STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

BAYFRONT HEALTH PORT CHARLOTTE,

Petitioner,

v.

SARASOTA COUNTY PUBLIC HOSPITAL DISTRICT d/b/a SARASOTA MEMORIAL HOSPITAL and STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

CASE NO. 17-0510CON
AHCA NO. 2016014824
RENDITION NO.: AHCA- 18-0426-FOF-CON

FAWCETT MEMORIAL HOSPITAL, INC. d/b/a FAWCETT MEMORIAL HOSPITAL and ENGLEWOOD COMMUNITY HOSPITAL, INC. d/b/a ENGLEWOOD COMMUNITY HOSPITAL,

Petitioners,

v.

SARASOTA COUNTY PUBLIC HOSPITAL DISTRICT d/b/a SARASOTA MEMORIAL HOSPITAL and STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

CASE NO. 17-0551CON
AHCA NO. 2016014826

FAWCETT MEMORIAL HOSPITAL, INC. d/b/a FAWCETT MEMORIAL HOSPITAL and ENGLEWOOD COMMUNITY HOSPITAL, INC. d/b/a ENGLEWOOD COMMUNITY HOSPITAL,

Petitioners,

CASE NO. 17-0553CON
AHCA NO. 2016014827

v.

VENICE HMA HOSPITAL, LLC d/b/a VENICE REGIONAL BAYFRONT HEALTH and STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

SARASOTA COUNTY PUBLIC HOSPITAL DISTRICT d/b/a SARASOTA MEMORIAL HOSPITAL,

Petitioner,

CASE NO. 17-0556CON
AHCA NO. 2016014832

v.

VENICE HMA HOSPITAL, LLC d/b/a VENICE REGIONAL BAYFRONT HEALTH and STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

VENICE REGIONAL BAYFRONT HEALTH,

Petitioner,

CASE NO. 17-0557CON
AHCA NO. 2016014833

v.

SARASOTA COUNTY PUBLIC HOSPITAL DISTRICT d/b/a SARASOTA MEMORIAL HOSPITAL and STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

FINAL ORDER

These cases were referred to the Division of Administrative Hearings (DOAH) where they were consolidated and the assigned Administrative Law Judge (ALJ), W. David Watkins, conducted a formal administrative hearing. At issue in this proceeding is whether, on balance, Certificate of Need ("CON") application number 10457 by Sarasota County Public Hospital District d/b/a Sarasota Memorial Hospital ("SMH") to build a 90-bed acute care hospital in Venice, Florida, AHCA Subdistrict 8-6, and/or CON application number 10458 by Venice HMA Hospital, LLC d/b/a Venice Regional Bayfront Health a/k/a Venice Regional Medical Center ("VRMC") to build an 210-bed acute care hospital near Venice, Florida, AHCA Subdistrict 8-6, as a replacement for its current facility, satisfy the applicable criteria and should be approved. The Recommended Order entered on May 8, 2018 is attached to this final order and incorporated herein by reference.

RULINGS ON EXCEPTIONS

Fawcett Memorial Hospital, Inc. d/b/a Fawcett Memorial Hospital ("Fawcett") and Englewood Community Hospital, Inc. d/b/a Englewood Community Hospital ("Englewood") jointly filed exceptions to the Recommended Order, and SMH filed a response to Fawcett and Englewood's joint exceptions.

In determining how to rule upon Fawcett and Englewood's joint exceptions and whether to adopt the ALJ's Recommended Order in whole or in part, the Agency for Health Care Administration ("Agency" or "AHCA") must follow section 120.57(1)(*l*), Florida Statutes, which provides in pertinent part:

> The agency may adopt the recommended order as the final order of the agency. The agency in its final order may reject or modify the conclusions of law over which it has substantive jurisdiction and interpretation of administrative rules over which it has substantive jurisdiction. When rejecting or modifying such

> conclusion of law or interpretation of administrative rule, the agency must state with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. . . .

§ 120.57(1)(*l*), Fla. Stat. Additionally, "[t]he final order shall include an explicit ruling on each exception, but an agency need not rule on an exception that does not clearly identify the disputed portion of the recommended order by page number or paragraph, that does not identify the legal basis for the exception, or that does not include appropriate and specific citations to the record." § 120.57(1)(k), Fla. Stat. In accordance with these legal standards, the Agency makes the following rulings on Fawcett and Englewood's joint exceptions:

In Exception 1, Fawcett and Englewood take exception to Paragraphs 6, 23, 27, 54, 59, 62, 66, 68, 69, 70, 71, 128, 153, 182, 183, 184, 185, 186, 189 and 206 of the Recommended Order, arguing that: 1) the findings of fact are not based on competent, substantial evidence; 2) The ALJ impermissibly placed the burden on Fawcett and Englewood to prove SMH could not expand its existing campus; and 3) accepting the findings of fact creates a virtually irrefutable basis for establishing need for new hospitals by shifting the burden of proof to the party contesting the application. In regard to Fawcett and Englewood's first argument, the findings of fact in Paragraphs 6, 23, 27, 54, 59, 62, 66, 68, 69, 70, 71, 128 and 153 of the Recommended Order are based on competent, substantial record evidence. See Transcript, Volume 1, Pages 44-45, 88-90 and 95-97; Transcript, Volume 3, Pages 344-345, 347 and 351; Transcript, Volume 6, Page 868; Transcript, Volume 7, Pages 945-947, 949-950, 952-953, 969-970, 973-975 and 977-

980; Transcript, Volume 8, Page 1139; Transcript, Volume 10, Pages 1323, 1329-1334 and 1363-1365; VRMC Exhibit 1; SMH Exhibits 5, 17 and 58; and Fawcett/Englewood Exhibits 18 and 19. Thus, the Agency cannot reject or modify them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz v. Department of Business Regulation, 475 So. 2d 1277, 1281 (Fla. 1st DCA 1985) (holding that an agency "may not reject the hearing officer's finding [of fact] unless there is no competent, substantial evidence from which the finding could reasonably be inferred"). Furthermore, the Agency finds that, while it has substantive jurisdiction over the conclusions of law in the first sentence of Paragraph 128 and Paragraphs 182, 183, 184, 185, 186, 189 and 206 of the Recommended Order because it is the state agency in charge of administering Florida's CON program, it cannot substitute conclusions of law that are as or more reasonable than those of the ALJ. Fawcett and Englewood's second and third arguments are simply incorrect. The Recommended Order clearly demonstrates that both VRMC and SMH did an excellent job of meeting their burden of proof of demonstrating by a preponderance of the evidence that they both were entitled to have their CON applications granted. Fawcett and Englewood are simply re-arguing the case in front of the Agency to try to convince the Agency to re-weigh the evidence, which it cannot do. See Heifetz. Therefore, for all the reasons stated above, the Agency denies Exception 1.

In Exception 2, Fawcett and Englewood take exception to Paragraphs 128, 182, 189, 190 and 206 of the Recommended Order, arguing the paragraphs erroneously conclude that SMH established need for its proposed hospital, contrary to prior Agency precedent. However, the cases Fawcett and Englewood cite to are not "very similar" to the case at hand. Instead, the cases of Memorial Healthcare Group, Inc. d/b/a Memorial Hospital Jacksonville v. Agency for Health Care Admin. and Shands Jacksonville Medical Center, Inc., Case No. 12-0429CON

(DOAH Dec. 7, 2012; AHCA Apr. 10, 2013); Columbia Hospital (Palm Beaches) Limited Partnership d/b/a West Palm Hospital and Jupiter Medical Center, Inc. d/b/a Jupiter Medical Center v. Florida Regional Medical Center and Agency for Health Care Admin., Case Nos. 12-0428CON and 12-0496CON (DOAH Apr. 30, 2013; AHCA Jun. 6, 2013); Lee Memorial Health System v. Agency for Health Care Admin., Case Nos. 13-2508CON and 13-2558CON (DOAH Mar. 28, 2014; AHCA Apr. 24, 2014); and, most recently, Kendall Healthcare Group, Ltd. d/b/a Kendall Regional Medical Center v. The Public Health Trust of Miami-Dade County, Florida d/b/a Jackson Hospital West and Agency for Health Care Admin., Case Nos. 16-0112CON – 16-0115CON (DOAH Mar. 16, 2017; AHCA Apr. 26, 2018) are easily distinguishable. In contrast to the Memorial Healthcare, Columbia Hospital, Lee Memorial and Kendall Healthcare cases, the evidence in the case at hand demonstrates that there is a need for SMH's proposed facility because the proposed service area has a growing population, SMH already has an existing patient base in the proposed service area, and SMH's proposed facility will improve geographic and financial access for residents of the proposed service area "who are currently traveling great distances to access inpatient services at the SMH main campus." See Paragraph 206 of the Recommended Order. In addition, contrary to the Memorial Healthcare, Columbia Hospital, Lee Memorial and Kendall Healthcare cases, SMH's proposed facility will have minimal adverse impact on existing providers. Id. Finally, unlike the Memorial Healthcare, Columbia Hospital, Lee Memorial and Kendall Healthcare cases, SMH cannot feasibly address serious physical plant issues at its current facility from a logistical and financial standpoint.[1] See Recommended Order at Paragraphs 66 and 206. Thus, the Memorial Healthcare, Columbia Hospital, Lee Memorial and Kendall Healthcare cases are not similar to the case at hand, and thus not binding precedent

[1] Both the Lee Memorial and Kendall Healthcare cases involved applicants who claimed that there were physical plant issues at current facilities that could only be resolved by building a new facility, but the evidence in the cases

that necessitates the Agency overturn the ALJ's conclusion that there is a need for SMH's proposed facility. Instead, the Agency finds that, while it has substantive jurisdiction over the conclusions of law in the first sentence of Paragraph 128 and Paragraphs 182, 189, 190 and 206 of the Recommended Order because it is the state agency in charge of administering Florida's CON program, it cannot substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, the Agency denies Exception 2.

In Exception 3, Fawcett and Englewood take exception to Paragraphs 6, 55, 56, 57, 58, 59, 60, 62, 64, 110, 111, 113, 117, 120, 128, 182, 183, 184, 185, 186, 187, 188, 189, 190 and 191 of the Recommended Order, arguing the ALJ erroneously relied on occupancy percentages of SMH in order to make a determination that its CON application should be granted. The Agency sees no such error having been made by the ALJ. Instead, the ALJ correctly weighed and balanced the relevant criteria that should be examined when determining whether to grant or deny a CON application, and reached the correct result. In addition, the findings of fact in Paragraphs 6, 55, 56, 57, 58, 59, 60, 62, 64, 110, 111, 113, 117, 120 and 128 of the Recommended Order are based on competent, substantial record evidence. See Transcript, Volume 1, Pages 44-45, 53-54, 85, 88-90 and 94-97; Transcript, Volume 2, Pages 225-226; Transcript, Volume 3, Pages 344-352 and 366-367; Transcript, Volume 8, Page 1139; Transcript, Volume 10, Pages 1323, 1329-1334, 1335-1336 and 1363-1365; SMH Exhibits 5, 58, 62 and 63; and AHCA Exhibit 1. Thus, the Agency cannot disturb them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Finally, the Agency finds that, while it has substantive jurisdiction over the conclusions of law in the first sentence of Paragraph 128 and Paragraphs 182, 183, 184, 185, 186, 187, 188, 189, 190 and 191 of the Recommended Order because it is the state agency in charge of administering Florida's CON program, it cannot substitute conclusions of law that

proved otherwise.

are as or more reasonable than those of the ALJ. Therefore, for all these reasons, the Agency denies Exception 3.

In Exception 4, Fawcett and Englewood take exception to Paragraphs 61, 112, 122, 123, 124, 182, 186, 187 and 206 of the Recommended Order, arguing the paragraphs make findings pertaining to travel conditions and traffic congestion in Sarasota County that are not based on competent, substantial evidence. The findings of fact in Paragraphs 61, 112, 122, 123 and 124 of the Recommended Order are based on competent, substantial record evidence. See Transcript, Volume 3, Pages 330-332; Transcript, Volume 5, Pages 633-634; Transcript, Volume 6, Pages 822-23 and 827; Transcript, Volume 10, Pages 1322-1324 and 1360-1361; and SMH Exhibits 5, 46, 58 and 99. Thus, the Agency cannot disturb them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Paragraphs 182, 186 and 187 of the Recommended Order have already been addressed by the Agency in its ruling on Fawcett and Englewood's Exception 3 supra, which is hereby incorporated by reference. Paragraph 206 of the Recommended Order has already been addressed by the Agency in its rulings on Fawcett and Englewood's Exceptions 1 and 2 supra, which are hereby incorporated by reference. Therefore, for all these reasons, the Agency denies Exception 4.

In Exception 5, Fawcett and Englewood take exception to Paragraphs 157 through 175 and 188 of the Recommended Order, arguing the findings of fact concerning adverse impact in Paragraphs 157-175 are not based on competent, substantial evidence and conflict with the conclusions of law in Paragraph 188. Whether findings of fact conflict with other parts of a recommended order is not a valid basis for the Agency to reject or modify them. See § 120.57(1)(*l*), Fla. Stat. The findings of fact in Paragraphs 157 through 175 of the Recommended Order are based on competent, substantial record evidence. See Transcript, Volume 1, Pages 68

and 86; Transcript, Volume 5, Page 611; Transcript, Volume 8, Pages 1181-1183; Transcript, Volume 9, Pages 1213-1214; Transcript, Volume 10, Pages 1387-1388, 1391-1392, 1396-1400 and 1402-1403; Transcript, Volume 12, Pages 1600-1601, 1604, 1620 and 1669-1671; Transcript, Volume 13, Pages 1740 and 1783-1784; Transcript, Volume 17, Pages 2322 and 2356-2359; Transcript, Volume 18, Pages 2465, 2469 and 2484; Transcript, Volume 19, Pages 2577-2582 and 2700-2706; SMH Exhibits 5, 58, 62 and 63; VRMC Exhibits 1 and 232; and AHCA Exhibit 1. Thus, the Agency cannot reject or modify them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Paragraph 188 of the Recommended Order has already been addressed by the Agency in its ruling on Fawcett and Englewood's Exception 3 supra, which is hereby incorporated by reference. Therefore, for all these reasons, the Agency denies Exception 5.

In Exception 6, Fawcett and Englewood take exception to Paragraphs 6, 126 and 128 of the Recommended Order, arguing these paragraphs make findings and conclusions that unequivocally demonstrate that SMH's need argument is facility specific. What the findings of fact in Paragraphs 6, 126 and 128 of the Recommended Order may or may not demonstrate is irrelevant to whether the Agency can reject or modify them. The Agency can only reject or modify findings of fact if they are not based on competent, substantial evidence. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Since the findings of fact in Paragraphs 6, 126 and 128 of the Recommended Order are based on competent, substantial record evidence (See Transcript, Volume 1, Pages 44-45, 88-90 and 95-97; Transcript, Volume 8, Page 1139; Transcript, Volume 10, Pages 1323, 1329-1334, 1335-1336 and 1363-1365; Transcript, Volume 19, Page 2624; Transcript, Volume 30, Page 4201; and SMH Exhibit 5), the Agency cannot disturb them. The conclusion of law in the first sentence of Paragraph 128 has already been

addressed by the Agency in its ruling on Fawcett and Englewood's Exception 1 supra, which is hereby incorporated by reference. Therefore, the Agency denies Exception 6.

In Exception 7, Fawcett and Englewood take exception to Paragraphs 24, 64 and 167 of the Recommended Order, arguing the findings of fact in these paragraphs are not based on competent, substantial evidence. Contrary to Fawcett and Englewood's argument, the findings of fact in Paragraphs 24, 64 and 167 of the Recommended Order are based on competent, substantial record evidence. See Transcript, Volume 1, Page 85; Transcript, Volume 3, Pages 366-367 and 370; Transcript, Volume 7, Pages 999-1000 and 1036-1038; Transcript, Volume 10, Pages 1334-1335; Transcript, Volume 11, Pages 1471-1472 and 1547-1548; and SMH Exhibits 5 and 58. Thus, the Agency cannot disturb them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Exception 7.

FINDINGS OF FACT

The Agency hereby adopts the findings of fact set forth in the Recommended Order.

CONCLUSIONS OF LAW

The Agency hereby adopts the conclusions of law set forth in the Recommended Order.

ORDER

Based upon the foregoing, both SMH's CON application no. 10457 and VRMC's CON application no. 10458 are hereby approved subject to the conditions contained in their respective applications. The parties shall govern themselves accordingly.

DONE and **ORDERED** this 9th day of July, 2018, in Tallahassee, Florida.

JUSTIN M. SENIOR, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH THE FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by the method indicated to the persons named below on this 25 day of July, 2018.

RICHARD J. SHOOP, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308-5403
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STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

BAYFRONT HEALTH PORT CHARLOTTE

Petitioner,

vs. Case No. 17-0510CON

SARASOTA COUNTY PUBLIC HOSPITAL DISTRICT, d/b/a SARASOTA MEMORIAL HOSPITAL, AND AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

FAWCETT MEMORIAL HOSPITAL, INC., d/b/a FAWCETT MEMORIAL HOSPITAL; AND ENGLEWOOD COMMUNITY HOSPITAL, INC., d/b/a ENGLEWOOD COMMUNITY HOSPITAL,

Petitioners,

vs. Case No. 17-0551CON

SARASOTA COUNTY PUBLIC HOSPITAL DISTRICT, d/b/a SARASOTA MEMORIAL HOSPITAL, AND AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

FAWCETT MEMORIAL HOSPITAL, INC., d/b/a FAWCETT MEMORIAL HOSPITAL; AND ENGLEWOOD COMMUNITY HOSPITAL, INC., d/b/a ENGLEWOOD COMMUNITY HOSPITAL,

Petitioners,

vs. Case No. 17-0553CON

VENICE HMA HOSPITAL, LLC, d/b/a VENICE REGIONAL BAYFRONT HEALTH, AND AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

SARASOTA COUNTY PUBLIC HOSPITAL DISTRICT, d/b/a SARASOTA MEMORIAL HOSPITAL,

Petitioner,

vs. Case No. 17-0556CON

VENICE HMA HOSPITAL, LLC, d/b/a VENICE REGIONAL BAYFRONT HEALTH, AND AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

VENICE REGIONAL BAYFRONT HEALTH,

Petitioner,

vs. Case No. 17-0557CON

SARASOTA COUNTY PUBLIC HOSPITAL DISTRICT, d/b/a SARASOTA MEMORIAL HOSPITAL, AND AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondents.
_____/

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its designated Administrative Law Judge, W. David Watkins, held a formal hearing in the above-styled case on August 7 through 11, 14 through 18, 21 through 25, and September 19 and 22, 2017, in Tallahassee, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

Whether Certificate of Need (CON) Application 10457 filed by Sarasota County Public Hospital District (SCPHD), d/b/a Sarasota Memorial Hospital (SMH), seeking approval for a new 90-bed acute care hospital to be located in Venice, Florida, zip code 34275, acute care service district 8, Subdistrict 8-6, on balance, satisfies the applicable statutory and rule review criteria.

Whether CON Application 10458 filed by Venice HMA Hospital, LLC, d/b/a Venice Regional Bayfront Health, a/k/a Venice Regional Medical Center (VRMC), seeking approval to replace its existing 312-bed general acute care hospital with a 210-bed hospital to be located near Venice, Florida, in zip code 34292, acute care service district 8, Subdistrict 8-6, on balance, satisfies the applicable statutory and rule review criteria.

Whether Agency for Health Care Administration (AHCA) rule 59C-1.008(4) (Rule) requires a CON application for a general hospital to contain an audited financial statement and, if so, whether the Rule is an invalid exercise of delegated

legislative authority upon which the substantial interests of a party have been determined, in violation of section 120.57(1)(e), Florida Statutes.[1/]

PRELIMINARY STATEMENT

This case involves applications for CONs filed by SMH for a new hospital, and by VRMC for a replacement hospital, both to be located in the southern part of Sarasota County, AHCA Subdistrict 8-6.

In the August 2016 batching cycle for hospital beds and facilities, SMH filed a letter of intent (LOI) to establish a 90-bed acute care hospital in Venice, Florida. VRMC filed a "grace period" LOI to establish a replacement hospital of up to 312 beds. The applications were for distinct projects to fulfill separate needs and, on December 2, 2016, AHCA issued its State Agency Action Report (SAAR) preliminarily approving both projects.

On December 23, 2016, VRMC and its sister hospital Bayfront Health Port Charlotte (BHPC), filed petitions challenging SMH's approval. That same day, Fawcett Memorial Hospital (Fawcett) and Englewood Community Hospital (Englewood), located in Subdistricts 8-1 and 8-6, respectively, filed petitions challenging both applications. On December 27, 2016, SMH filed a petition challenging VRMC's preliminary approval. All petitions were timely filed.

AHCA referred the petitions to the Division of Administrative Hearings (DOAH) on January 23, 2017. The undersigned was assigned to conduct a formal administrative hearing and issue a recommended order.

On May 25, 2017, VRMC filed a petition under section 120.56(3), Florida Statutes, challenging the Rule, arguing that audited financial statements (AFS) are not required for a general acute care hospital CON application, and that applying the Rule to require an AFS in support of VRMC's application is an invalid exercise of delegated legislative authority.[2/] All cases were consolidated on June 21, 2017. On June 23, 2017, VRMC amended its answer to assert that the Rule is invalid and that denying VRMC's application based on the Rule would adversely affect its substantial interests.

Pursuant to notice, the final hearing was conducted from August 7 through 11, 14 through 18, 21 through 25, and September 19 and 22, 2017.

At the final hearing, SMH presented the testimony of: David Verinder, chief executive officer (CEO) of SMH and expert in health care administration and finance; Janet Steves, expert in nursing administration, including organizational capacity and patient throughput; Karen Johnson, expert in nursing care; Pam Beitlich, expert in nursing practice and obstetrics program management; James D. Fox, M.D., expert in interventional

cardiology; Christopher Hatton, expert in traffic engineering; Charles A. Michelson, expert in health care architecture; Roy Brady, expert in health care planning; and Michael C. Carroll, expert in health care planning and finance.

SMH offered the following deposition transcripts and exhibits which were admitted into evidence: Exhibit 94 (C. Taylor); Exhibit 97 (J. Moeckel); Exhibit 98 (J. Singer) and Exhibit 99 (S. Ewens); Exhibits 1, 3, 22, 25-27, 30, 31-35, 40, 43-51, 53-61, 92.1, 92.1A, 92.2-92.4, 92.7, 122 (Tab C), 160.1 and 160.2. SMH's Exhibits 5, 10, 17, 24, 28, 29, 52, 62, 63, and 78 were received in evidence over objection.

Fawcett and Englewood presented the testimony of: William Hawley, Fawcett CEO and expert in hospital administration; Valerie Powell-Stafford, Englewood CEO and expert in hospital administration; Kenneth Pfahler, M.D., cardiology expert; Jankristof Devastey, expert in transportation planning and traffic engineering; Marc Rowland, expert in health care architecture; George Huddleston, civil engineering expert; Darryl Weiner, health care finance expert; and Gene Nelson, health planning expert.

Fawcett and Englewood offered the following deposition transcripts and exhibits which were admitted into evidence: Exhibit 206 (R. James); Exhibit 207 (P. Chupka); and Exhibit 214 (S. Grimwood); Exhibits 3, 8-11, 13, 14, 17, 19, 21, 22, 37, 38,

40, 43, 101, and SMH Exhibit 160.5. The following Fawcett/Englewood Exhibits were received in evidence over objection: 1, 4-7, 12, 15, 18, 23-27, 29 (pp. 1-73, 78-88), 35, 35.1, 35.2, 41, 109-121, 174, 191, 197, and 214.2.

VRMC and BHPC presented the testimony of: Timothy J. Cerullo, BHPC CEO and expert in hospital administration; Jerome Sturm, M.D., obstetrics and gynecology expert; John McClain, former CEO of VRMC and expert in hospital administration; Mark Smith, expert in health care architecture; Hugh Nash, Jr., expert in electrical engineering; Charles R. Cummings; Seth Peterson, expert in health care information technology; Ray Miller, expert in hospital physical plant operations; Ki Hassler, D.O., cardiology and nuclear cardiology expert; Scott Fell, emergency medicine expert; Nicholas Ganick, expert in engineering; Kristen Gentry, expert in hospital operations and administration; Patricia Greenberg, expert in health care planning and finance; Vincent Palmire, M.D., expert in anesthesiology and perioperative transesophageal echocardiography (TEE); and community support witnesses Jeffery Boone and Nelda Thompson.

VRMC and BHPC offered the following deposition transcripts or exhibits which were admitted into evidence: Exhibit 201 (W. Barr), Exhibit 202 (P. Bartolotta), Exhibit 204

(E. Carlesimo), Exhibit 205 (R. Cervera), Exhibit 206 (J. Chebli), Exhibit 208 (D. Dreier), Exhibit 216 (O. Gruhonjic), Exhibit 218 (L. Joyner), Exhibit 219 (C. Koski), Exhibit 220 (J. Landis), Exhibit 221 (R. Lifton), Exhibit 228 (P. Smith), Exhibit 229 (T. Stephenson) and Exhibit 232 (J. D'Abarno); Exhibits 6, 16, 19, 21, 23-25, 28, 33, 47, 53-55, 84, 88-93, 95, 96, 103, 104, 106, 107, 110-115, 117-133, 137-145, 149, 164, 165, 171, 176, 196, 197, 199, 200, 217, 273, and 274. The following VRBH Exhibits were received into evidence over objection: 1, 3, 4, 7-9, 11-15, 22, 26, 27, 29-32, 34-41, 44-46, 48-52, 56-83, 85, 101, 102, 116, 146-148, 151, 155, 160, 161, 163, 168, 173, 174, 183, 187, 191, 198, 217 (Exhibit 1, only), and 275. Exhibit 10 was received into evidence over limited post-hearing objections timely filed by SMH on September 29, 2017.

AHCA presented the testimony of Marisol Fitch, expert in certificate of need and health care planning. AHCA Exhibit 1 was admitted into evidence.

The Transcript (Volumes 1 through 34) of the final hearing was filed on October 23, 2017. The parties were directed to file their proposed recommended orders on or before November 29, 2017.

Thereafter, all parties timely filed their Proposed Recommended Orders, each of which has been duly considered in preparation of this Recommended Order.

FINDINGS OF FACT

I. The Parties

A. Agency for Health Care Administration (AHCA)

1. AHCA is designated as the single state agency responsible for administering the CON program under the Health Facility and Services Development Act, sections 408.031-408.045, Florida Statutes.

2. AHCA conducts its health planning and CON review based on "health planning service district[s]" defined by statute. § 408.032(5), Fla. Stat. The service district relevant to this case is district 8, consisting of: Subdistrict 8-1, Charlotte County; Subdistrict 8-2, Collier County; Subdistrict 8-3, DeSoto County; Subdistrict 8-4, Glades and Hendry Counties; Subdistrict 8-5, Lee County; and Subdistrict 8-6, Sarasota County. Fla. Admin. Code R. 59C-2.100(3)(h).

B. Sarasota Memorial Hospital (SMH)

3. SMH opened in 1925 as a 32-bed community hospital. It is owned and operated by SCPHD, a special taxing district created by the Legislature in 1949. SCPHD is governed by an elected board of unpaid Sarasota County (County) citizens distributed throughout the County.

4. Through good stewardship and capable management, SMH has grown into an 829-bed public hospital and regional medical center with 5,000 staff, 900 physicians, and 650 volunteers. SMH offers a full array of health care services including specialty heart, vascular, cancer, orthopedic, child and adult psychiatric, and neuroscience programs, as well as a network of outpatient centers, urgent care centers, long-term care, and a new, dedicated rehabilitation pavilion. SMH is a comprehensive stroke center and is home to the County's only Level II trauma center and neonatal intensive care unit (NICU). In addition, SMH offers the only behavioral health program and is the only obstetrical (OB) provider in Sarasota County.

5. SMH is consistently recognized for excellent patient care. It is the only Florida hospital to earn a CMS (Centers for Medicare and Medicaid Services) 5-Star quality rating. It has maintained Magnet designation, the highest standard of nursing care, since 2004. SMH is a regional tertiary and quaternary safety net provider with a mandate to provide health care to Sarasota County residents regardless of ability to pay.

6. As a result of substantial growth in its patient population; substantial market share in southern Sarasota County; the size, complexity, and congestion of the main campus; and changing standards since SMH's patient towers were constructed, SMH is at capacity and must expand southward to

continue to care for patients at its main campus, and to meet its mission of providing care to all Sarasota County residents, regardless of ability to pay or proximity to the northerly main campus.

C. Venice Regional Medical Center (VRMC)

7. VRMC is a 312-bed acute care and tertiary hospital located in Venice, southern Sarasota County. VRMC sees 32,000 emergency department (ED) visits annually; admits 9,000 patients a year; and has 200 open-heart surgeries a year. VRMC has received numerous awards, including several awards for its stroke and heart programs. VRMC's current occupancy rate is about 40 percent.

8. VRMC has an employed multispecialty physician group, Gulf Coast Medical Group, consisting of 31 primary care physicians and 41 specialists, including physicians specializing in interventional cardiology, rheumatology, pulmonology, neurology, plastics, gynecology (GYN), podiatry, and computed tomography (CT) surgery. Gulf Coast Medical Group has 25 locations in Sarasota County, with offices in North Port and near SMH's proposed location on Laurel Road. Gulf Coast Medical Group sees over 200,000 patients a year and is responsible for about 60 percent of the patients admitted to VRMC.

9. VRMC has experienced growth through a "hodge-podge" of renovation and expansion projects occurring between 1951 and

1985, without any master plan. For years, the capital needs of the hospital were funded through community fundraising and donated labor.

10. In 1951, VRMC opened with 14 beds in an old boarding house. In 1957, the community raised $376,000 to add a 30-bed wing, a laboratory, a radiology unit, and surgical areas. In 1965, the community again raised a total of $700,000 to build a 33-bed addition. Over the next two decades, the growth at VRMC was funded through fundraising efforts, where the hospital only added the space it could afford based upon donations received. There were seven major additions to VRMC between 1968 and 1985, all funded and built in this piecemeal fashion. The result is a facility that lacks a coordinated, integrated plan or design.

D. Bayfront Health Port Charlotte (BHPC)

11. BHPC is a 254-bed acute care and tertiary hospital located in district 8, Subdistrict 8-1, near the Charlotte/Sarasota county line. In addition to the full range of acute care services, BHPC offers open-heart surgery, interventional catheterization, pediatrics, OB services, and NICU services. BHPC handles 31,000 ED visits annually, performs 8,200 surgeries a year, and has 11,000 admissions per year. BHPC's occupancy rate is around 54 percent.

E. Fawcett Memorial Hospital (Fawcett)

12. Fawcett is an HCA-affiliated hospital located in Port Charlotte, Charlotte County, Florida, close to the Sarasota County border. Fawcett serves the Charlotte County communities of Port Charlotte, Punta Gorda, and South Punta Gorda; the Sarasota County of North Port; and all of DeSoto County. Fawcett provides care to all patients without regard for their ability to pay for services, and provided $5.2 million in uncompensated charity care in 2016. It received no compensation from any sources for the provision of care to indigent or under-insured patients.

13. Fawcett has 237 beds, including 20 comprehensive medical rehabilitation beds. Fawcett provides almost all subspecialty services including cardiac surgery services, percutaneous coronary intervention (PCI), oncology, vascular surgery, general surgery, orthopedic surgery, neurosurgery, comprehensive medical rehabilitation, general medicine, interventional radiology, and compatibility-area surgery, among other services. The only services not provided at Fawcett are OB, pediatric, and transplant services.

14. Fawcett is a high-quality provider and enjoys an outstanding reputation in the communities it serves. Fawcett is one of two hospitals in the entire state of Florida that has been recognized as a Top 100 Hospital by Healthgrades, has been

named the hospital of choice and the emergency room of choice by the local newspaper for 12 consecutive years, and has garnered numerous other quality designations and certifications.

15. The communities served by Fawcett currently enjoy broad access to hospital services due to the fact that BHPC is located directly across the street from Fawcett; Punta Gorda Hospital is four miles from Fawcett; and the SMH freestanding ED is seven miles from Fawcett.

16. All but 10 of Fawcett's acute care beds are semiprivate. Fawcett has two meetings per day to ensure their semiprivate beds are appropriately staffed and patients are appropriately assigned to beds. Fawcett's 12 observation beds are housed in a dedicated observation unit that is contiguous with the ED. Fawcett's annual in-patient occupancy is approximately 75 percent, and it experiences approximately 32,000 ED visits per year.

F. Englewood Community Hospital (Englewood)

17. Englewood, which has served its community for over 32 years, is an existing licensed 100-bed hospital that currently operates in AHCA Service district 8, Subdistrict 8-6, Englewood, Sarasota County. All of Englewood's beds are semiprivate. It does not operate a separate observation unit, utilizing its licensed acute care beds for patients in observation status.

18. As a small community hospital, Englewood offers 24/7 emergency services, robotic surgery, nephrology, PCI services, gastroenterology, pulmonology, geriatric care, urology, orthopedic surgery, and a stroke program, among other services.

19. Englewood also offers a robust, high-quality cardiology program, complete with general cardiology services, cardioversions, transesophageal echoes, stress testing, nuclear stress testing, cardiac catheterization, angioplasty, interventional cardiology with stents, implanting of pacemakers, and more. Englewood's cardiology program is modeled after cardiology programs at Harvard and Emory medical schools.

20. Englewood serves approximately 21,000 patients annually, primarily the elderly, through its ED. Admissions to the hospital have remained relatively flat. Englewood serves the Englewood, Venice, and North Port areas in Charlotte and Sarasota Counties, and its administration is very active in the community. Englewood provides care to all patients without regard to their ability to pay, and provided $2.7 million in charity care in 2016.

21. Englewood is a high-quality provider, with excellent medical and nursing staffs. It was ranked first among HCA-affiliated hospitals for quality. Englewood has been a Leapfrog A-Rated hospital for nine consecutive years and is a CMS 4-Star

facility. Englewood was named by Modern Healthcare as one of the top 100 places to work, and has garnered several other quality indicators and awards.

22. Notwithstanding Englewood's quality and awards, it has struggled financially, experiencing a reduction in admissions and operating at an approximate annual occupancy of only 35 percent. In 2015, Englewood lost $200,000. It does not fully staff its 100 beds due to its low census, and even with a low census it has a shortage of nurses and must rely on "travelers."

II. The Proposals

A. The SMH Proposal: "SMH Laurel Road"

23. To enhance access to south Sarasota County residents, including SMH's existing south county patients, and address its capacity constraints, SMH proposes a new 90-bed hospital (80 adult medical/surgical and 10 obstetric beds) on a 65-acre parcel that SCPHD owns at the southwest corner of Laurel Road and Interstate 75 in the southern part of Sarasota County.

24. The project is conditioned on SMH delicensing 90 beds from its main campus, which it will remove from semiprivate rooms, converting those to single-occupancy, increasing functional capacity, and mitigating burdens presented by semiprivate rooms.

25. The primary service area (PSA) for SMH Laurel Road includes the following North Port, Nokomis, and Venice zip codes: 34287, 34293, 34275, 34286, 34285, 34292, and 34288. The secondary service area (SSA) for SMH Laurel Road includes the remaining North Port zip codes of 34291 and 34289 in addition to Osprey and Englewood zip codes 34223, 34229, and 34224.

26. SMH Laurel Road will focus on adult (ages 15 and older), non-specialty, non-tertiary services and will include 10 integrated labor, delivery, recovery, and postpartum (LDRP) obstetrics beds. SMH will continue to offer tertiary services at the main campus in order to provide Sarasota County residents access to those needed services. SMH also will remain the only pediatrics, NICU, trauma, and psychiatric provider in Sarasota County, and the region's only state-certified Comprehensive Stroke Center.

27. To address a critical gap in services in the region, a new, comprehensive oncology center is in the planning for the SMH main campus and will consume the remaining footprint of the campus that is suitable for acute patient care space.

28. SMH Laurel Road will serve as an enabling project for these needed services and allow patients to continue accessing tertiary and specialty services at the main campus as opposed to

sacrificing that space to provide lower acuity care to south-county residents forced to travel north.

29. The majority of SMH Laurel Road service area patients currently accessing SMH's main campus, based on 2015 market shares and discharges, are projected to shift to the new hospital. This anticipated shift is supported by existing and historical market data and trends concerning patient choice for SMH. Thus, approval of a local SMH facility, expressly conditioned on providing "needed medical care to all patients in need, regardless of ability to pay," and providing a higher percentage of Medicaid, non-pay, self-pay, and charity care than is now being provided by south Sarasota County providers, will significantly reduce financial access barriers in the proposed service area.

B. The Venice Regional Proposal

30. VRMC is seeking to build a 210-bed replacement hospital four and a half miles from its current location, offering the same services currently offered at its existing facility. VRMC's original construction began 66 years ago, and was not done in a coherent, cohesive manner. Due to its age and piecemeal construction, the facility has significant problems, such as:

- VRMC is undersized and has small, semiprivate rooms, inadequate and non-ADA compliant bathrooms, and significant adjacency problems;

- The building's mechanical, plumbing, and electrical infrastructure are failing;

- The building is under negative pressure causing its cast-iron piping system to deteriorate and causing mold problems; and

- VRMC's IT infrastructure is inadequate to meet current standards of care.

31. VRMC's facility problems are so numerous and significant that the experts who reviewed the facility all came to the same conclusion: the hospital is at the end of its useful life, and replacing it is the only sensible option. There was no contrary evidence offered to refute this conclusion. In fact, multiple witnesses called by the other parties conceded VRMC should be replaced.

III. Statutory Review Criteria

A. Need for the Proposed Projects: § 408.035(1)(a), Fla. Stat.; Fla. Admin. Code R. 59C-1.008(2)(e)

1. SMH Laurel Road

a. Capacity Constraints at SMH Main Campus

32. SMH has an available 621[3/] licensed, acute care beds; 49 adult psychiatric and 37 child psychiatric beds; 44 comprehensive medical rehabilitation beds; and 33 Level II and III NICU beds. The majority of SMH's licensed

medical/surgical beds are in four patient towers: Northwest, Waldemere, East, and Courtyard.

33. Northwest Tower is the oldest acute care patient space at SMH at over 50 years old. The third and fourth floors have 53 licensed beds, and 40 are semiprivate. Semiprivate rooms in Northwest Tower are 11 feet, seven inches wide. The typical hospital bed is eight feet long. Placing two of these beds in a room makes it difficult for patients to navigate, especially when attempting to access the restroom. Semiprivate rooms in Northwest typically have a toilet and a sink in the common part of the room, but no shower. Bathrooms are not Americans with Disabilities (ADA) compliant.

34. SMH nursing personnel witnessed a patient bathing in a sink in the middle of a Northwest semiprivate room while a roommate's spouse refused to give him privacy. Another patient used a portable commode in the doorway of his room because his roommate, who had a gastrointestinal bleed, was using the toilet and the portable commode did not fit into the room.

35. Northwest Tower acute care patient areas have one shower per floor, which is in the hallway.

36. Small private rooms in Northwest Tower make mobility difficult: they are essentially full once the patient bed, trashcan, chair, and small table are added, and they must also accommodate large, modern equipment and larger patients.

Hallways are crowded and difficult to navigate, portable work stations and equipment are frequently in hallways due to a lack of storage, showers are used as pantry space, and the nurses' stations are inadequate for modern nurse-to-patient ratios. Today's patients are sicker and require more nursing staff and ancillary help than the spaces were designed to accommodate, which adds to overall congestion.

37. The design and space constraints within Northwest Tower pose significant ergonomic challenges for staff working in the units as a result of the routine shuffling of equipment, crowding, and maneuvering to access patient headwalls. Nursing staff is embarrassed to place patients in these subpar spaces compared to patients' expectations of SMH as a CMS 5-Star hospital. The conditions in Northwest Tower impact and challenge staff ability to provide quality patient care.

38. East Tower is the next oldest acute patient care space, built in 1972. The fifth through eighth floors have 180 licensed beds, 121 of which are semiprivate. The ninth and tenth floors previously housed rehabilitation patients. Those units were moved to a new rehabilitation pavilion, giving SMH the rare opportunity to renovate the vacant floors to add 52 private rooms.

39. East Tower private rooms are so narrow that beds are positioned parallel to the headwall to allow footwall clearance.

This makes it difficult for staff to care for a patient who codes (experiences a life-threatening emergent condition), needs a bath, or requires fresh bed linens. Architect Charles Michelson described the configuration as "not an acceptable standard of practice of medicine" because, at any time, providers require access to both sides of a patient.

40. At least one cardiac unit cannot be used to full capacity because the nurses' station is too small to accommodate the required cardiac monitors.

41. Semiprivate rooms in East Tower are so small that chairs do not fit in the room when both beds are occupied, and the rooms do not have showers.

42. Storage is so limited that equipment is stored in hallways and in the only shower available to patients in semiprivate rooms. The nursing station is too small to accommodate the required personnel, so nurses are forced to stand and complete their patient charting on rolling laptops.

43. The cramped spaces in East Tower present safety concerns, and disruptions for staff and patients who must be moved in order to allow other patients to come and go, as well as navigate cords and objects placed along the footwall such as commodes, chairs, and trashcans.

44. Waldemere Tower was built in 1985 and houses the majority of SMH's medical patients in 188 beds on floors five

through 10. It has many of the same deficiencies as Northwest and East Towers, including an abundance of small, semiprivate rooms with all of the previously described attendant problems, including narrow rooms.

45. In one photo received in evidence, a weight dangles from the foot of the hall-side bed. The weight is attached to a pin through the bottom of a patient's fractured leg to separate the patient's muscles and tendons before surgery. In this semiprivate room, lab personnel, nurses with workstations, physicians, visitors, other patients, and possibly a stretcher, all must travel past that weight without bumping it. If bumped, the weight could fall off or displace the fracture.

46. SMH provides the highest quality care possible in the cramped spaces, but they are challenged to do so every day.

47. The Courtyard Tower was built in 2013, has only a few semiprivate rooms, and was presented at the final hearing as an example of what a modern patient tower should look like. The other towers are 40 to 50 years old and house most of SMH's licensed acute care beds in semiprivate rooms. Problems common to the three older towers include insufficient utilities in patient headwalls; insufficient storage, forcing SMH to use needed functional space for storage; lack of patient showers; lack of sinks in patient bathrooms; lack of family waiting

areas; lack of ADA-compliant bathrooms to allow for staff assistance; and aged electrical, mechanical, medical gas, and nurse call infrastructure.

48. Semiprivate rooms at SMH range in size from 183 square feet in Northwest, to 222 square feet in East, and 239 square feet in Waldemere. Even in the mid-size East Tower rooms, this means patients sharing a room could, from their beds, easily hold hands. This contrasts with the 571-square-foot semiprivate and 226-square-foot private rooms in the modern Courtyard Tower. Semiprivate rooms in SMH's older towers hold twice the beds, equipment, patients, nurses, and visitors in a room half the size of a modern patient room. Semiprivate rooms also present challenges to a hospital in terms of patient flow, logistics, infection control, and privacy. Before a patient can be placed in a semiprivate room, staff must consider gender because only same-sex patients may share a room.

49. For efficient patient care, SMH's acute care spaces are divided into condition or program-specific units. Thus, even if an appropriate roommate is identified for a new admission, SMH staff must consider whether the bed is on an appropriate unit. Staff must also consider space constraints; Patients are larger now than when the SMH patient rooms were built. They require larger beds and equipment, which takes up more space. Patients with infectious diseases cannot room with

other patients. With mostly semiprivate rooms, this means isolation patients commonly occupy semiprivate rooms, thereby decommissioning the other bed.

50. SMH treats patients with respiratory illnesses. Related equipment and noise make it difficult to place these patients in a room with another patient. Other types of patients whose conditions prevent use of all beds in a semiprivate room include those who: refuse shared rooms; have behavioral or substance withdrawal issues and are disruptive or frightening to a neighbor; have hearing difficulty; forensic patients; cancer patients with radiation seed implants; and patients with mobility constraints requiring bedside commodes.

51. Semiprivate rooms compromise patient privacy by making each patient's neighbor, and neighbor's visitors, privy to conversations with caregivers. These are undesirable complications for all of SMH's semiprivate rooms.

52. Specific to the three older towers, the semiprivate rooms are so small that, to move a patient to or from the window-side bed, the hall-side bed must be moved. This disrupts the hall-side patient and it occurs at all times, regardless of whether the patient is sleeping, in pain, or clinically inappropriate for that type of motion. When a window-side patient "crashes," the hall-side patient has to be moved from the room in order to get the crash cart in.

53. Space constraints pose fall hazards to patients and make it difficult for families to visit, assist with patient care, or receive education on care for their loved ones upon discharge. Not surprisingly, semiprivate rooms do not contribute to patient satisfaction with their hospital experience.

54. To combat problems with semiprivate rooms and cramped patient care areas, SMH launched the "private bed initiative," seeking to host patients in a single occupancy room when possible. But even in its mostly semiprivate configuration, and despite what appears to be manageable average annual occupancy, SMH cannot meet the growing demand for acute care services at its main campus.

55. Between 2013 and 2015, SMH experienced 16.9 percent growth in its total patient days, more than any other hospital in Sarasota County, higher than the district average, and more than five times the state rate. SMH experienced an even greater 22.6 percent increase in patient days from 2014 to 2016, again exceeding the state rate by more than five times. Much of that growth is from south Sarasota County, despite its remoteness from SMH's northerly main campus. SMH projects this growth to continue.

56. Semiprivate beds hamper SMH's ability to actually use all of its beds, as described above. In addition, observation

patients--who require the same level of care as inpatients--commonly occupy licensed beds, but are omitted from publicly-reported occupancy data. They have become an increasingly significant component of assessing available bed capacity. On average, SMH cares for nearly 63 observation patients per day on acute care units while awaiting final determination of inpatient admission or discharge.

57. In part, to comply with CMS regulations, placement decisions for observation patients are made by clinical personnel based on the appropriate level of care for each patient, rather than on assumptions that, until a patient is deemed to require admission, he or she warrants lesser care. SMH's 52.4 percent average annual occupancy of licensed, acute care beds jumps to nearly 63 percent when including observation patients in licensed beds.

58. In season, SMH's observation population in licensed beds on an average day increases to 82 patients. The growth in observation status cases was unchallenged at the final hearing. Accordingly, it is reasonable to conclude that the AHCA acute care "occupancy percentage" must be viewed in context of this shift in the delivery of medical services.

59. SMH's opponents argue that this issue could be solved by simply adding observation units. But the evidence showed that SMH does not have the physical capacity on its campus to

add new units to accommodate the segmenting of observation patients. Accordingly, the issue of "functional occupancy" (acute inpatients plus observation patients), represents a mitigating factor in assessing published "acute care occupancy" based on current medical care delivery.

60. When SMH's inpatient and observation patients are considered in light of the number of operational beds at SMH, occupancy increases to 66.3 percent. Considered in light of the private bed initiative, SMH's average annual occupancy, including inpatient and observation patients during the 12 months ending March 2017, was 91.3 percent. Average occupancy of that level is problematic, not only because SMH utilization is increasing, but also because Sarasota County's population is highly seasonal and hospital volumes increase dramatically in winter months. SMH volume during peak seasonal months of January to March 2017, measured against the number of licensed beds and including observation patients, was 71.5 percent. Considered in light of the beds actually available during those months, SMH's bed occupancy was nearly 77 percent, and the occupancy of its available patient rooms assuming single-occupancy placement would have been 105.5 percent. For these reasons, Tim Cerullo, CEO of BHPC, criticized average annual occupancy as a metric for hospital

capacity: "if you are just looking at the law of averages, you would not be able to judge whether a hospital was full on any given day . . . ."

61. From the patient's perspective, congestion at SMH is first experienced during travel to the hospital on congested roadways. Once a patient arrives on campus, parking, valets, and traffic jams are a challenge. Patients take circuitous routes into the hospital from the parking garage. Volunteers are required to guide foot traffic inside the hospital. Elevators are overloaded and patients may wait five to 10 minutes for an elevator. Once a patient is admitted, SMH begins the process of identifying an appropriate room based on unit, gender matching, disease processes, and more.

62. These issues are amplified during season, the resulting overcapacity problems being described by one SMH witness as SMH's "burning platform." To address the problem, SMH leadership initially spent $2,800,000 to develop comprehensive efficiency and capacity enhancement strategies. They hired two dedicated capacity managers, re-operationalized all beds decommissioned for storage or office space, and hired more staff.

63. SMH created and fully staffed a logistics center with clinical and administrative personnel, transfer coordinators, and others to manage patient flow, transfers, and housekeeping

to expedite room turnover. The logistics center is a command center for patient flow and throughput and includes real-time dashboards on monitors showing the status of capacity indicators at the hospital. SMH added a departure lounge where discharged patients awaiting a ride or other accommodation can comfortably wait without occupying a needed bed.

64. SMH also looks for ways to improve its configuration and service lines to address capacity and efficiency, and to satisfy its mission to provide quality health care to all residents of Sarasota County. Those strategies include the planned addition of a cancer center with 30 licensed, inpatient beds to be pulled from existing semiprivate rooms; and relocation of rehabilitation services, which are less reliant on core hospital and critical care functions, to make room for 52 private, acute care patient rooms in East Tower. The 45 beds AHCA agreed to hold in abeyance when the outdated Retter Tower was demolished will fill most of the 52 rooms in the soon-to-be-renovated East Tower ninth and tenth floors. Despite these best efforts, the evidence on whole showed that SMH faces daily challenges with capacity, and does not realistically expect to have enough room to handle even the 2018 seasonal volume.

b. Expansion of Main SMH Campus to Address the Problem?

65. SMH's existing bed towers are not capable of being renovated to modern and ADA-compliant standards while

maintaining capacity and unit efficiency. The best options to address campus congestion and problems with semiprivate rooms would be to use existing semiprivate rooms as single occupancy by removing one of the two beds. This would help with decompression and efficiency because it would mean fewer patients per floor, fewer staff, decreased room turnover, and less shuffling of patients to troubleshoot semiprivate accommodations. But doing so would sacrifice patient beds in a hospital that already struggles with functional capacity limitations. For the reconfiguration to be possible, other space must be identified to allow for transfer of the lost patient beds.

66. But with the exception of the projects SMH has currently proposed, the campus is saturated and SMH cannot increase its general medical/surgical capacity in a manner that will position it to meet patients' needs into the future. Even if existing spaces could be renovated, SMH cannot afford to close units and lose beds while renovations are made.

67. The parties opposing the SMH Laurel Road proposal advanced the argument that a new, nine-story tower could be constructed on the existing SMH campus. The new building, dubbed the "Tamiami Tower," could be located on the northeast quadrant of the SMH campus, parallel to U.S. 41, Tamiami Trail, touching the SMH critical care tower, and bridging to the

Courtyard Tower at scattered points on floors three through nine. According to SMH's challengers, the Tamiami Tower would alleviate the overcapacity problems that now exist, and obviate the need for a new hospital on Laurel Road.

68. However, the Tamiami Tower concept did not include a column layout for the open-air first and second floors, unit or programmatic specifics, space for mechanical and electrical systems, or elevators. The Tamiami Tower would obscure the SMH emergency room entrance, constrict the helipad servicing the SMH trauma center, and exacerbate congestion and wayfinding challenges both during and after construction.

69. Moreover, the Tamiami Tower alternative is impractical from an operational perspective in that it invites public traffic into the most sensitive units of SMH, including labor and delivery, NICU, and mother/baby units, and cannibalizes needed spaces within those newly-constructed units.

70. There were numerous caveats and assumptions noted in the Tamiami Tower architectural report offered by the Fawcett/Englewood architect. For example, the report assumes that "existing infrastructure would be sufficient or that new infrastructure could be included in the expanded construction." The reasonableness of that assumption was not persuasively established at hearing. What is clear is that the practicality of the Tamiami Tower proposal would require extensive additional

study in order to determine its feasibility. Even then, no evidence was presented to counter the operational, congestion, adjacency, and other problems the project would present.

71. In short, the evidence failed to establish that the Tamiami Tower concept would be a reasonable and practicable solution to SMH's functional space limitations and capacity constraints.

2. Venice Regional Replacement Hospital

a. VRMC is Undersized and Outdated

72. Like many older hospitals in Florida, VRMC was not designed for the modern health care environment, where patients are larger, sicker, and require more medical equipment and staff to care for them. VRMC's inadequate size is demonstrated by its total hospital square footage per bed, which is almost half the size of VRMC's proposed hospital. The existing hospital has 983 square feet per bed, compared to 1,900 square feet per bed in the proposed hospital.

73. The majority of VRMC's existing patient rooms are semiprivate, and about half the size required by current codes. VRMC has 113 semiprivate rooms that are 160 square feet: EDmeaning patients treated in 226 of its 312 licensed beds have less than 80 square feet per bed. The private rooms are only 130 square feet, compared to today's minimum code requirement of 300 square feet per private room.

74. The patient bathrooms are woefully undersized, with only 10 percent being ADA compliant. Kristen Gentry, VRMC's chief operating officer, testified that given the elderly nature of VRMC's patients, all the bathrooms should be ADA compliant so that staff can assist patients in the bathrooms and patients can use walkers and other equipment, which is currently impossible. The surgical intensive care unit (SICU) has "swivette" toilets that swing out of cabinets, which are problematic and not code-compliant.

75. Due to the "hodge-podge" construction, there are adjacency and patient flow issues. For example, postoperative open-heart surgery patients are transported via a small public elevator to the ICU on a different floor, increasing the risks of adverse incidents. The elevator is too small to allow the appropriate medical personnel to accompany the patient on the elevator, and balloon-pump patients must have the balloon pumps placed on their stretchers to fit in the elevator, which increases the risk of dislodging their cannulas.

76. The operating rooms at VRMC are inadequate. All but one is less than 400 square feet, whereas today's code requires over 600 square feet. The operating room that meets the current minimum code requirements for size is being evaluated as the place to implement a transcatheter aortic valve replacement (TAVR) operating room. However, it is undersized for that

purpose, as a TAVR operating room should be 1,000 to 1,200 square feet, due to the numerous personnel in the room during the procedure.

77. The ED is undersized and frequently relies upon hallway beds in season because there are not enough treatment bays. The ED ancillary areas are undersized and inadequate. There is no electronic tracking system to expedite the patient flow process.

b. Mechanical, Electrical Plumbing Systems Failures

78. VRMC's mechanical, electrical, and plumbing systems are failing. VRMC has experienced numerous disruptions in patient care related to its deteriorating building, including: sewer and fresh water pipes breaking and exhibiting signs of rust, a rodent infestation, and mold and asbestos issues.

79. VRMC presented experts in the fields of electrical engineering, mechanical engineering, roofing, architecture, industrial hygienic engineering, and hospital physical plant operations. The universal consensus from these experts was that VRMC's current facility has so many problems that renovating it is not a viable option. Many of these experts testified VRMC's physical plant was one of the worst they had seen in their careers.

80. In 2015, VRMC had two very highly publicized concurrent incidents that resulted in a significant market shift

of health care services: a sewer pipe rupture and discovery of a rodent infestation. These issues directly relate to the aged hospital facility, and are illustrative of some of the ongoing and future potential infrastructure challenges VRMC faces.

81. The sewer pipe rupture was caused by disposable towels being flushed down the toilets and getting caught on the rusty, corroding sewer pipes, causing blockages and raising the pressure in the pipes. Unbeknownst to VRMC, a prior owner had replaced sections of the cast iron sewer piping in the interstitial space with polyvinyl chloride (PVC) piping and a PVC cap. The pressure buildup caused the PVC end cap to burst off, sending a tremendous amount of sewer waste into the interstitial space.

82. The sewer waste seeped down through the old gravel roofing (which was the floor of the interstitial space), through the ceiling, down the walls, and onto the second story hallway floor. The sewer waste flowed down the hallway until nurses could divert its flow to an elevator shaft.

83. VRMC hired a licensed, independent contractor specializing in cleanups of this nature to do the cleanup. Upon completion, there were no obvious signs of the sewer leak inside the hospital. However, an AHCA complaint survey conducted a month after the initial cleanup revealed that the cleanup was inadequate, leaving sewer waste that had soaked into the gravel

roofing material in the interstitial space, and a small amount of sewer waste remnant in the elevator shaft. The uncleaned sewer waste was not readily detectable from the patient care areas inside the hospital. Ultimately, the entire gravel roof on the interstitial space had to be removed to thoroughly clean the sewer waste.

84. VRMC's investigation of the sewer pipe incident revealed additional facility problems: the vertical stacks in the North Tower were cracking and had to be replaced. The stacking project and gravel roof removal were major disruptions to VRMC's ability to care for patients, with constant shutdowns of significant portions of the hospital, including the operating rooms at one point. The remediation impacted patients and physicians, including: unavailable operating rooms, constant vibrations due to construction, noise issues, and sewer smells.

85. The sewer pipe cleanup, consisting of entirely removing the gravel roofing material, sealing the floor of the interstitial space, and replacing the vertical stacks in the North Tower, cost VRMC $10 million (excluding business interruption damages and consequential damages), and took two years to complete. Unfortunately, during this remediation process, there was a fresh water pipe break, which led to the discovery that the subsurface sewer drainage pipes in the South Tower also had to be replaced because the pipes had completely

disintegrated, leaving only the built-up sludge in the pipes as the conduit for the sewage to flow through.

86. With the operating rooms shut down and other facility interruptions caused by the remediation, and with patients raising concerns about the safety of the hospital (predominantly based upon the media sensationalism), many of VRMC's general surgeons and orthopedic surgeons began taking elective cases to other hospitals. Elective surgery, and particularly orthopedic surgery, is a very profitable service line for a hospital, so this had a significant adverse financial impact on VRMC.

87. In the aftermath of the sewer pipe incident, VRMC's open-heart surgeon, Dr. Fong, moved his practice to SMH. After Dr. Fong left, VRMC's open-heart surgery cases dropped from around 350 cases a year to 200 cases a year. Open-heart surgery is also a profitable service line for hospitals, and this also had a severe negative financial impact on VRMC. VRMC also lost several neurologists around this same time, including Dr. Coleman, who is now employed by SMH.

88. Despite replacing the vertical sewer pipes in the North Tower, VRMC has continued to experience plumbing issues throughout the hospital, including in the North Tower. Many of the horizontal pipes cannot be accessed without literally tearing the entire hospital apart, and because of the deteriorated condition of the pipes, it is not appropriate to

use other methods to clean out the pipes, such as jetting or rotoring, since that could cause further damage to the pipes.

89. The rodent infestation discovered during the same AHCA complaint survey as the inadequate sewer clean up, is also indicative of the aged facility. The surveyor removed a ceiling tile in the kitchen area to check for additional sewer waste remnants in the crawlspace between the second-floor ceiling and the interstitial space floor. When he put his head into the crawlspace ceiling area, he saw and heard rodents. VRMC's administration was not aware of the rodent infestation prior to the survey; and if they had known about it, they would have taken steps to correct it. It is likely the rodent infestation went unnoticed because of the thickness of the ceiling tiles, which are designed as fire and moisture barriers.

90. The rodent infestation resulted in the kitchen having to be shut down, and a temporary mobile kitchen being put into place while the cleanup was done. It was subsequently discovered that the rodents were entering the kitchen ceiling through an abandoned sewer pipe that had either not been capped off at its termination or where the cap had come off over time. The rodents entered the pipe through the uncapped termination end, and because the pipes were so deteriorated, were able to eat their way through the pipes above the kitchen ceiling to gain access to the crawlspace.

91. The rodent infestation in the kitchen has been fully remediated; however, due to the aged building, preventing future rodent infestations from occurring is a constant battle. VRMC has hired a pest control contractor to do daily rounds of the facility; searching for signs of rodents and eliminating any that are found.

92. In addition to the serious plumbing and vermin issues at the hospital, there are also significant electrical and mechanical issues at VRMC. Hugh Nash, VRMC's expert in hospital electrical engineering, walked through numerous problems with the mechanical and electrical systems at VRMC, and pointed out several components that were well beyond their expected useful life, some dating back to the hospital's original construction. For example, he explained that a hospital's transfer switches are critical components of a hospital's electrical system because they control the generator power coming on in a power outage. A transfer switch typically has a useful life of 25 years. Many of VRMC's transfer switches are over 30 years old. They also lack important safety features, such as being grounded or requiring manual operation to initiate the switch (something Mr. Nash testified he had never seen before in any hospital).

93. The generators that were installed in 1969 do not have appropriate ventilation, and are located below the 100-year

floodplain. Mr. Nash has rarely seen generators in hospitals that are over 30 years old; VRMC's are 48 years old. He also testified that any significant renovation to the electrical system at VRMC would require the generators be moved above the floodplain, which would be very costly.

94. Mr. Nash explained that one reason hospitals wait so long to replace transfer switches is because of how disruptive it is to the hospital's operations. He also testified that given the lack of available space in the conduits and ceilings, it would be nearly impossible to make the necessary renovations to VRMC's electrical systems; and even if it were possible, the exorbitant costs to do so would make it impractical.

95. VRMC's facility infrastructure problems are a constant source of irritation to the physicians that care for patients at VRMC. For example, Dr. Dreier testified:

> It's falling apart around us.
>
> * * *
>
> It seems like every few weeks there is a pipe that's broken. The medical ICU has flooded several times. The surgical ICU has flooded several times. Water is not available because the water is being shut down because it's been contaminated from broken pipes.

96. Dr. Landis compared fixing the problems at VRMC to trying to fix an old car:

> The damage is extensive in this hospital, and the wearing of this hospital is - as I said, it's a case of original sin. It was the way this hospital was constructed. It's not going to get any better. And you can put good money after bad, but the fact of the matter is, is that it's just not going to happen. You would have to reconstruct this entire building from the inside. And then when all is said and done, the space that this hospital has and the way it was built and what is expected by patients in 2017 this hospital doesn't have. So why would you do that? I mean, it gets to the point where you replace the trannie, you replace - you replace the alternator, you replaced the battery, but the motor sucks. And the bottom line is that's what we have here.

97. Dr. Joseph Chebli, a bariatric surgeon, recounted having to interrupt a surgical procedure that was about to start when a sewer pipe leak occurred outside his operating room. This was after the vertical stack remediation had been completed. He summarized his frustrations saying the hospital is a "constant embarrassment" to him and his patients.

c. The Negative Pressure Problems

98. Prior to HMA purchasing VRMC, the prior owner, the Bon Secours Health System, identified a significant moisture intrusion problem. In 2005, HMA attempted to address the moisture intrusion problem by coating the building with an elastomer paint that would act as a barrier to moisture coming

into the building. However, the hospital has severe negative pressure, which causes it to suck moisture into the building. Once the moisture gets under the coating, whether it is through roof leaks, window leaks, cracks in the elastomer coating, internal plumbing leaks, or just evaporation caused by temperature changes, it cannot escape and creates mold issues. VRMC experienced a recent mold issue in its SICU that closed the unit for several months for remediation.

99. Nick Ganick, a mechanical engineer, testified that the "severe" negative pressure situation and moisture intrusion has been "disastrous" for the hospital, and could have caused the deterioration of the cast-iron pipes, resulting in the numerous system failures:

> One of the things that I look at as a mechanical engineer in healthcare is negative pressure. Building negative pressure is disastrous to hospitals. It's bad for the envelope, it's bad for mold down here in Florida, it carries bad things into the hospital that are unfiltered.
>
> * * *
>
> The reason for the condition of the pipe could have been negative pressure, it could have been some of the moisture in the building.

100. Charles Cummings, an expert in industrial hygienic engineering, testified that negative pressure in a hospital raises safety concerns:

> You have to control the environment in a hospital, and the inability to do that allows humidity to run rampant, it allows airborne diseases and other infectious - mold spores, for instance, other bacteria, other things that just live inside and outside of any building, much less a hospital building, it gives them a fertile ground to grow.

101. VRMC has attempted to correct the negative pressure issues, but this is a daunting task with such an old, porous building. The situation is compounded by the fact that there are 20 to 30 heating, ventilation, and air conditioning (HVAC) units in the interstitial space, some the size of dump trucks, that are old and not able to keep up with the porous building; however, replacing them requires disassembling the old equipment (by cutting them into small pieces with a blow torch) just to get them out, disassembling the new pieces of equipment to get them into the interstitial space, and reassembling them in the interstitial space before they can be installed. This dramatically increases the complexity and costs of replacing the HVAC equipment, and there is no guarantee that replacing the HVAC equipment would resolve the negative pressure problem.

d. Information Technology (IT) Problems

102. Not surprisingly, VRMC needs a complete IT overhaul. It does not have an integrated electronic medical record (EMR) system, which is the current standard of care for hospitals. Implementing an EMR system at VRMC has been considered on

multiple occasions, but the building has raised such substantial obstacles it has proven nearly impossible. One significant obstacle is the lack of space to incorporate computers into the end-user work spaces--patients' rooms, nurses' stations, and other patient treatment areas. Some of the other problems, such as cabling or storage and charging of computers on carts, individually might be surmountable, but collectively and in light of the inability to get the computers where clinicians can access them at the points of care, becomes somewhat moot.

103. The IT limitations of the facility go beyond the inability to implement an EMR system. Currently VRMC's surgeons dictate medical records on folding tables stuck in corridors outside operating rooms because there are no other adjacent spaces to accommodate this function. Elective surgery is profitable and if there was any practical solution, VRMC would have already implemented it to encourage surgeons to operate there.

104. The ED has a separate medical record system that is not integrated with the rest of the hospital. Patients admitted through the ED must have information manually re-entered, delaying admissions and increasing the potential risk of errors.

105. Numerous physicians voiced their frustrations with VRMC's IT issues, including, among other things: the lack of ability to communicate via cell phones and text messages in the

hospital; slow computer systems; the limited ability to access patients' full medical records from their offices; and the lack of a "true" integrated EMR system.

106. Dr. Palmire testified:

> So the cell phones don't work in that hospital. You cannot call out. I cannot call out anywhere in that hospital.
>
> * * *
>
> And it's a real - and that is - and communication, you can't be a physician and not be able to communicate with people. So you're stuck with landlines. You know, cell phones enhance my productivity substantially because I can walk around or do something else. I'm not tied to a phone. There's only so many phones, you know, and lines. You can't provide a phone and a line for every physician in that hospital. So this kind of communication is critical, and you cannot do it within that facility.

107. The are no viable options to replace VRMC on site without completely disrupting hospital operations and effectively shutting the hospital down because of the limited size of the hospital campus and the surrounding existing residential uses of the adjacent parcels. Further, it would not make sense to replace VRMC onsite even if it were possible given the vulnerability of the existing site to hurricanes. SMH's CEO, Mr. Verinder, conceded VRMC's current location was problematic and if SMH had purchased the facility it would have filed a replacement hospital to move the location.

B. Availability/Accessibility/Utilization of Existing Facilities; and Enhanced Access for Residents of the District: § 408.035(1)(b) and (e), Fla. Stat.

1. SMH Laurel Road

108. Subdistrict 8-6 is home to SMH, VRMC, Englewood, and Doctor's Hospital of Sarasota. Adjacent Charlotte County, part of district 8, is home to Fawcett and BHPC. Except for SMH, all are private, for-profit hospitals.

109. SMH is the Sarasota County's safety net hospital, providing nearly 90 percent of Medicaid and charity care in Sarasota County, and more than 65 percent of the County's uninsured care. SMH is the sole provider in Sarasota County for Medicaid-heavy service lines like OB, Level II and III NICU, pediatrics, adult and pediatric psychiatric, and trauma.

110. Utilization at SMH has steadily increased since 2013 at a rate far greater than district, or state averages. The proposed service area for SMH Laurel Road is growing and aging faster than the rest of the County and, by 2021, will represent 60 percent of the 65 and older population of Sarasota County.

111. In addition to growth at its main campus, from 2014 to 2016, SMH experienced 25-percent growth in its south county ambulatory care centers. SMH's employed physicians group, with locations throughout Sarasota County, including North Port and

Venice, also is growing. This established network demonstrates SMH's commitment to providing care to south county residents.

112. The SMH network will serve as a referral base for south county residents requiring inpatient care--including a substantial and increasing elderly population--who could be treated at SMH Laurel Road without traveling to the main campus. Many of these patients already bypass closer hospitals to travel from south Sarasota County to the SMH main campus, despite substantial distance and drive times, particularly in season.

113. In 2015, nearly 25 percent of SMH Laurel Road service area residents chose to receive inpatient care at SMH, which captured 17.3 percent of the inpatient market share in that service area. By 2016, SMH's inpatient market share in the SMH Laurel Road service area had increased to 21.3 percent, and 19 percent of SMH main campus patients came from that service area. SMH Laurel Road is expected to capture approximately 3,548 of what otherwise would be SMH main campus adult, non-tertiary, non-OB discharges during its first year of operations, or about 80 percent of the main campus's 2016 proposed service area market share.

114. As SMH's market share in the Laurel Road service area increased, VRMC, Fawcett, and Englewood market shares declined and BHPC's market share was essentially stagnant.

115. SMH's opposition argued that the presence of other providers with available beds serving the SMH Laurel Road service district weighs against need for SMH Laurel Road. To the contrary, market conditions showing faster growth at the more distant hospital more likely indicate accessibility challenges with the closer hospitals.

116. SCPHD's focus on avoiding hospital admissions, promoting positive outcomes, and managing chronic conditions, hinges on access to primary care and follow-up continuity of care. SCPHD was anticipated to record over 272,000 south Sarasota County ambulatory care visits in the fiscal year ending September 30, 2017, indicating strong patient-alignment with SCPHD. The top 43 attending physicians accounting for over 61 percent of SMH admissions from the SMH Laurel Road service area did not admit a single patient to VRMC, BHPC, Englewood, or Fawcett in the 12 months ending September 30, 2016.

117. In an abstract evaluation of acute care occupancy versus actual patient flow, it could be argued that "patient convenience" should not outweigh traditional health planning need assumptions of available licensed bed capacity. But the dynamics of contemporary medical care delivery cast doubt on the traditional planning metric: The fact that SMH gained four-percent market share among residents of its proposed PSA in less

than one year, likely resulted from SCPHD initiatives to promote access to primary and diagnostic services for residents of south Sarasota County.

118. The SMH Laurel Road proposal will enhance access to inpatient services and promote continuity of care for south Sarasota county residents who have already aligned with SCPHD. This symbiosis also will ensure continued financial viability, and therefore accessibility, of SMH without the need to increase the ad valorem tax burden on county citizens.

119. SMH Laurel Road will offer a full-service OB program, a service currently not available within the proposed service area. Currently, SMH is home to Sarasota County's only OB, NICU, and pediatrics programs, including high risk maternal fetal medicine, 24/7 OB hospitalist coverage in-house, 24/7 neonatology coverage in-house, and a maternal neonatal transport team for high-risk transfers. The SMH NICU serves as a transfer destination and back-up NICU to several hospitals in the region.

120. SMH already captures over 70 percent of SMH Laurel Road service area OB discharges, 85 percent of which are expected to shift to SMH Laurel Road upon opening. While BHPC's OB market share has declined, SMH's has increased steadily since 2013. Even in south Sarasota County zip codes closer to BHPC than SMH, SMH has a larger OB market share than BHPC.

121. Shon Ewens, executive director of the Sarasota County Healthy Start Coalition, a support organization for mothers and children, testified via deposition that the majority of her clients are Medicaid recipients, many come from southern Sarasota County, births from that area are on the rise, and her clients receive OB services at SMH.

122. It is burdensome for south Sarasota County OB patients to travel to the SMH main campus for OB services. As pregnancy progresses, the number of prenatal appointments increases. Mothers may be expected to visit their providers as often as twice a week, driving 45 minutes to an hour to SMH, and interrupting jobs and other obligations. These burdens cause interruptions in prenatal care to the detriment of the expectant mothers' health. These are barriers to accessibility of OB services in Sarasota County that would be alleviated by the approval of SMH Laurel Road. Ms. Ewens testified that, for her clientele, the SMH Laurel Road OB program is needed. Her conclusion was echoed by health care planning expert, Roy Brady.

123. The large numbers of southern Sarasota County residents, who already travel to SMH main campus for medical care, including pregnant women and the elderly, face challenging road conditions, particularly in season. Residents of the SMH Laurel Road service area who, either by necessity (unique or specialty service line, financial accessibility), or choice

(previous experience, recommendation), seek care at SMH main campus do not have access to care within 30 minutes, with the exception of the northwest section of the proposed service area.

124. With respect to the elderly, geographic challenges are exacerbated by visual impairment, hearing loss, and reduced reaction time. To compensate, elderly drivers avoid driving at night, dusk, and dawn; during rush hour, and in bad weather; plan routes that are familiar, and avoid interstates and left turns. This impedes seniors' access to acute care services, particularly when congested I-75 and Tamiami Trail are the primary roadways to SMH main campus.

125. Approval of SMH Laurel Road will also allow SMH to redirect some of its lower-acuity patients to a location closer to their homes, ensuring accessibility of main campus services only offered at that location.

126. SMH's opponents argue that SMH's capacity and decompression argument is SMH-specific need. While this is true in that SMH is the only area provider for certain service lines and the only safety net provider in the County, had the other area hospitals established OB, pediatric, psychiatric, and trauma programs, perhaps capacity at SMH would not pose access barriers to these services within the district overall. Until then, to the extent SMH capacity constraints threaten access to

otherwise unavailable services, those capacity constraints support SMH's need argument and are not institution-specific.

127. The undersigned considered arguments from SMH's opposition that SMH filed an application in a prior batching cycle which was virtually identical to the CON application at issue, and was denied, suggesting that the more recent application should also be denied. However, AHCA's representative, Marisol Fitch, noted that the addition of OB services to the application at issue was a "major change," as was VRMC's changed position with respect to its facility deficiencies which, in essence, altered the landscape in terms of the availability and accessibility of services in the region.

128. Taken together, the existing capacity constraints at the SMH main campus, and issues of availability and accessibility of services described above, establishes need for the SMH Laurel Road proposal. Specifically, SMH provides the vast majority of Medicaid services to residents of the district, suggesting access barriers to these underserved patients through other providers; utilization of its existing hospital and outpatient services has increased substantially in recent years; there is a large, growing population of south Sarasota County patients, including medically underserved, elderly, and OB patients, seeking services at SMH; its proposal enhances access to needed services within the district with the inclusion of an

OB program which, currently, is not accessible through any other provider; and SMH's main campus is at capacity and requires decompression in order to ensure access to needed services for all Sarasota County residents, including many services that only SMH provides.

2. Venice Regional Replacement Hospital

129. VRMC's replacement hospital will positively impact subdistrict utilization rates. The utilization forecast used VRMC's three-year historical market shares by zip code, and assumed VRMC would slowly recapture its premarket shift market shares. By year three, VRMC's replacement hospital will be 70 percent occupied, with an average daily census of 147 patients. Currently, VRMC is only about 40-percent occupied. Thus, approval of VRMC's replacement hospital will enhance the subdistrict utilization rates.

130. VRMC's relocation will bring the facility closer to residents in every zip code within its current and proposed service areas (which are the same), except its current home zip code. Residents in that zip code should not have trouble accessing VRMC's new location, which will only be a few miles away. Further, VRMC is leaving a freestanding ED on the island to ensure emergency access.

131. VRMC's new site will also enhance accessibility during and after a major hurricane. VRMC is currently located

on an island, very proximate to the coast, with many of its critical systems (including its generators) located below the 100-year flood plain. The building is not built to current hurricane strengthening codes. VRMC's proposed location will be much more accessible during and after a major hurricane because it will not be on an island and will be further from the coast. Current building codes will require the hospital be built so that the generator and other crucial systems will not be impacted by hurricane flooding, and that the hospital be constructed to meet or exceed the applicable hurricane wind-resistance standards.

132. VRMC's current facility limits its ability to provide certain state of the art health care services, including TAVR and interventional neurology. VRMC's replacement hospital will enhance residents' access to these services.

133. Structured heart procedures, including the TAVR procedure, are the wave of the future in cardiovascular surgery. TAVR reduces the need to perform open-heart surgery by performing valve replacements intravenously, which means shorter hospital stays and recovery times. TAVR requires a blended team of open-heart surgery and interventional clinicians, and the equipment used is very large and specialized. Thus, in comparison to standard operating rooms, TAVR operating rooms must be very large.

134. VRMC is struggling with implementing TAVR capability at its existing facility. The operating rooms are too small to accommodate the TAVR equipment and team. While VRMC is trying to find ways to squeeze it in within the confines of its existing space, the ability to develop and grow the entire structured heart program is limited by the physical capacity of the facility. Approval of VRMC's replacement hospital will allow this program to flourish, and will enhance access.

135. Venice and North Port stroke patients will have enhanced access to neurological intervention if VRMC's replacement hospital is approved. Sarasota County Emergency Medical Services (EMS) takes all stroke patients under 80 years old to the closest comprehensive stroke center. SMH is the only comprehensive stroke center in Sarasota County and Charlotte County. Thus, when EMS transports stroke patients from southern Sarasota County, they bypass closer hospitals to go to SMH. In stroke cases, every second of delay in reperfusion means loss of brain tissue, which results in physical and cognitive impairments. VRMC is striving to become a comprehensive stroke center and has everything in place to meet the requirements, except an interventional neurologist.

136. According to hospital administrators, VRMC has not been able to recruit an interventional neurologist because of its aged, outdated facility. Approval of VRMC's replacement

hospital will make it easier for VRMC to recruit an interventional neurologist and become a comprehensive stroke center. When VRMC becomes a comprehensive stroke center, EMS will no longer have to bypass VRMC, and south County stroke victims who are closer to VRMC than SMH will be able to have their intervention sooner, resulting in less brain injury and impairment.

137. VRMC's replacement hospital will enhance access to disenfranchised former patients of VRMC. The market shift caused former VRMC patients to travel farther to receive acute care services. Replacing VRMC will shift many of these patients back to VRMC, enhancing their access to care closer to home.

138. South Sarasota County residents will also have enhanced access to continuity of care with their primary care physicians and other established specialists. It is difficult for physicians who are not on staff to get access to information from hospitals. Shifting patients back to VRMC will fix this disconnect and enhance patients access to a coordinated system of care.

C. The Extent to Which the Proposal Will Foster Competition that Promotes Quality and Cost Effectiveness: § 408.035(1)(g), Fla. Stat.

1. SMH Laurel Road

139. Approving SMH Laurel Road will add a high-quality, cost-effective, competitive alternative to existing providers.

SMH has the lowest average charge for adult general acute med/surg cases compared to VRMC, Englewood, BHPC, and Fawcett. SMH has lower charges than VRBH across the board for the top 20 diagnosis related groups. Thus, introduction of SMH Laurel Road into south Sarasota County can be expected to have a positive impact on charges for patients in that market.

140. In reaching this finding, the undersigned considered argument from SMH's opponents that its status as a tax-supported public hospital gives it an unfair pricing advantage over private hospitals. The argument was not persuasive. SCPHD is governed by an elected Board with authority to set millage rates and levy taxes. If voters are unhappy with tax burdens, they can take corrective action.

141. At the same time SMH's opponents were challenging SMH's proposal on the basis that it receives local funds, they were suing to receive those funds themselves. They prevailed and, on July 6, 2017, the Supreme Court of Florida held that the relevant special law requires Sarasota County to reimburse not just public, but also private hospitals for indigent care. Venice HMA, LLC v. Sarasota Cnty., 228 So. 3d 76 (Fla. 2017). If SMH's access to public funds gave it a competitive advantage in pricing, the Venice HMA decision should level the playing field.

142. The addition of SMH Laurel Road to south Sarasota County also will increase non-price competition, such as quality and service offerings, as SMH is the only CMS 5-Star rated hospital in the state.

143. In addition to providing residents of the district a new access point for low-cost, high-quality care, SMH Laurel Road will bring new services to the area, such as OB.

144. Historically, VRMC has had a significant competitive advantage when it comes to treating residents of southwest Sarasota County who require hospital care within a close distance of their home. The addition of SMH Laurel Road will give residents a choice and encourage VRMC to enhance its patient satisfaction and quality--all to the benefit of district residents.

145. On balance, the record here shows that SMH Laurel Road will foster competition that promotes quality and cost-effectiveness.

2. Venice Regional Replacement Hospital

146. Approval of VRMC's replacement hospital would promote competition that will enhance quality and cost-effectiveness. Despite there being six hospitals that serve Sarasota County residents, SMH is the dominant provider with more than 50-percent market share.

147. VRMC is at a distinct competitive disadvantage currently because of its aged and obsolete facility, and the numerous, highly publicized problems that have occurred. These problems have resulted in a significant market shift from VRMC to SMH. If VRMC is not replaced, the market shift will not correct itself, but if VRMC is replaced, it is likely the hospital will recapture a significant portion of its lost market share.

148. Approval of VRMC will promote quality in several ways:

- It will end the constant facility problems that disrupt patient care;
- It will eliminate the risks to patients caused by the worn-out facility infrastructure;
- It will eliminate the risk of asbestos, mold, and the effects of a building that operates under "severe" negative pressure;
- It will eliminate risk related to the "hodgepodge" design, such as having to transport postoperative open-heart surgery patients in a small elevator to the ICU;
- It will enhance patient experiences with larger, private patient rooms and ADA compliant bathrooms;
- It will enhance the nurse call system and overall positioning of nursing units to patient rooms, so nurses can be more responsive to patients' needs;

- It will reduce unnecessary emergency room bottlenecks caused by too few emergency room treatment areas, lack of appropriate ancillary space, and reentering patient data;

- It will add additional large operating rooms, keeping patients from having to leave their community to receive elective orthopedic surgery;

- It will provide VRMC with IT capacity to meet today's standard of care by implementing an EMR;

- It will reduce the risk of medical errors by having more ability to safety check information in patients records and having more automated safety functions;

- It will reduce the physician frustration level related to the various IT inadequacies and other facility infrastructure problems;

- It will allow physicians better access to their patients' medical records from their offices, enhancing post-hospital follow-up care;

- It will allow the expansion of services like structured heart and comprehensive stroke certification;

- It will provide southern Sarasota County residents with quicker access to stroke care, minimizing their brain tissue losses and resulting physical and cognitive impairments;

- It will lessen the number of patients that travel to receive acute care;

- It will enhance continuity of care for patients with their established primary care and specialty physicians;

- It will prevent further erosion of VRMC's volumes and ensure adequate patient volumes to maintain existing specialty services;

- It will enhance VRMC's ability to recruit top quality physicians and nurses; and

- It will make VRMC much more likely to be available during and after a hurricane to meet the community needs.

149. Approval of VRMC's replacement hospital will also result in more cost-effective care. The costs in terms of dollars and man-hours to maintain VRMC, due to its facility problems are substantial. The one sewer pipe break alone was a $6 million expense, not including business interruption and consequential damages, such as lost referral patterns.

D. The Applicant's Past and Proposed Provision of Health Care Services to Medicaid Patients and the Medically Indigent: § 408.035(1)(i), Fla. Stat.

1. SMH Laurel Road

150. SMH is the safety net provider for Sarasota County. It is mandated to ensure that all Sarasota County residents, regardless of their ability to pay, have access to needed care and services. SMH's track record is reflective of this mission. Of the 23 general acute care facilities in district 8, SMH provided the highest number of Medicaid/Medicaid HMO patient days (21,576). Over the past three years, SMH provided in excess of 85 percent of all the Medicaid and medically indigent care to Sarasota County residents.

151. Not surprisingly, SMH far exceeds other area hospitals with respect to the amount of Medicaid and medically indigent care it provides through its ED. Of the 93,077 total ED visits at SMH for the twelve-month period ending September 30, 2016, 43,390 visits were Medicaid or medically indigent, far exceeding all other area hospitals.

152. Looking only at the patients from VRMC's proposed service area (same as its existing service area) for fiscal year 2016, VRMC had 5,013 Medicaid and medically indigent ED visits (26.3 percent of VRMC's total ED visits) compared to 11,556 Medicaid and medically indigent SMH ED visits (45.5 percent of SMH's total ED visits).

153. SMH's historically high Medicaid and indigent patient volumes are explained, not only by its mission, but also by the product lines it offers. SMH provides services that are typically highly utilized by the medically underserved, such as OB, NICU, pediatrics, and behavioral health. The vast majority of hospitalized Medicaid beneficiaries are pregnant women, newborns, and young children. By offering OB and decompressing the main SMH campus, which provides all Medicaid-dominant service lines, SMH Laurel Road will improve health care access to Medicaid patients throughout Sarasota County.

154. SMH's historical commitment to the provision of health care services to Medicaid patients and the medically

indigent is not in dispute, and the addition of SMH Laurel Road will further enhance access to inpatient care for Medicaid and medically indigent patients.

155. SMH's past and proposed provision of services to Medicaid patients and the medically indigent weighs in favor of approval of SMH Laurel Road.

2. Venice Regional Replacement Hospital

156. VRMC has a history of providing care to Medicaid and indigent patients. However, VRMC's service area residents are typically covered by Medicare. VRMC conditioned its CON on providing its current level of Medicaid and indigent care. VRMC will also be seven to ten minutes closer to North Port, which has a higher percentage of Medicaid and indigent patients. There was no credible evidence of record that VRMC denies care to Medicaid or indigent patients, or that such patients are discouraged from accessing care there. Approval of the VRMC replacement hospital is consistent with this statutory criterion.

IV. Adverse Impact

157. SMH and VRBH are existing providers with significant market shares in their proposed service areas. Therefore, projecting adverse impact on existing providers, as would be the case with new entrant proposals, where the success of the program is reliant on capturing market share from existing

providers is unlikely in this instance. Both applicants built their proposals on the assumption that they primarily would be supported by their existing patient bases resulting in minimal impact on existing providers.

158. The only evidence presented at final hearing implicating adverse impact of VRMC's proposal related to its market share projections, which, presumably, would require it to regain lost patient volume by taking patients from other providers. However, the evidence does not weigh in favor of denying VRMC's application based on lost market share, particularly in light of SMH's criticism that the projections were unrealistic.

159. As for SMH, for nearly two decades, SCPHD has developed a south Sarasota County network of facilities and physicians to respond to patient demand. Undisputed evidence was presented that the SCPHD south County network of providers would generate over 270,000 ambulatory care visits in the fiscal year ending September 30, 2017. The result is an established base of south County patients, including those from the SMH Laurel Road service area who currently, and in increasing numbers, travel to SMH main campus for hospital services.

160. For all inpatient services, nearly 25 percent of south County residents in the SMH Laurel Road service area already seek inpatient care at the SMH main campus. Isolating

the adult non-tertiary medical/surgical patient population, it was established that SMH's inpatient market share increased from 17.3 percent in 2015 to 21.3 percent in fiscal year 2016. This is a significant four-point increase in nine months, continuing the trend of an average quarterly increase of 0.6 percent in SMH's inpatient market share for adult non-tertiary medical/surgical services over the last 14 quarters. SMH Laurel Road is expected to have a service area medical/surgical market share of 22 percent when it opens in 2021.

161. With the relatively small size of its proposed hospital, and the large base of existing SMH patients, the impact of SMH Laurel Road on other providers in the area will be minimal; a combined average daily census (ADC) impact on all providers of 11.4, wholly unlike the impact of a brand new entrant to the market.

162. SMH Laurel Road's most significant impact will be the projected ADC loss of 5.8 at VRMC. The impact on VRMC is relatively minimal, particularly in comparison to VRMC's forecasted market share losses, which far exceed the projected SMH Laurel Road impact.

163. Expected impact in terms of lost adult, non-tertiary ADC for the other hospitals will be 1.6 at Fawcett, 1.4 at Englewood, and .8 at BHPC, none of which is substantial compared to overall hospital operations. These inconsequential losses

will be mitigated by growth in the population, particularly among seniors, in the service area. And, the various adverse impact models presented by health planning experts for VRMC/BHPC and Fawcett/Englewood did not consider any mitigating initiatives by management that would further alleviate potential loss.

164. SMH's opponents argued that approving SMH Laurel Road would impact existing providers' ability to appropriately recruit for, and staff, their facilities. But no empirical evidence was offered concerning the known, nationwide nurse and physician shortage, or how it impacts, or is projected to impact, hospitals in the district.

165. Rather, the evidence showed that local providers already recruit from around the country, not from a limited pool of Sarasota and Charlotte County candidates who might be targeted by SMH Laurel Road.

166. Despite staffing SMH to provide the highest level of quality and safety, SMH is able to achieve appropriate staffing levels. Witnesses for VRMC, BHPC, and Fawcett/Englewood conceded that, in spite of staffing challenges common to all hospitals, and seasonal population increases more specific to the Sarasota and Charlotte County areas, local hospitals are able to staff their facilities appropriately. In a highly seasonal area like district 8, proper staffing mandates use of

contract staffing because hospitals cannot afford to maintain seasonal staffing levels on a year-round basis. BHPC and VRMC have the unique, added benefit of sharing staff with one another during times of increased need, which further mitigates their concerns regarding staffing pressures.

167. The realities of the health care delivery system in district 8, coupled with the fact that SMH Laurel Road is a proposed transfer of existing, presently-staffed beds, rather than an addition of new beds, alleviates any concerns regarding staffing pressures that might be occasioned by the approval of SMH Laurel Road.

168. The greatest impact of SMH Laurel Road will be on SMH's main campus, which is expected to redirect 3,548 patients annually to SMH Laurel Road for an ADC reduction of 41.8. This patient redirection will serve the goals of decompressing the main SMH campus, and enhancing access to south Sarasota County patients. Financial experts for VRMC/BHPC and Fawcett/Englewood conceded that this volume shift would not jeopardize the financial stability of SCPHD.

169. BHPC argued that OB volume losses will threaten its ability to maintain its NICU. Dr. Jennifer D'Abarno testified that a minimum of 1,000 births per year is required to sustain a NICU. But BHPC already operates successfully without that many

births and the evidence established that the impact on BHPC resulting from an OB program at SMH Laurel Road will be minimal.

170. In 2015, the SMH main campus captured 68 percent of the OB market share from the SMH Laurel Road service area. By 2016, that figure increased to 72.3 percent. Over the same period, BHPC's OB discharges from the SMH Laurel Road service area dropped from 299 to 256 (over 14 percent), without the addition of an OB provider to the area.

171. SMH main campus and SMH Laurel Road are projected to capture a combined 75 percent of the OB market share for the SMH Laurel Road service area in 2021. Of that 75 percent, 62 percent is expected to access SMH Laurel Road with the other 13 percent continuing to rely on the main campus. In other words, SMH Laurel Road's OB market share in its proposed service area is projected to be less than the main campus' existing share of that same market.

172. With respect to impact on BHPC's NICU, the evidence established that ten to 15 percent of births result in NICU placement. Approximately half of those NICU placements are identified prior to birth. SMH Laurel Road's OB program will target only the lower risk portion of the NICU-bound population. Thus, BHPC's minimal loss of OB discharges to SMH Laurel Road would have a nominal, if any, effect on the BHPC NICU.

173. SMH presented the most reasonable assessment of the anticipated impact of SMH Laurel Road. That impact will be minimal, and does not justify denying the application.

174. As with the SMH Laurel Road proposal, approval of the VRMC replacement hospital would likewise have a minimal impact on existing providers in the area. While it is true that the construction of a state-of-the art replacement hospital should enable VRMC to recapture some of the market share it has lost to competitors in recent years, that increase is likely to be gradual, and any adverse impact on existing providers will be offset by population growth, particularly in the elderly age cohort. Thus, any adverse impact caused by approval of the replacement hospital will be minimal, and does not justify denying the application.

175. The combined effect of approving both the SMH and VRMC applications will be a net reduction in the number of licensed beds in Sarasota County, and the creation of an additional access point for acute care services.

CONCLUSIONS OF LAW

176. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of these consolidated cases. §§ 120.569, 120.57(1), and 408.039(5), Fla. Stat. The parties stipulated that section 408.035(2) establishes the statutory review criteria applicable to general

hospital applications. The review criteria are set forth in section 408.035(1). An applicant must also address the criteria in Florida Administrative Code Rules 59C-1.008 and 59C-1.030, including "health care access criteria" in rule 59C-1.030(2). See Mem'l Healthcare Group, Inc. v. AHCA, Case No. 12-0429CON, RO at 36 (Fla. DOAH Dec. 7, 2012; Fla. AHCA April 10, 2013); Lee Mem'l Health Sys. v. AHCA, Case Nos. 13-2508CON, 13-2558CON, RO at 30 (Fla. DOAH Mar. 28, 2014; Fla. AHCA Apr. 22, 2014).

177. Each of the applicants has party status and, therefore, appropriate standing in this matter. § 120.52(13) and 408.039(5), Fla. Stat. The others have standing to participate as existing providers who allege the addition in south Sarasota County of a new hospital, in the case of SMH's application, or a replacement hospital, in the case of VRBH's application, will have a substantial and adverse impact on their operations.

178. The award of a CON must be based on a balanced consideration of all applicable statutory and rule criteria. Balsam v. Dep't of HRS, 486 So. 2d 1341 (Fla. 1st DCA 1986). The appropriate weight to be given to each criterion is not fixed, but rather varies based upon the facts of the case. See, e.g., Morton F. Plant Hosp. Ass'n, Inc. v. Dep't of HRS, 491 So. 2d 586, 589 (Fla. 1st DCA 1986) (quoting North Ridge Gen. Hosp., Inc. v. NME Hosp., Inc., 478 So. 2d 1138, 1139

(Fla. 1st DCA 1985)); Collier Med. Ctr., Inc. v. Dep't of HRS, 462 So. 2d 83, 84 (Fla. 1st DCA 1986).

179. A CON applicant bears the burden to prove by a preponderance of the evidence that its CON application should be approved. See, e.g., Boca Raton Artificial Kidney Ctr., Inc. v. Dep't of HRS, 475 So. 2d 260, 263 (Fla. 1st DCA 1985); § 120.57(1)(j), Fla. Stat. An administrative hearing involving disputed issues of material fact is a de novo proceeding in which the Administrative Law Judge (ALJ) independently evaluates the evidence presented. Fla. Dep't of Transp. v. J.W.C., Co., Inc., 396 So. 2d 778, 787 (Fla. 1st DCA 1981); § 120.57(1), Fla. Stat. AHCA's preliminary decision on a CON application, including its findings in the SAAR, is not entitled to a presumption of correctness. Id.

180. AHCA no longer determines need for acute care beds through a need methodology. Instead, the Agency requires applicants to demonstrate need through a "needs assessment methodology" which must include, at a minimum, consideration of population demographics and dynamics; availability, utilization and quality of like services in the district; medical treatment trends; and market conditions. Fla. Admin. Code R. 59C-1.008(2)(e).

181. Applications submitted in the same batching cycle are generally subject to comparative review. § 408.039(5)(c), Fla.

Stat. In this instance, however, the two applications are not truly competing in the sense of two entities vying to build a new hospital through the transfer of existing licensed beds in an area that has a defined need for only one new hospital. Rather, here, VRMC seeks to replace its existing hospital, while SMH seeks to build a new hospital. In such a case, each application rises or falls on its own merits, and both can be approved if the statutory and rule criteria are met for each, as evidenced by AHCA's preliminary approval of both applicants.

SMH Laurel Road

182. SMH clearly established a need for its hospital based on the proposed service area's growing population, its existing patient base in the proposed service area, and the need to improve access to service area residents who are currently traveling great distances to access inpatient services. In addition, SMH's ability to continue providing care to residents of the subdistrict, including both those needing lower acuity services, as well as those needing the tertiary and other services that are only available at SMH's existing hospital within the subdistrict, is limited by its physical and functional capacity and lack of viable options for expansion onsite. SMH Laurel Road is needed to decompress the existing SMH campus to ensure the continued availability and accessibility of those services to all residents of the

subdistrict, including the medically underserved who rely heavily on SMH for access to inpatient services.

183. SMH's opponents questioned whether SMH has capacity or viable options for expansion on its existing campus. The evidence clearly established that the existing SMH campus is at capacity at times during the seasonal months. Even when SMH is not at full capacity during the off-season times of the year, the fact that a majority of the acute inpatient beds are in older, semiprivate rooms mean that patients throughout the year must be housed in semiprivate rooms. Such accommodations, while grandfathered for older facilities, are not the current standard of care in the industry, fail to provide patients with adequate privacy, expose patients and healthcare providers to unnecessary risks and potentially delayed care, and are less efficient and much more difficult to utilize to capacity due to, for example, gender matching, infectious disease, and other challenges that limit the ability to fully occupy semiprivate beds.

184. Without the ability to redirect some patients from the SMH main campus, there are no viable options for renovating the existing spaces to modern accommodations. SMH's opponents argued that the main campus of SMH could be renovated while continuing to serve patients if SMH simply established separate medical observation-status hold areas. This is an impractical solution given the space constraints. For example, the space

requirements to establish two or more 36-bed medical observation units is similar to adding two acute care tower floors, something SMH does not have space to do. Even if there were a way to renovate the main campus, any renovations to create modern accommodations at the existing SMH campus would substantially reduce available acute inpatient beds, further exacerbating capacity constraints.

185. Building a new bed tower on the main campus is equally impractical. Fawcett's and Englewood's proposed solution of building the "Tamiami Tower" was the result of a cursory review, and one need only look at the many caveats and assumptions in the architectural analysis to recognize the significant hurdles that must be considered and overcome for such a project. Such an option, even if possible, would further congest and overburden the existing main campus, and will not give a safety net provider, such as SMH, the ability to meet the needs of the residents of Sarasota County into the future.

186. Constructing SMH Laurel Road is the most prudent option, and the better one for patients. It will allow significantly improved access to SMH's non-tertiary inpatient services for patients in south Sarasota County, many of whom are currently traveling great distances to the SMH main campus. That includes the large and growing elderly population, as well as the medically underserved population, in south Sarasota

County, who are heavily reliant upon SMH for inpatient hospital services. SMH's proposed hospital will also significantly enhance access to OB services for residents of the proposed service area, a Medicaid-heavy service that is currently only available at SMH's existing hospital within the Subdistrict.

187. SMH Laurel Road will create an additional health care access point for residents of the district seeking inpatient services. In addition to enhancing geographic access, SMH Laurel Road will enhance access for residents of the subdistrict by providing a new, modern facility at Laurel Road, and also allowing an opportunity for SMH to renovate or reconfigure some of the older, outdated spaces at its existing campus to provide more modern spaces. Thus, patients accessing both facilities will see enhanced availability, accessibility, and quality of services compared to the existing spaces at SMH main campus.

188. The transfer of existing licensed beds to the new SMH Laurel Road hospital, operated by the entity with the only CMS 5-Star rated hospital in the State of Florida and average charges well below the existing hospitals serving the proposed service area, will increase competition in southern Sarasota County and enhance access to high-quality services. It will also force the other existing providers to continuously improve their own facilities and programs in order to remain

competitive, thereby enhancing the availability and accessibility of hospital services at all hospitals in the area.

189. SMH persuasively established need for its proposed hospital. On the whole, access will be significantly enhanced for all residents of the subdistrict geographically, financially, and programmatically. And, given the capacity issues at SMH, availability and accessibility of services at SMH will be significantly negatively impacted if the proposal is denied, thereby limiting access to the safety net provider which provides almost 90 percent of the Medicaid services provided in Sarasota County, as well as the provider of many important services that are unavailable elsewhere in the County, and in some cases, the district.

190. While the impact on existing providers may be sufficient to establish standing, the impact will not significantly impair the operations of those entities sufficiently to justify denial of SMH's application.

191. A balanced consideration of the applicable criteria weighs in favor of approval of the SMH Laurel Road proposal.

Venice Regional Replacement Hospital

192. VRMC filed a related rule challenge proceeding and a claim pursuant to section 120.57(1)(e), and has asserted that the Rule is an invalid exercise of delegated legislative

authority to the extent that the Rule is construed to require an applicant for a general hospital to include an AFS in its CON Application.

193. For the reasons more fully set forth in the Final Order in DOAH Case No. 17-3108RX, issued contemporaneously herewith, it is concluded that the VRMC application is not defective for failing to include an AFS within the application.

194. Section 120.57(1)(e)1, provides:

> An agency or an administrative law judge may not base agency action that determines the substantial interests of a party on an unadopted rule or a rule that is an invalid exercise of delegated legislative authority. This subparagraph does not preclude application of valid adopted rules and applicable provisions of law to the facts.

195. In this instance, VRMC's substantial interests have not been determined based upon the challenged rule, which the undersigned has invalidated. Rather, the testimony of the AHCA representative was that, notwithstanding the challenged rule, AHCA does not require AFS to be included in applications for general hospitals, and did not require them from the two applicants at issue. Indeed, AHCA granted preliminary approval of the VRMC application, even though an AFS was not included therein.

196. VRMC provided ample and uncontroverted evidence of substantial physical plant deficiencies, including: patient

flow and adjacency problems; lack of adequate OR space; undersized patient rooms; water and moisture intrusion issues; mold growth; rodent infestations; IT limitations associated with inadequate ceiling heights and "dead zones"; and overall severe architectural, mechanical, electrical, and plumbing problems. In short, the existing hospital is the result of a hodge-podge of expansion projects cobbled together over the years, and the entire hospital is aging and deteriorating. It has reached the end of its useful life and the CON should be approved to construct a modern hospital facility under today's standards.

197. The Agency has historically granted applications for replacement hospitals under facts and circumstances similar to those presented here. Fla. Health Sciences Ctr., Inc., d/b/a Tampa Gen. Hosp. v. Ag. for Health Care Admin., Case No. 08-0614CON, RO at 324-25 (Fla. DOAH Aug. 8, 2011; Fla. AHCA Dec. 8, 2011); see also Fla. Health Sciences Ctr., Inc., d/b/a Tampa Gen. Hosp. v. Ag. for Health Care Admin., Case No. 08-0614CON (Fla. DOAH Aug. 8, 2011; Fla. AHCA Dec. 8, 2011); Morton Plant Hosp. Ass'n, Inc., d/b/a North Bay Hosp. v. Ag. for Health Care Admin., Case No. 02-3232CON (Fla. DOAH Mar. 19, 2004; Fla. AHCA May 19, 2004); Mem'l Healthcare Group, Inc., d/b/a Mem'l Hosp. Jacksonville v. Ag. for Health Care Admin., Case No. 02-0447CON (Fla. DOAH Feb. 5, 2003; Fla. AHCA Apr. 11, 2003); HCA Health Servs. of Fla., Inc., d/b/a Oak Hill Hosp. v. Ag. for Health

Care Admin., Case No. 02-0454CON (Fla. DOAH Dec. 24, 2002; Fla. AHCA Feb. 21, 2003); Flagler Hosp. v. Dep't of HRS, Case No. 84-0236 (Fla. DOAH Feb. 25, 1985; Fla. DHRS May 29, 1985).

198. The established precedents involving CON review of applications for replacement facilities confirm that consideration of the "need" for a proposed replacement general hospital is different than assessing the need for a new general acute care hospital. See Tampa General, Case No. 08-0614CON, RO at 287-318. VRMC is already an existing health care provider in the district and the overall "need" for the hospital was previously demonstrated when it was first licensed. See S. Broward Hosp. Dist. v. AHCA and Plantation Gen. Hosp. Ltd. P'ship, Fla. DOAH Case Nos. 15-0129CON and 15-0130CON (Fla. DOAH Apr.1, 2016; Fla. AHCA May 16, 2016). Thus, the hospital is needed, and the question is whether the applicant can demonstrate a need to replace the existing physical plant. Recognized problems that have led to approval of replacement hospital applications have included substantial mechanical, electrical, and plumbing problems, and physical plant limitations that impair the existing hospital's ability to compete effectively. Morton Plant, Case No. 07-3232CON. The newest parts of VRMC are now over 30 years old, and large portions of the facility were built in the 1950s and 1960s, a far different era in health care. Compare Oak Hill, Case

No. 02-0454CON (hospital found to be outdated and CON approved, even though only 18 years old at time of replacement CON application; new hospital facility and location would allow it to compete more effectively).

199. Additional benefits of the VRMC replacement hospital include: moving the location off the coastal island, approximately seven miles inland, which will improve emergency planning in the event of a major hurricane; and the commitment to continue a freestanding ED and outpatient presence on Venice Island. See Plantation General, Case No. 15-0129CON, RO at 188 (regarding freestanding ED at current site as additional benefit).

200. While VRMC does not provide the same level of Medicaid and charity care as the tax-supported SMH, it does have a demonstrated history of providing services to Medicaid and medically indigent patients. Moreover, it has served and will continue to serve the large elderly and primarily Medicare population that resides in southern Sarasota County.

201. Approving VRMC's replacement hospital will foster its competitive footing, and will allow for enhancements to quality, such as implementation of a TAVR program and enhanced neurosurgical and stroke care. Cost-effectiveness is promoted by allowing investment into a building that can serve the community for many years to come, rather than investing capital

dollars into a building that is deteriorating and does not have a design to meet modern health care demands.

202. A balanced consideration of the applicable criteria weighs in favor of approval of the VRMC replacement hospital.

203. The undersigned is aware of the recent Final Order in Kendall Healthcare Group, Ltd., d/b/a Kendall Regional Medical Center v. The Public Health Trust of Miami-Dade County, d/b/a Jackson Hospital West, and Agency for Health Care Administration, Case No. 16-0112CON et seq. (Fla. DOAH Mar. 16, 2017; Fla. AHCA Apr. 26, 2018)(Doral Final Order). In its Final Order, AHCA denied the competing applications to establish a new hospital in the City of Doral in Miami-Dade County, filed by Jackson Hospital West and East Florida-DMC, Inc. Both applications were denied notwithstanding AHCA's preliminary approval of the Jackson West application, and ALJ Robert Cohen's Recommended Order recommending that the East Florida-DMC, Inc., application be approved and the Jackson West application be denied.

204. In denying both applications, AHCA cited Memorial Healthcare Group Inc., d/b/a Memorial Hospital Jacksonville v. Agency for Health Care Administration and Shands Jacksonville Medical Center Inc., Case No. 12-0429CON (Fla. DOAH Dec. 7, 2012; Fla. AHCA Apr. 10, 2013); Columbia Hospital (Palm Beaches) Limited Partnership, d/b/a West Palm Hospital; and Jupiter

Medical Center, Inc., d/b/a Jupiter Medical Center v. Florida Regional Medical Center and Agency for Health Care Administration, Case Nos. 12-0428CON and 12-0496CON (Fla. DOAH Apr. 30, 2013; Fla. AHCA Jun. 6, 2013); and Lee Memorial Health System v. Agency for Health Care Administration, Case Nos. 13-2508CON and 13-2558CON (Fla. DOAH Mar. 28, 2014; Fla. AHCA Apr. 24, 2014), as representing factually similar circumstances to those present with the Doral applications. In each of the above cases, applications for new general hospitals were denied due to a lack of demonstrated need, underutilized existing bed capacity in the proposed service area, no enhanced geographic or programmatic access, and no enhanced access for Medicaid and indigent patients.

205. In a footnote, the Doral Final Order noted that AHCA did not discuss the case of South Broward Hospital District d/b/a Memorial Healthcare, which was also decided subsequent to the 2008 amendments to section 408.035 "because it is not relevant to the case at hand since it involved a CON application for a replacement hospital, which would not result in any new providers being added to a district."

206. The circumstances present in the case sub judice are quite dissimilar to those in the three cases discussed in the Doral Final Order. As to the SMH application, the evidence clearly established a need for the Laurel Road hospital based on

the proposed service area's growing population, SHM's existing patient base in the proposed service area, and the need to improve geographic and financial access for service area residents who are currently traveling great distances to access inpatient services at the SMH main campus. In addition, SMH's ability to continue providing care to residents of Sarasota County, including both those needing lower acuity services, as well as those needing the tertiary and other services that are only available at SMH's main campus, is limited by its physical and functional capacity and lack of viable options for expansion onsite. SMH Laurel Road will improve geographic, programmatic, and financial access to hospital services, including OB, and will decompress the existing SMH campus to ensure the continued availability and accessibility of those services to all residents of the subdistrict. Moreover, there will be minimal adverse impact on existing providers in the service area because of the projected population growth, and because SMH already serves a large number of the residents of its proposed service area, including OB patients.

207. As acknowledged in the Doral Final Order, the three cases cited above are not relevant to the VRMC proposal since the VRMC application is for a replacement hospital.

208. The combined effect of approving both the SMH and VRMC applications will be a net reduction in the number of

licensed beds in the subdistrict, and the creation of an additional needed access point for acute care services in Sarasota County.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a final order be entered: approving CON Application No. 10457 filed by Sarasota County Public Hospital District, d/b/a Sarasota Memorial Hospital, subject to the conditions contained in the application; and approving CON Application No. 10458 filed by Venice HMA Hospital, LLC, d/b/a Venice Regional Bayfront Health, subject to the conditions contained in the application.

DONE AND ENTERED this 8th day of May, 2018, in Tallahassee, Leon County, Florida.

W. DAVID WATKINS
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of May, 2018.

ENDNOTES

[1/] Unless otherwise noted, all statutory references are to the 2017 version of the Florida Statutes.

[2/] VRMC's challenge pursuant to section 120.56(3) is the subject of a separate Final Order being issued concurrently herewith. However, VRMC's challenge to the rule, pursuant to section 120.57(1)(e), is addressed herein.

[3/] SMH is licensed for 666 acute care beds, but 45 of those licensed beds were held in abeyance by AHCA during the demolition of the Retter Wing, a building constructed in 1969. Those 45 acute care beds will be reactivated in the form of private rooms with the pending renovation of the ninth and tenth floors of the East Tower.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.