RMC have visible damage almost one year after the hurricanes. According to information provided by the applicant on page 59 of the CON application, Wuesthoff – Rockledge hospital kept its emergency department open during the storm and Wuesthoff – Melbourne remained fully operational before, during and after the storm. While if not hit by a storm, VMC would be one more functioning facility, need for this is not so great as to solely justify construction of an additional facility, which would have year-round repercussions on existing facilities. It is true that hurricane codes have strengthened in the last few years and VMC would be held to these stricter codes.

The applicant states that the VMC campus would have additional acreage adjacent to the facility that would act as a casualty collection point (CCP) for any terrorist event and/or any issues relating to the local nuclear power plant. The site would support a Disaster Medical Assistance Team (DMAT) and Alternate Treatment Site (ATS) operations

¹⁰ The address used for the proposed site is that of a Super Target store located at the same intersection as that of the designated site.

for Brevard County, and be equipped to be a Point of Dispensing with stockpiles of medications and/or vaccines in the event of a biological attack or other significant event. The nearest DMAT to Brevard County is in Orlando, where reportedly several Health First associates are members. However, unless Holmes RMC and Wuesthoff – Rockledge were directly impacted by a terrorist event, their broader services and greater capacity would make them more likely resources for the community, rather than the limited size and scope of services at the proposed facility.

The applicant did not demonstrate need for the proposed project once planned bed additions have been made at Wuesthoff facilities and Palm Bay Community Hospital. The applicant did not demonstrate why Holmes RMC could not be decompressed at the under-utilized Palm Bay Community Hospital. As seen below in section E.3.a., Wuesthoff facilities have experienced significant increases in utilization over the last three years, while Health First facilities have experienced slight to heavy decreases in utilization during this same time. The proposed project may have been submitted to recapture slipping market share rather than in response to need in the community.

2. Agency Rule Criteria

The Agency does not currently have adopted preferences or Rule criteria relating to acute care beds. The acute care rule was repealed as a result of statutory changes made on July 1, 2004. The rule repeal was effective April 21, 2005.

3. 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(1), (2), (5) and (7), Florida Statutes.**

Availability and Utilization

The average utilization percentage for the subdistrict was 67.49 percent from July 2003 through June 2004. The applicant's flagship facility Holmes RMC led the subdistrict for average annual utilization during this period with 79.23 percent, but the applicant's Palm Bay facility demonstrated the second lowest utilization in the subdistrict during this same time with 52.58 percent. The absolute lowest occupancy percentage for this period was 45.85 percent at the subdistrict's Disproportionate Share Hospital, Parrish Medical Center. Of the three facilities falling below the subdistrict average for utilization, two were Health First facilities as seen below:

Utilization of Licensed Acute Care Beds in District 7-1 from 7/2003-6/2004

Facility	Occupancy
*Cape Canaveral Hospital	54.05%
*Holmes Regional Medical Center	79.23%
*Palm Bay Community Hospital	52.58%
**Parrish Medical Center	45.85%
Wuesthoff Medical Center – Rockledge	73.84%
Wuesthoff Medical Center – Melbourne	70.26%
Subdistrict 1	67.49%
District 7	67.98%

*Health First facility

** Disproportionate Share Provider

Source: Florida Hospital Bed and Service Utilization by District, Volume II, January 2005 Batching Cycle

Holmes RMC not only led the subdistrict in utilization during this time, but also reached a peak season utilization of 83.46 percent, also higher than any other facility. Seasonal utilization from July 2003 through June 2004 is illustrated in the table below:

Seasonal Utilization of Licensed Acute Care Beds in District 7-1 from 7/2003-6/2004

Facility	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Annual
Cape Canaveral Hospital	51.50%	51.38%	61.36%	52.01%	54.05%
Holmes Regional Medical Center	77.70%	78.56%	83.46%	77.22%	79.23%
Palm Bay Community Hospital	44.06%	51.56%	60.42%	54.38%	52.58%
*Parrish Medical Center	40.01%	45.03%	52.27%	46.19%	45.85%
Wuesthoff Medical Center - Rockledge	70.45%	72.58%	81.94%	70.43%	73.84%
Wuesthoff Medical Center - Melbourne	64.48%	71.81%	76.33%	68.47%	70.26%
Subdistrict 1	64.14%	66.53%	73.48%	65.85%	67.49%
District 7	64.94%	67.47%	72.08%	67.46%	67.98%

* Disproportionate Share Provider

Source: Florida Hospital Bed and Service Utilization by District, Volume II, January 2005 Batching Cycle

Considering the low utilization levels prevalent at Palm Bay Community Hospital, it is not clear why decompression of Holmes RMC cannot occur there. The applicant states its intention to add beds at Palm Bay, which would likely further dilute that facility's occupancy levels. With almost half of Palm Bay's beds sitting vacant, the applicant does not demonstrate that it does not currently have the resources to decompress Holmes RMC.

The following table is repeated from earlier discussion to illustrate primary market share in this proposed service area:

Non-Tertiary Primary Market Share as Percent of Admissions and as a Percent of Patient Days Subdistrict 1 for Calendar Year 2004

Facility	% Admissions	% Patient Days
Holmes Regional Medical Center	49.09%	52.82%
Wuesthoff – Rockledge	23.06%	22.96%
Wuesthoff – Melbourne	17.60%	13.61%
Cape Canaveral Hospital	2.94%	2.71%
Palm Bay Community Hospital	1.22%	0.88%
*Parrish Medical Center	0.26%	0.27%

*Disproportionate Share Hospital

Source: State Center for Health Statistics

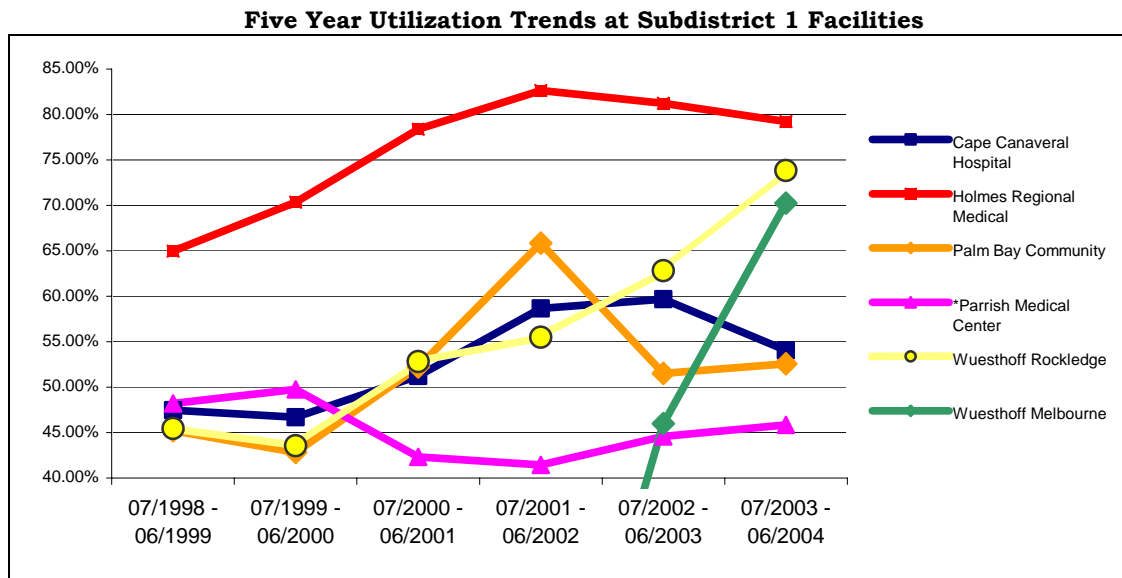
As seen above, Holmes RMC and the two Wuesthoff facilities provide the majority of services to patients residing in the PSA, and therefore any impact resulting from the proposed project would likely most affect these three facilities.

The need to improve the availability of emergency department services is a primary focus of the applicant's argument. Several points are listed on page 73 of the CON application listing the applicant's over capacity issues in the Holmes RMC ED, including: increasing "Left Without Treatment" (LWOT) numbers; patients delaying going to the ED because of long wait times, resulting in increased acuity; diversion of the ED and denials of requests for diversion of the ED; ambulances wait times at the Holmes ED due to unavailability of staff, thereby preventing EMS personnel from responding to calls. The applicant provides numerous articles and editorials from *Florida Today* further detailing problems with overcrowding in the Holmes ED.

As seen in the seasonal utilization table above, Holmes RMC led the subdistrict in utilization through all seasonal fluctuations, yet Palm Bay Community Hospital, the applicant's secondary facility, maintained levels significantly below that of the subdistrict average. As demonstrated above, busier seasons drive Holmes over 80 percent occupancy while slower seasons do not provide great decreases in these levels. Palm Bay Community Hospital maintains levels consistently and significantly below subdistrict averages year round, and Palm Bay alternates places

with Cape Canaveral Hospital (Health First facility) for the second and third lowest utilization spots in the subdistrict throughout the illustrated time period. Evaluation of utilization levels in the subdistrict and evidence of decreased availability of services at Holmes RMC demonstrate a need for decompression at Holmes RMC, but it is not clear why available space has not been utilized at Palm Bay, particularly considering the applicant’s stated intention to add 40 beds to that currently underutilized facility.

As seen below, utilization has significantly increased over the last five years for Holmes RMC and both Wuesthoff campuses; however, utilization at other subdistrict facilities has been volatile, with the most recent percentages resembling those of five years ago. In the case of Parrish Medical Center, the subdistrict’s Disproportionate Share Hospital, utilization has actually decreased over the last five years. Palm Bay’s utilization decreased about the time of the initiation of services at Wuesthoff – Melbourne, as did the utilization at Cape Canaveral Hospital, which had been slowly increasing its percentages during these years. Holmes RMC experienced an interruption in its upward trend right about that same time.



Source: AHCA’s Florida Hospitalization and Service Utilization by District for each period shown

The drop in utilization at area facilities with the initiation of services at Wuesthoff-Melbourne could be due to insufficient clinical personnel in the area to support an additional facility. If that is the case, then the addition of a seventh facility could show further decline in existing facility utilization. While this would help Holmes RMC, it would not help any other facility, including Palm Bay and Cape Canaveral.

No additional services would be offered with the proposed project than are already available in the subdistrict. District 7, Subdistrict 1 had a total of 1,207 licensed acute care beds¹¹ with an occupancy rate of 67.49 percent for the July 2003 through June 2004 reporting period, and Holmes RMC saw a 79.23 percent occupancy during this same time. An additional 68 beds¹² are approved for Wuesthoff - Rockledge in Subdistrict 1 and will bring the subdistrict's total number of licensed beds to 1,325. In addition, the applicant states its intent to expand Palm Bay Community Hospital by 40 beds, with an explanation that does not fully address need given the low occupancy rate. The applicant states that Palm Bay is expected to achieve market share growth through 2008 at the expense of Holmes RMC, but this would seem to further contradict the applicant's argument for the proposed project. The applicant states that in an attempt to alleviate high volumes at Holmes RMC, non-clinical support services have been moved out of the hospital into separate buildings to free space for clinical functions, and 46 beds have recently been added¹³ to accommodate overflow patients. Several other areas are mentioned as having been added or converted so as to accommodate ED patients. Availability of services and utilization of existing acute care beds at Holmes RMC suggest evidence of need for the proposed project, but this same analysis on Palm Bay, Parrish Medical Center and Cape Canaveral Hospital suggests no need.

In District 7 Subdistrict 1, overall utilization levels do not indicate need for the proposed project. Further, additional beds are in approval processes.

¹¹ 1,207 beds were used to compute the utilization percentage of 67.49. Since that percentage was calculated, Wuesthoff Medical Center-Melbourne added 50 beds (resulting in the bed count quoted in Florida Hospital Bed Need Projections by District Volume I) and Wuesthoff Medical Center-Rockledge added 22 beds. As of the writing of this report, the current bed count for District 7 Subdistrict 1 is 1,279.

¹² Agency records indicate that 22 of these had become licensed as of the writing of this report.

¹³ Agency records indicate a bed change was approved 12/01/2003.

Quality of Care

Quality of care at existing facilities could be affected by an approval of this project due to staffing shortages statewide. Many of the letters of opposition to this project are from area physicians expressing their inability to add another facility to their rounds. Emergency room specialty physicians would be a point of concern for this project, and the applicant's ability to staff its proposed facility with physicians is an important issue with this application. A few area physicians submitted letters of support and intentions of admitting privileges at the new facility, including intentions at the VMC ED. Should an insufficient number of physicians find it acceptable to add another facility to their rounds without dropping an existing facility from their rounds, staffing problems could develop at other facilities in the subdistrict and district. The utilization trend graph shown above demonstrates that the introduction of a new facility to this subdistrict will have impact on hospitals with low and high utilization levels. Further discussion of the applicant's ability to provide quality of care may be found in section E.3.b. of this report.

The applicant details its internal processes for quality assurance, including patient surveys, market research and various awards and accreditations that Health First facilities have received. There is no evidence to indicate quality of care is not present at the applicant's facilities.

Efficiency

The applicant suggests the efficiency of services within the Health First network would be unaffected with this project. Viera Medical Center would make use of centralized support functions such as human resources, risk management and quality management, thereby promoting economy of scale. Integrated clinical information support would be implemented with this project, further facilitating clinical decisions, physician order entry and access to patient information.

Managed care reimbursement efficiency in the subdistrict, however, would appear to decrease with this proposed project. As previously mentioned, Wuesthoff Health System provided a letter of opposition detailing case mix index (CMI)-adjusted average inpatient revenue per admission and per patient day figures for Health First and Wuesthoff facilities in Subdistrict 1. The agency financial reviewer attempted to validate these figures, and drew the similar conclusion that figures for Health First facilities trend higher than those for Wuesthoff facilities.

The following tables were provided in the Wuesthoff Health System letter of opposition:

Commercial Net Price Comparison of Health First vs. Wuesthoff for FY 2003-2004			
Facility	CMI Adjusted Commercial Average Net IP Revenue Per:		
		Admission	Patient Day
Wuesthoff - Melbourne			
	2003	\$ 4,822	\$1,717
	2004 through Aug	\$ 4,640	\$1,608
Wuesthoff - Rockledge			
	2003	\$ 4,940	\$1,494
	2004 through Aug	\$ 5,133	\$1,434
Holmes Regional Medical Center			
	2003	\$ 9,308	\$2,340
	2004 through July	\$11,189	\$2,781
Cape Canaveral Hospital			
	2003	\$ 8,377	\$2,634
	2004 through July	\$ 9,270	\$3,131
Palm Bay Community Hospital			
	2003	\$ 7,264	\$2,054
	2004 through July	\$ 9,594	\$2,875

Weighted System Commercial CMI-Adjusted Average IP Net Revenue Per Day		
Central Brevard	South Brevard	Fiscal Year
Wuesthoff Health Systems		
\$1,511	\$1,653	2003
\$1,447	\$1,558	2004 - Aug
Health First		
\$2,520	\$2,792	2003
\$2,995	\$2,792	2004 - July

As can be seen in the above two tables, Health First facilities have significantly higher revenues both per admission and per patient day. If Viera Medical Center would experience a level of net revenue consistent with Holmes RMC, then an approval of the proposed project would add a higher managed care reimbursement alternative to the service area.

Accessibility

Accessibility to existing facilities is a central point of the applicant's argument. As seen in the area map and the distance table previously discussed in E.1. above, the farthest distance to an existing subdistrict facility from the proposed site is 30.3 miles to Parrish Medical Center. The closest facilities are Wuesthoff – Melbourne at 7.8 miles away and Wuesthoff – Rockledge at 8.4 miles away.

In terms of geographical accessibility, it is not clear there is a barrier to care for residents of the Viera/Suntree area. Plans to widen roads throughout this community are detailed by the applicant, and no evidence is given to indicate the planned expansions are insufficient to handle projected traffic levels. The proposed site is within one block of an existing bus stop.

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. Current utilization and planned expansions of existing hospitals suggest that either this new facility will be underutilized or existing facilities will be impacted. Holmes anticipates the impact to be fully felt at its main facility, which is at capacity at times. With anticipated area growth in the proposed PSA and little room for expansion at its main facility, the applicant is likely concerned that it will lose more of its market to competitors if it does not build a new facility to continue to serve this growing area.

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

Holmes Regional Medical Center is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and other accreditations, affiliations, certifications and memberships shared by Holmes RMC and other Health First facilities are listed for review on pages 142-144 of the CON application.

There were nine closed confirmed complaints for Holmes Regional Medical Center and Palm Bay Community Hospital for the last three years ending March 28, 2005: two complaints for patient care, one for nursing service, one for medical services, one for infection control, one for medicine problems/errors/formulary, one for lack of assessment and one complaint for EMTALA (closed by CMS).

Quality of care at existing facilities could be affected by an approval of this project due to staffing shortages statewide. Many of the letters of opposition to this project are from area physicians expressing their inability to add another facility to their rounds. Emergency room specialty physicians would be a point of concern for this project, and the

applicant's ability to staff its proposed facility with physicians is an important issue with this application. Should area physicians opt to cover the new facility, it is possible that some of these physicians might find it difficult to maintain an on-call status at existing facilities, and staffing problems could develop at other facilities in the subdistrict and district; however, letters of support submitted by a few area physicians expressed intentions of staffing privileges at the new facility, and among those were intentions of working the Viera emergency department.

It should be noted that, while the above is also a major argument presented by those opposing this proposal, the applicant supplies an excerpt from a letter addressed to the Viera Company from the President and CEO of Wuesthoff Health System requesting that Wuesthoff be granted an "exclusive and sole right to build a hospital or hospital like facility in Viera"; the applicant dates this letter July 8, 2003, after the establishment of Wuesthoff Melbourne, suggesting that Wuesthoff Health Systems may agree on need for a facility in the Viera area.

Opposition to this proposed project has speculated that Viera Medical Center might become a "triage and transfer" facility similar to Wuesthoff Health Systems' description of current operations at Palm Bay Community Hospital.

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

The audited financial statements of Holmes Regional Medical Center, Inc. for the periods ending September 30, 2003 and 2004 were analyzed for the purpose of evaluating the applicant's ability to provide the capital and operational funding necessary to implement the project.

HOLMES REGIONAL MEDICAL CENTER, INC.

	<u>9/30/2004</u>	<u>9/30/2003</u>
Current Assets	\$ 220,893,000	\$ 219,167,000
Cash and Current Investment	\$ 154,199,000	\$ 159,342,000
Assets Restricted for Capital Projects	\$ -	\$ -
Total Assets	\$ 401,676,000	\$ 386,462,000
Current Liabilities	\$ 95,844,000	\$ 84,307,000
Total Liabilities	\$ 208,617,000	\$ 198,237,000
Net Assets	\$ 193,059,000	\$ 188,225,000
Total Revenues	\$ 443,370,000	\$ 400,036,000
Interest Expense	\$ 6,305,000	\$ 6,640,000
Excess of Revenues Over Expenses	\$ 16,489,000	\$ 14,427,000
Cash Flow from Operations	\$ 36,289,000	\$ 24,565,000
Working Capital	\$ 125,049,000	\$ 134,860,000
Current Ratio (CA/CL)	2.3	2.6
Cash Flow to Current Liabilities (CFO/CL)	0.4	0.3
Long-Term Debt to Net Assets (TL-CL/NA)	0.6	0.6
Times Interest Earned (NPO+Int/Int)	3.6	3.2
Net Assets to Total Assets (TE/TA)	48.1%	48.7%
Operating Margin (ER/TR)	3.7%	3.6%
Return on Assets (ER/TA)	4.1%	3.7%
Operating Cash Flow to Assets (CFO/TA)	9.0%	6.4%

Short-Term Position:

The applicant's current ratio of 2.3 indicates current assets are over two times current liabilities, a good position. The ratio of cash flow to current liabilities of 0.4 is well below average and indicates the applicant does not have sufficient cash flow to cover current obligations, a weak position. The working capital (current assets less current liabilities) of \$125 million is a measure of excess liquidity that could be used to fund capital projects. Overall, the applicant has an adequate short-term position.

Long-Term Position:

The long-term debt to equity ratio of 0.6 indicates long-term debt is less than equity, an adequate position. The cash flow to assets ratio of nine percent is slightly below average, a moderate position. The most recent year had excess revenues over expenses of \$16.5 million, which resulted in an operating margin of 3.7 percent. According to the audit, the applicant is required to make annual contributions to the parent company of the greater of 50 percent of excess revenues over expenses plus extraordinary items or six percent of unrestricted net assets. Overall, the applicant has an adequate long-term position.

Capital Requirements:

Schedule 2 indicates the applicant has \$433.4 million in capital projects and maturities of long-term debt due through 2008.

Available Capital:

Funding for this project will come from \$10.4 million in cash on hand and \$94.4 million from tax exempt bond financing. Operating cash flows for the most recent year were \$36.3 million. As discussed above working capital is \$125 million. The applicant provided a letter of interest from UBS Financial Services, Inc. outlining the issuance of tax-exempt bonds for the proposed project, which would be secured by Health First, Inc. A letter dated April 11, 2005, from Health First, Inc., the parent company, indicated that if necessary Health First would provide \$340 million of the amounts listed on Schedule 2 as cash in hand. The parent company reported \$213 million in working capital and \$88.3 million in cash flows from operations.

Conclusion:

Assuming the applicant will be able to obtain the debt financing discussed above, funding for this project and all capital projects should be available as needed.

Staffing:

As mentioned previously, the applicant's ability to adequately staff its emergency department without depleting the resources of existing facilities may be a crucial issue with this proposal. Letters of support from area physicians indicate some staffing would be available for this purpose, but how this additional responsibility for area physicians would affect their ability to maintain their current rounds cannot be adequately evaluated.

The applicant participates in recruitment and retention plans geared to limit the effects of the statewide nursing shortage, and the applicant expects few problems staffing Viera Medical Center, similarly to the few problems that it indicates Wuesthoff experienced staffing its Melbourne satellite.

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.

Because the applicant stated that the new hospital will serve the patient population in the following zip codes: 32940, 32955, 32935, 32904 and 32934, case mix data using the 19,339 patients discharged from the indicated zip codes during 2003, excluding DRGs for services not provided, was used in this analysis. The computed case mix index for these cases was 1.1975. Therefore, based on the range of services offered, number of beds and estimated patient days, as well as the computed case mix index; the applicant will be compared to the hospitals in Group 5. Per diem rates are projected to increase by an average of 3.6 percent per year. Inflation adjustments were based on the new CMS Market Basket, 4th Quarter, 2004.

Virtually all of the revenue projections and a majority of expense projections are dependant on the applicant's occupancy assumptions. An overstatement of the level of occupancy could have a materially negative affect on the projected financials. Therefore, an analysis of the applicant's occupancy assumptions has been conducted.

This application is for an 84-bed satellite hospital for Holmes Regional Medical Center (Parent Hospital). In 2004, the parent hospital accounted for 52.82 percent of the patient days (31,508) in the primary service area for the services expected to be provided by the satellite hospital (Viera Medical Center of VMC). The applicant is projecting 20,492 patient days in year two for VMC. This projection appears achievable since the parent hospital is already providing 31,508 patient days for the services expected to be delivered by the satellite hospital in the primary service area. This appears to be a conservative assumption and therefore is considered reasonable.

The projected payer mix was also tested with the payer mix in the proposed zip codes for the services to be provided by the satellite hospital. The projected payer mix is relatively consistent with the existing payer mix in the proposed service area. Based on the above, both the projected total occupancy and payer mix appear reasonable.

The applicant has offered a condition to serve three percent of total patient days through Medicaid, Medicaid HMO, and 2.6 percent of charges for charity patients. The current share of Medicaid, Medicaid HMO patient days in the projected service area for the services to be provided by the satellite hospital is 5.17 percent. The current share of charity patient days in the projected service area for the services to be provided by the satellite hospital is 2.54 percent. An analysis of the parent hospital's patient days indicates that, 4.65 percent of the parent hospital's patient days from the projected service area for the services to be provided by the satellite hospital were for Medicaid and Medicaid HMO payers and 4.38 percent of the parent hospital's patient days from the projected service area for the services to be provided by the satellite hospital were for charity days. It appears that the current payer mix of the proposed service area has a sufficient share of Medicaid, Medicaid HMO, and charity patient days, which should enable the applicant to meet the proposed condition.

Gross revenues, net revenues, and costs were obtained from Schedules 7 and 8 in the financial portion of the application. These were compared to the control group as a calculated amount per adjusted patient day.

Projected net revenue per adjusted patient day (NRAPD) of \$1,774 in year one and \$1,833 in year two is between the control group median and highest values of \$1,499 and \$2,163 in year one and \$1,542 and \$2,225 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).

Anticipated costs per adjusted patient day (CAPD) of \$2,064 in year one exceeds the highest value in the group of \$1,797. The highest level is generally viewed as the practical upper limit on economies of operation. Year one CAPD are not efficient when compared to the group.

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Anticipated CAPD of \$1,769 in year two is between the control group median and highest values of \$1,538 and \$1,849. This level of expense is considered feasible with projected cost falling between the control group median and highest values. (See Comparative Table). The applicant is projecting a decrease in CAPD between year one and year two of approximately 14.3 percent. It should be noted that this application is for a new acute care hospital. The first year of operation has a below average occupancy rate. The low occupancy rate decreases economies of scale and as the occupancy rate increases, CAPD would be expected to decrease.

The year one projected operating loss is \$6.3 million, which computes to an operating margin per adjusted patient day of a negative \$290. This is well below the lowest value in the group of a negative \$155. However, the Group 5 data is derived from mature hospitals. As discussed above, this application is for a new acute care hospital and economies of scale will not likely be realized until year two when the projected occupancy rate increases dramatically. The year two operating profit for the hospital of \$1.98 million computes to an operating margin per adjusted patient day of \$64 which is between the control group median and highest values of a negative \$18 and a positive \$355. The projected operating margin of 3.5 percent indicates that net revenues are proportional to costs.

Based on the above, financial feasibility of this project appears likely.

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COMPARATIVE TABLE

HOLMES REGIONAL MEDICAL CENTER, INC.

CON # 9836	2009	YEAR 2	VALUES ADJUSTED		
2003 DATA Peer Group 5	YEAR 2	ACTIVITY	FOR INFLATION		
	<u>ACTIVITY</u>	<u>PER DAY</u>	<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
ROUTINE SERVICES	113,522,000	3,663	1,216	704	312
INPATIENT AMBULATORY		0	363	91	34
INPATIENT SURGERY		0	0	0	0
INPATIENT ANCILLARY SERVICES		0	5,481	2,652	1,170
OUTPATIENT SERVICES	57,260,000	1,848	3,330	2,002	1,130
TOTAL PATIENT SERVICES REV.	170,782,000	5,511	9,821	5,388	3,292
OTHER OPERATING REVENUE	898,000	29	242	9	2
TOTAL REVENUE	<u>171,680,000</u>	<u>5,540</u>	<u>9,828</u>	<u>5,398</u>	<u>3,300</u>
DEDUCTIONS FROM REVENUE	114,871,000	3,707	0	0	0
NET REVENUES	<u>56,809,000</u>	<u>1,833</u>	<u>2,225</u>	<u>1,542</u>	<u>1,222</u>
EXPENSES					
ROUTINE	13,134,000	424	329	240	194
ANCILLARY	13,730,000	443	712	499	360
AMBULATORY	3,326,000	107	0	0	0
TOTAL PATIENT CARE COST	30,190,000	974	0	0	0
ADMIN. AND OVERHEAD	11,073,000	357	0	0	0
PROPERTY	13,569,000	438	0	0	0
TOTAL OVERHEAD EXPENSE	24,642,000	795	907	668	540
OTHER OPERATING EXPENSE	0	0	0	0	0
TOTAL EXPENSES	<u>54,832,000</u>	<u>1,769</u>	<u>1,849</u>	<u>1,538</u>	<u>1,266</u>
OPERATING INCOME	1,977,000	64	355	18	-155
		3.5%			
PATIENT DAYS	20,492				
ADJUSTED PATIENT DAYS	30,990				
TOTAL BED DAYS AVAILABLE	30,660		VALUES NOT ADJUSTED		
ADJ. FACTOR	0.6612		FOR INFLATION		
TOTAL NUMBER OF BEDS	84		<u>Highest</u>	<u>Median</u>	<u>Lowest</u>
PERCENT OCCUPANCY	66.84%		75.3%	58.8%	33.5%
PAYER TYPE	<u>PATIENT DAYS</u>	<u>% TOTAL</u>			
SELF PAY	1,136	5.5%			
MEDICAID	711	3.5%	17.9%	6.1%	0.9%
MEDICAID HMO	219	1.1%			
MEDICARE	12,184	59.5%	78.2%	62.0%	49.7%
MEDICARE HMO	1,798	8.8%			
INSURANCE	1,024	5.0%			
HMO/PPO	2,744	13.4%	38.2%	21.0%	2.7%
OTHER	676	3.3%			
TOTAL	<u>20,492</u>	<u>100%</u>			

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

Competition to promote quality and cost effectiveness is driven primarily by the best combination of high quality and low price. Competition forces hospitals to increase quality and reduce charges/cost in order to remain viable in the market.

The applicant already has 52.82 percent of the patient days in the projected primary service area for the services to be provided by the satellite hospital. This indicates the applicant already has a significant presence in the proposed market and therefore is not offering a new choice of provider or services.

The impact of the price of services on consumer choice is limited to the payer type. Most consumers do not pay directly for hospital services; rather they are covered by a third party payer. The impact of price competition would be limited to third party payers that negotiate price for services, namely managed care organizations. Therefore, price competition is limited to the share of patient days that are under managed care plans. The applicant forecasts managed care levels at 23.2 percent. Health First Health Plans is an HMO provider in the service area. This HMO provider is affiliated with the applicant. Managed care is a relatively small percentage of the patient days in the service area. The related party HMO provider limits the competition of these payer types due to its affiliation with the applicant to the extent that contracted prices are not negotiated at arms length. Based on the above, increased price competition will likely be limited.

Although the applicant is not a new provider in the service area, the satellite hospital will give consumers a new choice of location. The proposed satellite is directly between two existing hospitals (Wuesthoff Medical Center-Rockledge and Melbourne). The two hospitals are relatively close to the proposed satellite hospital (approximately eight miles) limiting the competitive advantage of a new choice of location. An evaluation of the primary service area for the DRGs expected to be delivered by the satellite hospital show that three facilities account for 89.4 percent of the patient days for the satellite services (Holmes Regional Medical Center 52.82 percent, Wuesthoff Medical Center-Rockledge 22.96 percent, and Wuesthoff Medical Center-Melbourne 13.61 percent).

The applicant would have to increase its current market share in order to put financial pressure on the competing facilities to increase quality and/or decrease charges/cost. The applicant already has a majority share of this market. Exceeding its current market share may be difficult to achieve. Therefore, this project will not likely have a measurable positive impact on competition to promote quality and cost-effectiveness.

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 a new 84-bed, 213,000 square foot hospital in Brevard County. A similar application was submitted for CON #9759 in May of 2004 and the plans submitted for this CON are identical to those previously reviewed.

A site for the new facility has been chosen adjacent to a proposed health park with several other health care-related facilities. From the information in the narrative, the owner is well aware of the requirements for disaster preparedness in the Florida Building Code, Section 419.4.56. The new facility will have a concrete frame and masonry walls, which is good from a disaster preparedness standpoint. However, no specific information is provided as to the elevation of the site and its relationship to the flood plain and storm surge issues. The applicant also mentions Homeland Security matters that will be addressed by the new facility.

The application included a site plan, floor plans of the three-story building and larger scaled plans of typical patient rooms. All patient rooms will be private and all patient toilet rooms will be wheelchair-accessible. The narrative makes a distinction between “wheelchair-accessible” and “ADA-compliant” that is not quite clear. All the in-patient rooms and the typical handicapped-accessible rooms are identical. The patient rooms shown meet the code requirements for area and headwall width. There is a lavatory within the rooms as well as the ones in the toilet room, which is required for new construction. Each room has a “family zone” so that a family member could sleep in the patient room.

The diagnostic and treatment areas have been planned for future expansion. It is also possible that the third floor could be enlarged to have the same footprint as the larger floors below. Because of the demographics of the area, the owner has elected not to provide obstetric services.

The overall building has a tripartite concept with two patient wings projecting from the main hospital area at the corner where they meet. Each patient wing is three stories high and the first two floors have 36 beds in each wing. The third floor has a 12-bed ICU and a 16-bed observation unit. Interestingly, human resources and the Chapel are on this floor as well as administration spaces.

An emergency department is provided as well as a full service Imaging suite including a cath lab, an MRI room and the surgical suite has four operating rooms. The surgical suite with the ORs and PACU are located on the second floor.

An interesting feature of the plan that the applicant thought was noteworthy is that the “concourses” (corridors) are on the exterior wall of the non-patient portions of the facility so that people can view the landscape features of the site. There does not seem to be any real advantage to this concept, particularly on the second floor where the patients will be most likely under sedation when they are in these corridors.

All the patient toilet rooms are on the exterior wall rather than on the corridor wall. This is for better observation of the patients by the staff. This works well because there is a niche for charting in the corridor for every two patient rooms and there are view windows into both rooms from the niche. Although a good idea, it could possibly compromise patient confidentiality, which has become a significant issue.

The overall project is straightforward and the layout is good. The ancillary spaces seem to be adequately sized and conveniently arranged for the functions that they support.

There is a list of applicable codes on the drawing, but by the time this project might be submitted to the AHCA Office of Plans and Construction, most of the codes will have been updated or changed. The information from Schedule 10 indicates that sufficient time has been allowed for construction.

The projected total project cost has decreased by about two million dollars and the cost per bed has gone down commensurately since the last submission. However, the construction costs and building size has remained the same and there was no readily apparent reason given in the narrative for this overall decrease. One would expect the building costs to have risen during the past year rather than remain the same.

Evidently the increase in total project cost is not in the building, but in movable equipment or other items. This makes review of the costs for the project less an architectural issue than a total proposal one.

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.**

There is no question that the proposed site is in a wealthier area: Census profiles show that median household income and per capita income in the proposed site’s zip code greatly exceed that of the zip codes for the other subdistrict facilities, while poverty levels and the percentage of the population without secondary education are higher in the areas surrounding the existing facilities.

The following chart illustrates the levels of Medicaid and charity care in Subdistrict 1:

District 7-Subdistrict 1 Medicaid and Charity Care Provision Percentages for Fiscal Year (FY) 2003

Facility	MCD	Charity Care	Total
Cape Canaveral Hospital	5.00%	1.70%	6.70%
Holmes Regional Medical	7.00%	2.60%	9.60%
*Parrish Medical Center	10.40%	2.30%	12.70%
Wuesthoff Memorial Hospital	10.90%	2.50%	13.40%
Wuesthoff Medical Center - Melbourne	9.80%	1.80%	11.60%
Subdistrict Average	8.62%	2.18%	10.80%
District 7	11.60%	2.50%	14.10%

* Disproportionate Share Hospital

Source: 2003 Hospital Financial Data, provided by the AHCA Financial Analysis Unit

For FY 2003, Holmes RMC and Palm Bay (reporting together) provided levels below average for Subdistrict 1 in Medicaid and charity care services. While Parrish Medical Center is the subdistrict’s Disproportionate Share Hospital (DSH), Parrish did not provide a higher level of combined Medicaid and indigent services than did Wuesthoff – Rockledge. The subdistrict’s DSH and the two Wuesthoff campuses provided the percentages higher than the subdistrict average during this

time, while the three Health First facilities provided levels below the subdistrict average. Considering the impact analysis given above, an approval of the proposed project would be granting market share to a provider somewhat less likely to provide Medicaid care than would the facilities it is most likely to affect.

Medicaid service in the subdistrict during FY 2003 ranged from a low at Cape Canaveral Hospital with 5.0 percent up to the high of 10.9 percent at Wuesthoff – Rockledge. The two applicant facilities, Holmes RMC and Palm Bay reporting together, provided 7.0 percent during this time. Figures for Subdistrict 1 are considerably below those of District 7 for Medicaid care.

Uncompensated care in the subdistrict ranged from a high of 2.6 percent at the two applicant facilities down to 1.7 percent at Cape Canaveral Hospital, the applicant's affiliate under common ownership. No facility is providing a significant amount of charity care in Subdistrict 1, and therefore it is unlikely that any reduction in any Subdistrict 1 facility's ability to provide charity care would make an impact on the community.

The applicant requests a condition for the provision of Medicaid/Medicaid HMO care to a minimum of 3.0 percent inpatients, and at least 2.6 percent of the proposed facility's gross revenues will be written off to charity care.

F. SUMMARY

Holmes Regional Medical Center, Inc. (CON #9836) is applying for a certificate of need (CON) to establish Viera Medical Center (VMC), an 84 all private bed acute care satellite hospital with a full-service emergency department in Viera, District 7, Subdistrict 1 in Brevard County. The applicant operates Holmes Regional Medical Center, a Class 1 not-for-profit hospital currently licensed for 504 acute care beds and 10 Level II NICU beds, as well as Palm Bay Community Hospital with 60 acute care beds¹⁴. The proposed VMC would be located west of Interstate 95 at the intersection of Lake Andrew Drive and Wickham Road on 50 acres purchased by Health First, Inc., with 20 acres allocated for the facility.

The reported total project cost is \$104,766,044. Total construction costs are reported at \$44,950,387 and the project will involve 213,334 GSF of new construction.

¹⁴ The applicant anticipates adding an additional 40 beds to its license for use at Palm Bay Community Hospital. With the 40 beds and this 84-bed proposal, the number of beds on the Holmes license would increase from 574 to 698.

After weighing and balancing all relevant criteria, the following issues are presented:

Need/Special Circumstances:

- The applicant contends that area circumstances warrant an approval based on rapid population growth rates in Viera/Suntree, and that insufficient community and health care infrastructures exist to support this population growth; however, the applicant's Palm Bay facility is under-utilized as is the affiliated Cape Canaveral Hospital, and with planned additions to bed counts at Palm Bay and Wuesthoff facilities, it is not clear that any growing need in this community will not be met outside of this proposal.
- County and district populations grew from 2000-2005 and are projected to continue growing through 2010, although at a decreasing rate, while elderly growth rates in the county are consistently lower than rates for the district and state. The applicant's growth figures for Viera cannot be verified by the reviewer, but it is likely these growth rates would be higher than that of the county and district due to new housing starts and the related infrastructure development; however, it remains that the applicant does not demonstrate why under-utilization at subdistrict facilities and the current ability to add beds without CON review are not sufficient to handle population growth.
- The Subdistrict 1 average utilization percentage was 67.49 percent from July 2003 through June 2004. The applicant's main facility led the subdistrict for average annual utilization during this period with 79.23 percent, but the applicant's Palm Bay facility demonstrated the second lowest utilization in the subdistrict during this same time with 52.58 percent. The applicant does not demonstrate why decompression of Holmes RMC could not take place at the under-utilized Palm Bay Community Hospital. It is not clear that existing resources are insufficient to decompress Holmes RMC, or that Viera Medical Center, farther away from Holmes RMC than is Palm Bay, would be any more successful at decompressing Holmes than has Palm Bay.
- Current subdistrict utilization and planned expansions of existing hospitals suggest that either this new facility will be underutilized or existing facilities will be impacted. Holmes anticipates the impact to be fully felt at its main facility, which is at capacity at times, and not at any other subdistrict provider. With anticipated area growth in the proposed PSA and little room for expansion at its main facility, the

applicant is likely concerned that it will lose more of its market to competitors if it does not build a new facility to continue to serve this growing area.

Quality of Care:

- There were nine closed confirmed complaints for Holmes Regional Medical Center and Palm Bay Community Hospital for the last three years ending March 28, 2005: two complaints for patient care, one for nursing services, one for medical services, one for infection control, one for medicine problems/errors/formulary, one for lack of assessment and one complaint for EMTALA (closed by CMS).
- Quality of care at existing facilities could be affected by an approval of this project due to staffing shortages statewide. Letters of support submitted by a few area physicians expressed intentions of staffing privileges at the new facility, and among those were intentions of working the Viera emergency department. Personnel impacts on surrounding facilities cannot be adequately evaluated.

Medicaid/charity care:

- During FY 2003, the applicant facilities provided levels below average for subdistrict 1 in combined Medicaid and charity care services. The subdistrict's DSH and the two Wuesthoff campuses provided the three highest percentages during this time, while the three Health First facilities provided levels below the subdistrict average.
- The two applicant facilities provided the highest level of uncompensated care in the subdistrict at 2.6 percent, yet the applicant's affiliate under common ownership provided the subdistrict's lowest amount at 1.7 percent. No facility is providing a significant amount of charity care in Subdistrict 1, and therefore it is unlikely that any reduction in any Subdistrict 1 facility's ability to provide charity care would make an impact on the community.

- The applicant requests a condition for the provision of Medicaid/Medicaid HMO care to a minimum of 3.0 percent inpatients, and at least 2.6 percent of the proposed facility's gross revenues will be written off to charity care.

Financial Feasibility:

- Assuming the applicant will be able to obtain the debt financing discussed in the financial review of this report, funding for this project and all capital projects should be available as needed.
- Financial feasibility of this project appears likely.
- The applicant already has a significant presence in the proposed market and therefore is not offering a new choice of provider or services. The related party HMO provider limits the competition of payer types due to its affiliation with the applicant to the extent that contracted prices are not negotiated at arms length; therefore, increased price competition will likely be limited with little measurable positive impact on competition to promote quality and cost-effectiveness.

Architectural Analysis:

- All patient rooms will be private and all patient toilet rooms will be wheelchair-accessible. The patient rooms shown meet the code requirements for area and headwall width. All the patient toilet rooms are on the exterior wall rather than on the corridor wall, with view-windows into rooms from the charting niche; this could possibly compromise patient confidentiality.
- An emergency department is provided as well as a full service-imaging suite including a cath lab, an MRI room and the surgical suite has four operating rooms.
- The projected total project cost has decreased by about two million dollars and the cost per bed has gone down commensurately since the last submission. However, the construction costs and building size has remained the same and there was no readily apparent reason given in the narrative for this overall decrease.

G. RECOMMENDATION

Deny CON #9836.

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