

**EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON
BEHALF OF PROVIDENCE HEALTH SYSTEM-WASHINGTON PROPOSING TO
LICENSE THE PROVIDENCE ST. PETER CHEMICAL DEPENDENCY HOSPITAL
UNDER PROVIDENCE ST. PETER HOSPITAL'S LICENSE**

PROJECT DESCRIPTION

Providence Health System-Washington/St. Peter Hospital (St. Peter) is a private non-profit hospital located at 413 Lilly Road Northeast in Olympia within Thurston County. St. Peter is licensed by the Washington State Department of Health as an acute care hospital and is also accredited by the Joint Commission. St. Peter Hospital offers healthcare services ranging from general to specialty care through programs such as a regional cancer center, along with inpatient acute care, outpatient services and surgery.

Providence Health System-Washington also operates the St. Peter Hospital Chemical Dependency Hospital (CD hospital/unit¹) located at 4800 College Street Southeast in Olympia within Thurston County. This facility serves all ages with medical detoxification and inpatient hospitalization services for adult chemical dependency. The CD hospital is licensed separately by the Washington State Department of Health as an Alcoholism hospital and is also accredited by the Joint Commission. [Providence Website; Application, p1 & 21]

On September 3, 2008, Providence Health System-Washington underwent a name change. Providence Health System-Washington now operates under the name of Providence Health & Services-Washington. Providence continues to operate a variety of healthcare facilities in Alaska, California, Oregon, Montana and Washington. [October 3, 2008 Supplemental Information, p1]

This application proposes to license the 50 beds currently licensed as a CD hospital with the 340 acute care beds currently licensed at St. Peter Hospital. The result would be a single acute care bed license of 390 beds. There will be no change to the number of beds at each location. [Application, p8]

As described by the applicant, the single license would allow St. Peter to become eligible for the classification as a Disproportionate Share Hospital (DSH). As a DSH, St. Peter would be able to participate in the federal 340B drug pricing program which requires drug manufacturers to provide certain outpatient drugs at a reduced price². The applicant projects that the result would help to reduce expenses and improve hospital efficiencies. The applicant anticipates that the changes will lead to a reduction of approximately \$750,000 in the subsidies which St. Peter Hospital currently pays to operate the CD hospital. [Application, p8]

¹ Throughout this evaluation, the St. Peter Chemical Dependency Hospital will be referred to as both a CD hospital and a CD unit. The CD unit reference will be used for instances referring to the post-project configuration.

² According to the U.S. Department of Health and Human Services, significant savings on pharmaceuticals may be seen by those entities that participate in this program. The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act.

As part of this project, St. Peter also intends to modify the configuration of the services currently provided in the CD hospital. Currently, the CD hospital serves both adolescents (13-18) and adults. The applicant has reported that 22 beds are set-up to care for adolescents and the remaining 28 beds are used to serve adult patients. To address adult treatment needs and to meet the requirements for licensing, the CD hospital will build a unit dedicated to medical detoxification. The unit will consist of 12 adult medical detoxification designated beds and will be housed in semi-private rooms. As a result of the changes, the adolescent unit will be reduced to 18 beds while the adult bed count will increase to total 32. [October 3, 2008 Supplemental Information, p2]

The total cost of the project is calculated to equal \$3,116,652. Of the total costs under review, 77% is related to construction at the CD unit; 10% is related to design development; and the remaining 13% is related to applicable taxes, planning costs, and fees. The totals are outlined below. [Application, p32]

Breakdown of Estimated Capital Costs	Total	% of Total
Building Construction	\$2,401,394	77.05%
Fixed Equipment	\$89,118	2.86%
Moveable Equipment	\$45,000	1.44%
Architect/Engineer Fees	\$312,180	10.02%
Site Preparation	\$11,520	0.37%
Sales Tax	\$212,983	6.83%
Other Project Costs - review fees	\$44,457	1.43%
Total	\$3,116,652	100.00%

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the change in bed capacity of an existing health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

APPLICATION CHRONOLOGY

April 23, 2007	Letter of Intent Submitted
August 20, 2008	Application Submitted
August 21, 2008 through October 7, 2008	Department's Pre-Review Activities <ul style="list-style-type: none"> • Screening activities and responses
October 8, 2008	Department Begins Review of the Application <ul style="list-style-type: none"> • Public comments accepted throughout review
November 19, 2008	End of Public Comment
January 22, 2009	Department's Anticipated Decision Date
February 23, 2009	Department's Updated Decision Date
February 18, 2009	Department's Actual Decision Date

AFFECTED PARTIES

Throughout the review of this project, no one applied to receive affected person status under WAC 246-310-010

SOURCE INFORMATION REVIEWED

- Providence Health System's Certificate of Need Application received August 18, 2008
- Providence Health System's supplemental information dated October 3, 2008
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Financial feasibility and cost containment evaluation prepared by the Department of Health's Office of Hospital and Patient Data Systems (January 13, 2009)
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2004, 2005, and 2006 summaries)
- Population data obtained from the Office Financial Management based on year 2000 census published November 2007.
- Healthcare Cost and Utilization Project (HCUP) database of Oregon State Hospital Discharge Data - 2006
- Licensing and/or survey data provided by the Department of Health's Office of Health Care Survey
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Data obtained from Providence Health & Services website (www.providence.org)

CRITERIA EVALUATION

To obtain Certificate of Need approval, Providence Health System must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment), and portions of the 1987 State Health Plan as it relates to the acute care bed methodology.³

CONCLUSION

For the reasons stated in this evaluation, the Certificate of Need application submitted on behalf of Providence Health & Services-Washington and St. Peter Hospital to license 50 beds, currently licensed as a chemical dependency hospital, with the 340 acute care beds currently licensed at St. Peter Hospital is consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need should be issued provided the applicant agrees to the condition stated below.

The approved capital cost of this project is \$3,116,652.

CONDITION

These 50 beds are limited to the provision of chemical dependent services as described in the application. To be used for any other type of acute care service, prior CN approval is required.

³ Each criterion contains certain sub-criterion. The following sub-criteria are not discussed in this evaluation because they are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

A. Need (WAC 246-310-210)

Based on the source information reviewed, the department determines that the applicant has met the need criteria in WAC 246-310-210.

- (1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.

This application involves an increase in the number of licensed acute care beds for St. Peter Hospital. The department uses the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan to assist in its determination of need for acute care capacity. This forecasting method is designed to evaluate need for additional capacity in general, rather than identify need for a specific project. The department prepared bed need forecasts to determine baseline need for acute care capacity. This set of projections is completed prior to determining whether the applicant should be approved to meet any projected need.

As stated in the project description portion of this evaluation, St. Peter proposes to add 50 acute care beds to its existing 340 licensed acute care beds. The 50 beds would be added as part of a relicensing of the CD hospital. Given that this application involves no major construction, St. Peter anticipates the CD unit will remain operational during construction and completion is expected by January 2010; with a licensed total of 390 beds. [Application, p17]

St. Peter provided a version of the acute care numeric methodology prepared using 1997-2006 historical CHARS data. The applicant's methodology will be reviewed and explained in greater detail within the step-by-step portion of the numeric methodology explanation below. The methodology was formulated according to the 12-step need projection utilized by the Department. [October 3, 2008 Supplemental information, Attachment 4]

A seven-year horizon for forecasting acute care bed projections will be used in this evaluation and is consistent with the recommendations within the state health plan which states, "For most purposes, bed projections should not be made for more than seven years into the future." Further, a seven year forecast is consistent with most projects for hospital bed additions reviewed by the CN Program. At the time this methodology was submitted, the seven-year projection year is 2014. As a result, the department will focus on the target year 2014, which is seven years after the most recent data (2007).

The method submitted by St. Peter based its projections on hospital discharges for years 1998-2007. This version resulted in a projected total of 86,386 patient days in year 2008; increasing throughout the projection period. Year 2014 forecasts identify 106,858 patient days. The surplus for 2008 is calculated to be 105 beds, with a steady decline in surplus capacity through 2014. A complete summary of the applicant's projections are shown below in Table 1. [September 8, 2008 Rebuttal Comments, p53]

Table 1
Summary of St. Peter Need Methodology for Thurston County Planning Area

	2008	2009	2010	2011	2012	2013	2014
Patient Days	86,386	89,170	91,966	95,064	97,742	102,107	106,858
Currently Available Beds	432	432	432	432	432	432	432
Adjusted Gross Need	327	337	348	359	370	386	404
Adjusted Net Need *	-105	-95	-84	-73	-62	-46	-28

* Negative number indicates a surplus of beds to meet projected need

The Department’s Determination of Numeric Need:

The determination of numeric need for acute care hospital beds is performed using the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP). Though the SHP was “sunset” in 1989, the department has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds.

The 1987 methodology was a revision of an earlier projection methodology prepared in 1979 and used in the development of subsequent State Health Plans. This methodology was developed as a planning tool for the State Health Coordinating Council (SHCC) to facilitate long-term strategic planning of health care resources. The methodology is a flexible tool, capable of delivering meaningful results for a variety of applications, dependent upon variables such as referral patterns, age-specific needs for services, and the preferences of the users of hospital services, among others.

The 1987 methodology is a twelve-step process of information gathering and mathematical computation. The first four steps develop trend information on hospital utilization. The next six steps calculate baseline non-psychiatric bed need forecasts. The final two steps are intended to determine the total baseline hospital bed need forecasts, including need for short-stay psychiatric services: step 11 projects short-stay psychiatric bed need, and step 12 is the adjustment phase, in which any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the pure application of the methodology to under- or over-state the need for acute care beds.

The completed methodology is presented as a series of appendices to this evaluation. (Exhibit A) The methodology presented here incorporates all adjustments that were made following preparation of the methodology. Where necessary, both adjusted and un-adjusted computations are provided. The methodology uses population and healthcare use statistics on several levels: statewide, Health Service Area (HSA)⁴, and planning area. The planning area for this evaluation is the Thurston County planning area located in HSA 2.

⁴ The state is divided into four HSAs by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Snohomish, and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum counties. HSA 3 is composed of Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan, and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman counties.

The Thurston County planning area is described in State Health Coordinating Council documents from 1987 as a set of 22 zip codes within Thurston County and requires the exclusion of the southwestern corner of the county for zip codes 98531 and 98579⁵. Population and discharge records indicate that the zip code 98531 has already been attributed to Lewis County. The population estimates and the patient day totals for 98579 will be removed from the applicable Thurston County planning area figures. [CN Historical Files]

When preparing acute care bed need projections, the department relies upon population forecasts published by the Washington State Office of Financial Management (OFM). For use in the HSA populations, the Department uses a set of OFM forecasts known as the “intermediate-series” county population projections, based on the 2000 census, revised in November 2007⁶. However, forecasts by age are not available for any area smaller than an entire county. Because OFM does not provide zip code specific population estimates at the level necessary for the review of this project, the department used population estimates purchased from Claritas, Inc., a recognized source of demographic information. In this application, St. Peter also relied upon zip code population estimates and projections developed by Claritas. As described below, the applicant’s figures are slightly different and may be largely attributable to the accounting of the zip codes mentioned above. [September 8, 2008 Rebuttal Comments, p53, p44]

This portion of the evaluation will describe, in summary, the calculations made at each step and the assumptions and adjustments made in that process. It will also include a review of any deviations related to the assumptions or adjustments made by St. Peter in its application of the methodology.

The titles for each step are excerpted from the 1987 SHP.

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least ten years preceding the base year.

For this step, attached as Appendix 1, the department obtained utilization data for 1998 through 2007 from the Department of Health’s Office of Hospital and Patient Data Systems’ CHARS (Comprehensive Hospital Abstract Reporting System) database. Total patient days were identified for the Thurston County Planning Area, HSA #2, and Washington State as a whole, excluding psychiatric patient days [Major Diagnostic Category (MDC) 19] and normal newborns [Diagnostic Related Group (DRG) 391⁷], according to the county in which care was provided. Normal newborn days were excluded because the normal newborn patients (babies) do not occupy a licensed acute care bed. The mothers of the normal newborns are included in the patient days.

St. Peter followed this step as described above.

⁵ Records identify these two zip codes are to be included in Planning Area #1, consisting primarily of Lewis County

⁶ Found on the World Wide Web at <http://www.ofm.wa.gov/pop/estimates.asp> and at <http://www.ofm.wa.gov/pop/poptrends/default.asp> and compiled internally by DOH

⁷ In October 2007, CMS released a new listing (v. 25) of DRG classifications. Data up to 2006 will continue to use the 391 citation, 2007 forward will use DRG 795.

Step 2: Subtract psychiatric patient days from each year's historical data.

This step was partially accomplished by limiting the data obtained for Step 1, above. The remaining data still included non-MDC 19 patient days spent at psychiatric hospitals. Patient days at dedicated psychiatric hospitals were identified for each year and subtracted from each year's total patient days. The adjusted patient days are shown in Appendix 2.

St. Peter followed this step as described above with no deviations.

Step 3: For each year, compute the statewide and HSA average use rates.

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each HSA by that HSA's population and multiplied by 1,000. Using the same process, the average use rate was also determined for the Thurston County planning area and is attached as Appendix 3. Historical and projected population figures for this analysis were derived using the process discussed above and applicant data relative to population age cohorts.

St. Peter followed this step as described above with no deviations.

Step 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.

The resulting trend lines from the ten-year history, 1998-2007, of rates uniformly exhibit an upward slope in HSA and State trends. A trend line for the specific planning area also indicates an upward trend. This conclusion is generally supported by increasing utilization reported by hospitals throughout the state in recent years. More significant than overall population growth is the fact that the state's population is growing older as the number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations.

St. Peter followed this step as described with no deviations and results concur with those produced by the Department.

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live. (The psychiatric patient day data are used separately in the short-stay psychiatric hospital bed need forecasts.)

The previous four steps of the methodology involved data identified by the planning area where care was provided. In order to determine the need for services for residents of a given planning area, patient days must be identified, instead, by the area where the patients live. Step 5, included as Appendix 5, identifies referral patterns in and out of the Thurston County planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also uses data from the Healthcare Cost and Utilization Project (HCUP) compiled by the Oregon Department of Human Services to identify patient days for Washington residents obtaining health care in Oregon (the department is not aware of similar data for the state of Idaho). The last available

Oregon data was for 2006, and without any more current information available, this data was included as to have some accounting to the out migration.

The original purpose for this methodology was to create comprehensive, statewide resource need forecasts. For this project, the state was broken into two planning areas – Thurston County and the State as a whole minus Thurston County (TC). Appendix 5 illustrates the age-specific patient days for residents of the Thurston County planning area and for the rest of the state, identified here as “WA – TC.”

St. Peter followed this step as described.

Step 6: Compute each hospital planning area’s use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+).

Appendix 6 illustrates the age-specific use rates for the year 2007, as calculated in Step 3, for the Thurston County planning area and for the rest of the state.

St. Peter followed this step as described above with no deviations.

Step 7A: Forecast each hospital planning area’s use rates for the target year by “trend-adjusting” each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the appropriate health planning region’s ten-year use rate trend, whichever trend would result in the smaller adjustment.

As discussed in Step 4, the department used the ten-year use rate trends for 1998-2007 to reflect the use patterns of Washington residents. The 2007 use rates determined in Step 6 were multiplied by the slopes of both the Health Service Area’s ten-year use rate trend line and by the slope of the statewide ten-year use rate trend line for comparison purposes. For the Thurston County planning area, the State trend is a lower projected rate (an annual increase of 2.9333) than the HSA planning area rate of 4.1484. As directed in Step 7A, the department applied the State trend to project future use rates.

The methodology is designed to project bed need in a specified “target year.” It is the practice of the department to evaluate need for a given project through seven years from the last full year of available CHARS data, or 2007 for purposes of this analysis. Therefore, the target year for this analysis will be 2014.

St. Peter applied this portion of step 7 with no modifications.

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area’s trend-adjusted use rates for the age groups by the area’s forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.

Using the statewide forecasted use rate for the target year 2014 and age cohort population projections submitted by the applicant for the planning area, the department’s projected patient days for Thurston County planning area residents is illustrated in Appendix 8. As noted in

Step 7 above, forecasts have been prepared for a series of years and are presented in summary in Appendix 10a & 10b as “Total Thurston County Res Days.”

St. Peter used this same approach in its projections.

Step 9: Allocate the forecasted non-psychiatric patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.

Using the patient origin study developed for Step 5, Appendix 9 illustrates how the projected patient days for the Thurston County planning area and the remainder of the state were allocated from county of resident to the area where the care is projected to be delivered in the target year 2014. The results of these calculations are presented in Appendix 10a & 10b as “Total Days in Thurston County Hospitals.”

St. Peter prepared this step as described above. Previously noted reductions in 65+ out migration resulted in differing patient day totals, and their related percentages, than those derived by the department.

Step 10: Applying weighted average occupancy standards, determine each planning area’s non-psychiatric bed need. Calculate the weighted average occupancy standard as described in Hospital Forecasting Standard 11.f. This should be based on the total number of beds in each hospital (Standard 11.b), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculation.

The number of beds in the planning area was identified in accordance with the SHP standard 12a, which states:

1. beds which are currently licensed and physically could be set up without significant capital expenditure requiring new state approval;
2. beds which do not physically exist but are authorized unless for some reason it seems certain those beds will never be built⁸;
3. beds which are currently in the license but physically could not be set up (e.g., beds which have been converted to other uses with no realistic chance they could be converted back to beds);
4. beds which will be eliminated.

The SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above. This information was gathered through survey, licensing, and cost report records. There are currently two acute care hospitals in the Thurston County planning area – Capital Medical Center and the applicant. [CN and OHCS files]

The weighted occupancy standard for a planning area is defined by the SHP as the sum, across all hospitals in the planning area, of each hospital’s occupancy rate times that hospital’s percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected in the 1987 SHP are higher than can be maintained by

⁸ These beds are beds associated with an unexecuted Certificate of Need

hospitals under the current models for provision of care. As a result, the department has adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds). As a result of this change, the Thurston County planning area's weighted occupancy has been determined to be 72.45% for 2008. This is reflected in the line "Wtd Occ Std" in Appendix 10a.

St. Peter is proposing to license the 50 beds currently licensed separately as an alcoholism hospital with the 340 acute care beds currently licensed at St. Peter Hospital. The Department prepared the bed need methodology to show the effect of implementing the licensing project as an increase in licensed acute care beds and detailed in Appendix 10b.

While the methodology states that short-stay psychiatric beds should be included in the above total, the fact that all psychiatric patient days were excluded from the patient days analyzed elsewhere in the methodology makes their inclusion inconsistent with the patient days used to determine need.

St. Peter also reduced the weighted occupancy consistent with the reductions outlined by the department, and did not include short stay psychiatric beds within in its calculations.

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from step 10 above to the psychiatric inpatient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.

The applicant is not proposing to add psychiatric services at the facility. In step 10, the department excluded the short stay psychiatric beds from the bed count total. For these reasons, the department concluded that psychiatric services should not be forecast while evaluating this project.

St. Peter also did not provide psychiatric forecasts within its methodology.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, out-of-area use and occupancy rates, following the guidelines in section IV of this Guide.

Within the department's application of the methodology, adjustments have been made where applicable and described above in relation to the 65+ age cohort.

Referring back to step 10, Appendix 10a calculates the planning area bed need without the project. Appendix 10b calculates the planning area bed need with the project completed. A summary of those appendices is shown below.

Table 2
Department Methodology
Appendix 10A – Without Project - Summary

	2008	2009	2010	2011	2012	2013	2014
Planning Area # of beds	422	422	422	422	422	422	422
Adjusted Gross Need	317.46	329.80	342.22	354.72	367.31	379.99	392.75
Need/(Surplus) – Without Project ⁹	-104.54	-92.20	-79.78	-67.28	-54.69	-42.01	-29.25

Appendix 10B – With Project – Summary

	2008	2009	2010	2011	2012	2013	2014
Planning Area # of beds	312	312	362	362	362	362	362
Adjusted Gross Need	317.46	329.80	340.92	353.38	365.92	378.54	391.25
Need/(Surplus) - With Project ⁹	-104.54	-92.20	-131.08	-118.62	-106.08	-93.46	-80.75

For the current year, Appendices 10a and 10b both illustrate a planning area surplus of beds. Appendix 10a indicates the planning area is projected to experience a continued surplus of beds throughout the projection years. Appendix 10b illustrates the effect on the planning area of this project. As would be expected, by adding 50 beds in 2010, St. Peter increases the existing surplus to over 131 beds. The surplus continues in the following years and reaches a surplus of 80 beds in 2014. Based solely on the numeric need calculations, the proposed bed addition would not be supported. However, additional factors exist which warrant further consideration. [Evaluation, Exhibit A]

St. Peter’s CD facility is the only provider of inpatient chemical dependency services in the planning area and for much the surrounding region. St. Peter states, “Over the past couple of years...utilization of the adolescent patients has declined slightly. While census is up in 2008, occupancy (on the 22 adolescent beds) is still less than 60%. At the same time, we have turned away adult patients for medical detoxification due to a lack of appropriate beds.” According to the applicant, the availability of these services can also be addressed through this project. [October 3, 2008 Supplemental Information, p2]

The department examined the issues above, and the material submitted by the applicant, and has determined that the expansion of the medical detoxification capacity and the lower drug pricing could have a cumulative positive impact upon the accessibility and availability of chemical dependency treatment. The department therefore concludes that approval of the project should be considered.

If this project is approved, the department would include a condition that these 50 beds are limited to the provision of chemical dependent services as described in the application. To be used for any other type of acute care service, prior CN approval is required. Provided that St. Peter would agree to the condition, this sub-criterion would be met.

⁹ A negative number indicates a surplus of beds

In summary, the department concludes that the applicant has not demonstrated need for additional general acute care beds in the planning area. However the Department concluded there are special circumstances that would maintain the availability and accessibility of services to the community if the project were approved. Therefore, pending acceptance of the condition noted above, the department concludes this criterion has been met.

- (2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

St. Peter is currently a provider of health care services to residents of Washington State, including low-income, racial and ethnic minorities, handicapped and other underserved groups. As an acute care hospital, St. Peter also currently participates in the Medicare and Medicaid programs. To determine whether all residents of the service area would continue to have access to an applicant's proposed services, the department requires applicants to provide a copy of its current or proposed admission policy. The admission policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and any assurances regarding access to treatment.

To demonstrate compliance with this sub-criterion, St. Peter provided a copy of the current Rights and Responsibilities Policy that would continue to be used at the main campus and the CD unit. The policies outline the process and scope that St. Peter will use to admit patients for treatment or care at either facility. The applicant states that any patient requiring care will be accepted for treatment without regard to "race, religion, sex, ethnicity, age, or handicap". [Application, Exhibit 8 & 9]

To determine whether low-income residents would have access to the proposed services, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. To determine whether the elderly would have access or continue to have access to the proposed services, the department uses Medicare certification as the measure to make that determination.

St. Peter currently provides services to Medicare and Medicaid eligible patients. Documents provided in the application demonstrate that St. Peter intends to maintain this status at both facilities. For this project, a review of the policies and data provided for St. Peter identifies the facility's financial resources as including both Medicare and Medicaid revenues. [Application, p39]

A facility's charity care policy should confirm that all residents of the service area including low-income, racial and ethnic minorities, handicapped and other underserved groups have, or would have, access to healthcare services of the applicant. The policy should also include the process one must use to access charity care at the facility.

St. Peter demonstrated its intent to continue to provide charity care to residents by submitting its current charity care policy that outlines the process a patient would use to access this service. Further, St. Peter included a 'charity care' line item as a deduction from revenue

within the pro forma financial documents for both the main hospital and the CD unit. [Application, Exhibit 10 & 12]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: Thurston County, Puget Sound (less Thurston County), Southwest, Central, and Eastern. St. Peter is located in Thurston County and is one of 14 hospitals located within the Southwest Washington Region. According to 2004-2006¹⁰ charity care data obtained from HPDS, St. Peter has historically provided more than the average charity care provided in the region. St. Peter's most recent three years (2004-2006) percentages of charity care for gross and adjusted revenues are detailed in Table 3 below. [HPDS 2004-2006 charity care summaries]

**Table 3
Providence St. Peter Charity Care Comparison**

	3-Year Average for Southwest Region	3-Year Average for St. Peter
% of Gross Revenue	2.56%	3.11 %
% of Adjusted Revenue	5.64%	7.31%

Historical reports indicate that St. Peter is likely to continue to provide charity care above the regional averages. Given the historical percentage of charity care provided by St. Peter at the hospital, and the projected rate of charity care calculated from this application's pro forma, the department concludes that St. Peter would continue to provide the amount of charity care consistent with, or above, the average for the hospitals in the region.

Based on the above information, the department concludes that the applicant has demonstrated that all residents of the service area currently have adequate access to the health services at Providence St. Peter and the CD hospital. Further, the information demonstrates that the relicensing of these beds under Providence St. Peter would not negatively affect this access. This sub-criterion is met.

B. Financial Feasibility (WAC 246-310-220)

Based on the source information reviewed, the department determines that the applicant has met the financial feasibility criteria in WAC 246-310-220.

(1) The immediate and long-range capital and operating costs of the project can be met.

To assist the department in its evaluation of this sub-criterion, Office of Hospital and Patient Data Systems (HPDS) provides a summary of the short and long-term financial feasibility of the project, which includes a financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios utilized are 1) long-term debt to equity ratio; 2) current assets to current liabilities ratio; 3) assets financed by liabilities ratio; 4) total operating expense to total operating revenue ratio; and 5) debt service

¹⁰ Year 2007 charity care data is not available as of the writing of this evaluation.

coverage ratio. If a project's ratios are within the expected value range, the project can be expected to be financially feasible.

The reported capital expenditure for this particular project is \$3,116,652. HPDS provides a summary of the 2007 balance sheets from the application in Table 4. [HPDS Analysis, p2]

**Table 4
Providence St. Peter FYE 2007 Balance Sheet**

Assets		Liabilities	
Current	\$ 63,535,417	Current	\$ 29,808,601
Board Designated	\$ 39,912,498	Long Term Debt	\$ 76,175,899
Property/Plant/Equipment	\$ 143,052,907	Other	-
Other	\$ 925,434	Equity	\$ 141,441,756
Total	\$ 247,426,256	Total	\$ 247,426,256

HPDS also provided a review of the percentages represented in the certificate of need expenditure when compared to various assets of Providence St. Peter at the 2007 fiscal year end.

**Table 5
Providence St. Peter Asset Ratios**

	Prov. St. Peter CN Project
Capital Expenditure	\$ 3,116,652
Percent of Total Assets	1.26%
Percent of Board Designated Assets	7.81%
Percent of Equity	2.20%

HPDS reports, "Providence St. Peter Hospital will use reserves for the costs of the project. The hospital is committing a reasonable portion of the hospitals assets on this project". The HPDS analysis continues, "Providence St. Peter also has the financial backing of its parent, Providence Health & Services which has assets of \$7.7 Billion to protect this project."

HPDS reviewed various ratios' that can give a snapshot of the financial health of Providence St. Peter as of 2007. Also detailed are the first three years of the proposed project expansion at the CD unit. HPDS also included the projected ratios for St. Peter as a whole for CON year 3. State 2007 ratios are included as a comparison and are calculated from all community hospitals in Washington State whose fiscal year ended in 2007. The data is collected by the Washington State Dept. of Health Hospital and Patient Data section of the Center for Health Statistics. Table 6 below displays the results. [HPDS Analysis, p3]

Table 6
Providence St. Peter Hospital and Chemical Dependency Unit
Projected Financial Ratios

Ratio Category	Trend ¹¹	State 2007	PSPH 2007	CD yr1 2010	CD yr2 2011	CD yr3 2012	PSPH-2012
Long Term Debt to Equity	B	0.523	0.539				0.353
Current Assets /Current Liabilities	A	2.135	2.131				1.654
Assets Funded by Liabilities	B	0.419	0.428				0.356
Operating Exp/Operating Rev.	B	0.950	0.923	1.582	1.599	1.606	0.923
Debt Service Coverage	A	6.041	10.370				4.442
Long Term Debt to Equity		<i>Long Term Debt/Equity</i>					
Current Assets/Current Liabilities		<i>Current Assets/Current Liabilities</i>					
Assets Funded by Liabilities		<i>(Current Liabilities + Long term Debt)/Assets</i>					
Operating Expense/Operating Revenue		<i>Operating Expense/Operating Revenue</i>					
Debt Service Coverage		<i>Net Profit + Depr and Int. Exp/Current Mat. LTD and Int. Exp</i>					

HPDS describes their analysis by stating that the only ratio available for CON year 1 through 3 of the CD unit is the Operating Expense/Operating Revenue. The others depend on consolidated hospital balance sheet information which are not maintained for the Chemical Dependency Unit. This does affect this review. The unit shows a loss for all three years. The hospital as a whole however does continue to have a strong Operating Expense/Operating Revenue ratio. Certificate of Need year three for Providence St. Peter Hospital as a whole are better than the State average or are within a reasonable span.” [HPDS Analysis, p3]

As mentioned above, the Department has determined that a profit by the third full year of operation is necessary to indicate financial feasibility of a project. In this instance, the CD hospital is an existing facility that has consistently been operating at a loss. Figures provided by the applicant indicate that the CD hospital is projected to lose in excess of \$3,200,000 in 2008. The losses are projected to continue, reaching \$4,476,592 in 2012. The applicant has identified avenue to reduce those losses. Based upon cost reductions associated with the DSH classification, St. Peter anticipates that the losses realized in 2012 may be reduced to total loss of \$3,726,157. This represents a reduction of \$750,435 in the costs associated with chemical dependency services when operated as a CD unit of the hospital. Although, this project would still be operating at a loss, the loss is over three quarters of a million dollars less than if the CD services continue to be operated as its own CD hospital. This may retain these services in the service area longer than might otherwise be possible.

The HPDS review of the financial and utilization information show that the immediate and long-range capital expenditure as well as the operating costs for the whole hospital can be met.

¹¹ The A means it is better if the number is above the State number and B means it is better if the number is below the state number.

Further, review of the operating losses in the delivery of chemical dependency care indicates that the proposed project may reduce the supplemental funding necessary to retain the services currently available. This criterion is met.

- (2) The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.

This application proposes to license the 50 beds separately licensed with the 340 acute care beds currently licensed at St. Peter Hospital. The result would be a single acute care bed license of 390 beds at two locations. The capital expenditure reported in the application provides a cost breakout for each phase and is estimated to total \$3,116,652. A breakdown of the capital costs for each phase is outlined in Table 7. [Application, p32]

**Table 7
Providence St. Peter Project - Capital Costs**

Item	Total
Building Construction	\$2,401,394
Fixed Equipment	\$89,118
Moveable Equipment	\$45,000
Architect/Engineer Fees	\$312,180
Site Preparation	\$11,520
Sales Tax	\$212,983
Other Project Costs - review fees	\$44,457
Total	\$3,116,652

By HPDS standards, the costs of the project are the costs and charges the patients and community are billed for. HPDS concludes that St. Peter's rates are similar to the Washington statewide averages. The rates are calculated in Table 8 below. [HPDS Analysis, p4]

**Table 8
Chemical Dependency Patient Rates Forecast**

Rate per Various Items	CD yr1 2010	CD yr2 2011	CD yr3 2012	PSPH Overall - 2012
Patient Days	1,114	1,148	1,182	-
Adjusted Patent Days	13,111	13,504	13,909	-
Gross Revenue	\$ 16,464,579	\$ 17,806,443	\$ 19,257,668	\$ 1,350,209,000
Deductions From Revenue	\$ 11,853,115	\$ 12,908,176	\$ 14,035,783	\$ 915,470,000
Net Patient Billing	\$ 4,611,464	\$ 4,898,267	\$ 5,221,885	\$ 434,739,000
Other Operating Revenue	\$ 873,391	\$ 899,593	\$ 926,581	\$ 19,398,000
Tax Revenue	-	-	-	-
Net Operating Revenue	\$ 5,484,855	\$ 5,797,860	\$ 6,148,466	\$ 454,137,000
Operating Expense	\$ 8,677,652	\$ 9,273,442	\$ 9,874,623	\$ 419,340,565
Operating Profit	\$ (3,192,797)	\$ (3,475,582)	\$ (3,726,157)	\$ 34,796,435
Other Revenue	-	-	-	\$ 89,000
Net Profit	\$ (3,192,797)	\$ (3,475,582)	\$ (3,726,157)	\$ 34,885,435
Operating Revenue per Admission	\$ 4,924	\$ 5,050	\$ 5,202	-
Operating Expense per Admission	\$ 7,790	\$ 8,078	\$ 8,354	-
Net Profit per Admission	\$ (2,866)	\$ (3,028)	\$ (3,152)	-
Operating Revenue per Patient Day	\$ 418	\$ 429	\$ 442	-
Operating Expense per Patient Day	\$ 662	\$ 687	\$ 710	-
Net Profit per Patient Day	\$ (244)	\$ (257)	\$ (268)	-
Operating Revenue per Adj Admissions	\$ 3,250	\$ 3,350	\$ 3,468	-
Operating Expense per Adj Admissions	\$ 6,115	\$ 6,342	\$ 6,558	-
Net Profit per Adj Admissions	\$ (2,250)	\$ (2,377)	\$ (2,475)	-
Operating Revenue per Adj Pat Days	\$ 276	\$ 285	\$ 295	-
Operating Expense per Adj Pat Days	\$ 520	\$ 539	\$ 557	-
Net Profit per Adj Pat Days	\$ (191)	\$ (202)	\$ (210)	-

Because the project is projected to reduce the losses the current CD hospital is experiencing, the project may result in a positive impact on the cost and charges when compared to the status quo. This sub-criterion is met.

(3) The project can be appropriately financed.

As stated in the project description portion of this evaluation, St. Peter proposes to license beds from two locations into a single acute care bed license. No change in the number of beds at either location is proposed. The estimated costs necessary at the CD unit are \$3,116,652.

HPDS writes, “St. Peter Healthcare will use reserves (Board Designated) for the project and has the reserves available now”. HPDS also confirms that, “The use of reserves is a very appropriate and inexpensive financing method since the only constraint would be the question, is this the best use of the reserves”. [HPDS Analysis, p4; Application, p34]

In summary, the financing methods used are appropriate. Therefore, the department concludes that this sub-criterion is met

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Based on the source information reviewed, the department determines that the applicant has not met the structure and process (quality) of care criteria in WAC 246-310-230.

- (1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

St. Peter provided estimates that the project will require an increase of approximately 4 FTEs, primarily to account for the expansion of the medical detoxification service at the CD unit. Additional FTEs are anticipated to be added incrementally and are depicted in the table below. [Application, p40]

**Table 9
Providence St. Peter CD Unit - FTE Forecast**

	Current	2010	2011	2012
RN	9.12	9.12	9.40	9.68
LPN	2.56	2.56	2.64	2.72
Nursing Asst.	12.82	12.82	13.20	13.60
Clerical	10.61	10.61	10.61	10.61
Environment & Food Service	6.55	8.55	8.55	8.55
Professional/Technical	33.31	34.31	34.31	34.31
Mgmt. & Supervisors	5.62	5.62	5.62	5.62
Mgmt. Physician	0.43	0.43	0.43	0.43
Physician	0.48	0.48	0.48	1.00
Other	3.33	3.33	3.33	3.33
Contract Agency	0.04	0.04	0.04	0.04
FTE Total	84.87	87.87	88.61	89.89

St. Peter indicates that they have a long and proven history of offering a competitive wage and benefit package and a strong positive work environment that encourages staff development and growth for all employees. The applicant also states, “Given the low level of incremental staff proposed, along with our history of recruitment and retention, we do not anticipate any difficulty in recruiting the additional staff for this project”. [Application, p41]

Based on the information, St. Peter is unlikely to have difficulty identifying the necessary staff for this project. This sub-criterion is met.

- (2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.

This application proposes to continue services currently offered at each of the two locations. Each hospital has retained the support services necessary to provide the appropriate care at the respective sites. Further, there is no indication that these relationships would not be able to accommodate the proposed reconfiguration of the chemical dependency portion of the CD unit. [Application, p41]

Therefore, the department concludes that there is reasonable assurance that St. Peter will continue its relationships with ancillary and support services within the hospital and this project would not affect those relationships. This sub-criterion is met.

- (3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.

St. Peter will continue to provide Medicare and Medicaid services at each of the two locations to the residents of Thurston County and surrounding communities. St. Peter contracts with the Joint Commission to survey and accredit the quality of service provided at both sites as well. The Joint Commission lists St. Peter Hospital and the current CD hospital in full compliance with all applicable standards following the most recent on-site survey in January 2007.¹²

Complementing reviews performed by the Joint Commission, are the surveys conducted by the Department's Office of Health Care Survey. Since 2004, the Department OHCS has completed one state compliance survey of St. Peter Hospital¹³ and a re-licensing survey of the CD hospital¹⁴. The most recent hospital compliance survey included issues related to several complaints but revealed no deficiencies were reported in either review. [Compliance survey data provided by Office of Health Care Survey]

Based on Providence's compliance history, the department concludes that there is reasonable assurance that the hospital would continue to operate in conformance with state and federal regulations after change in bed licensing. This sub-criterion is met.

- (4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

As outlined in the application, St. Peter is proposing to consolidate the licenses of two facilities currently licensed under separate state licenses in an effort to meet the qualification necessary to receive preferable rates from available drug purchasing programs. Specifically, the

¹² <http://www.qualitycheck.org>

¹³ Surveys of St. Peter Hospital completed in April, 2007

¹⁴ Survey of Chemical Dependency Hospital completed May, 2007

applicant proposes to add the licensed beds of the Providence St. Peter Chemical Dependency Hospital to the acute care license of Providence St. Peter Hospital. St. Peter states that the proposed licensing would maintain the current compliment of care available provided the planning area.¹⁵ Approval of this project is not expected to change the relationships in place with the health care providers in the area since it does not involve an increase in the number of beds currently available. [Application, p41]

The department concludes that there is reasonable assurance that approval of this project would assist in St. Peter ability to subsidize the care provided within the CD unit. Further, St. Peter's relationships within existing health care system would continue and not result in an unwarranted fragmentation of services. This sub-criterion is met.

- (5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.

This sub-criterion is addressed in sub-section (3) above and is considered met.

D. Cost Containment (WAC 246-310-240)

Based on the source information reviewed, the department determines that the applicant has met the cost containment criteria in WAC 246-310-240.

- (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.

The applicant notes four options that were considered;

1. Continue with current licenses/current status
2. Significantly reduce the number of CD beds
3. Eliminate the service
4. Transfer the chemical dependency program to the hospital license

The applicant contends that option 1 is not sustainable. St. Peter states, "While we can continue under the current status for the short-term future, prudent business practices require that a program requiring a subsidy of the magnitude of that currently required by the service be regularly evaluated for benefit, sizing, structure, models, etc.". Additional concerns regarding staff retention for a program constantly under evaluations of this manner helped lead to the rejection of this option.

Options 2 and 3 were discussed in tandem in the application. The potential reduction to 25 beds, through the elimination of the adolescent program, or the elimination of the service in total, would not address the needs of the community currently being served. The applicant concedes, "Option #2 may need to be considered again in the future if the consolidation of licenses does not achieve most of the benefits currently anticipated". [Application, p45]

¹⁵ The applicant does propose a reduction from 22 to 18 beds currently allocated to adolescent care at the CD unit

As addressed in detail in the need section of this analysis, there is a surplus of acute care bed capacity. The proposed licensing change would:

- Allow for continued access and availability to chemical dependency services in the planning area and the surrounding region,
- Provide an opportunity to more efficiently deliver the prescribed services, and
- Potentially lower the subsidy of costs currently associated with chemical dependency treatment.

With these factors considered, option 4 is viewed by the Department to be the best available option. With acceptance of the condition that limits the care in this projects beds currently provided to chemical dependency, this criterion is met.

(2)(a) In the case of a project involving construction: The costs, scope, and methods of construction and energy conservation are reasonable.

The applicant is proposing to remodel and expand two wings of the CD unit. At project completion, the CD unit will have an approximately 1,632 square feet of additional space. Staff from HPDS examined the construction costs of this project and provided the following analysis. [HPDS Analysis, p4]

Table 10
Providence Health System Construction Projections

Providence St. Peter CD Unit	Cost
Total Capital	\$ 3,116,652
Construction Cost	\$ 3,082,195
Gross Square Footage	39,804
Beds/Stations/Other (Unit)	50
Total Capital per Gross Square Foot	\$ 78.30
Total Const. per Gross Square Foot	\$ 77.43
Total Capital per Unit	\$ 62,333.04

As HPDS states, “The costs shown are within past construction costs reviewed by this office. Also construction cost can vary quite a bit due to type of construction, quality of material, custom vs. standard design, building site and other factors. Providence St. Peter Hospital is building in a facility it currently occupies for healthcare services and will construct the new area to the latest energy and hospital standards”. [HPDS Analysis, p4]

The Department is satisfied the applicant’s plans, if approved, are appropriate. This criterion is satisfied.

(2)(b) In the case of a project involving construction: The project will not have an unreasonable impact of the costs and charges to the public of providing services by other persons

HPDS and program staff are satisfied that adding 50 licensed beds to the acute care license that are dedicated to an under served need will not have an unreasonable impact of the costs and charges to the public of providing services by other persons.

- (3) The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

After the review of the financial losses currently being realized through the CD hospital, the department acknowledges that the services currently provided could be at risk if the losses continue. The prospect of qualifying for the pricing advantages associated with a DSH classification may provide the necessary savings to retain the level of services currently provided for the area. St. Peter also notes that this project will improve system efficiency for the hospital and increase certain reimbursement. [Application, p46]

The Department acknowledges that facilities which make moves toward program efficiencies have the potential to increase the quality of care while reducing overall costs to the hospital. This criterion is met.

EXHIBIT A