

**EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF OF
SACRED HEART MEDICAL CENTER AND CHILDREN'S HOSPITAL PROPOSING TWO
SEPARATE PROJECTS:
1) ADDITION OF 152 ACUTE CARE BEDS; AND
2) RECONCILIATION IN THE USE OF 21 LEVEL II INTERMEDIATE CARE BASSINETTES**

PROJECT DESCRIPTION

Sacred Heart Medical Center and Children's Hospital (Sacred Heart) is a 623 bed acute care, not for profit hospital located in the city of Spokane within Spokane County. Sacred Heart is part of Providence Health & Services that includes 26 hospitals, more than 35 non-acute facilities, and related clinics and educational locations throughout Alaska, Washington, Montana, and Oregon. Sacred Heart provides Medicare/Medicaid acute care services to the residents of Spokane County and surrounding areas, and currently holds an accreditation from the Joint Commission. [Providence website; Application, Exhibit 2; Joint Commission website]

On October 23, 2008, Sacred Heart submitted a Certificate of Need application proposing two separate, but interrelated, projects at the hospital. One project proposes the addition of 152 acute care beds to the hospital's existing 623 licensed beds. The 152 beds would be added in five phases beginning in 2011 and extending through 2015.

The second project involves 21 intermediate care nursery - level II (ICN-level II) bassinets that are currently in use, but not licensed as part of the hospital's bed capacity. This part of the project proposes to correct this flaw. It also includes the relocation of the ICN level II bassinets with the Neonatal Intensive Care (NICU) level III unit. The first phase is the immediate relocation of five bassinets from their current location into space within the NICU level III unit. The second phase would be completed in 2011 when the NICU level III bassinets and the remaining 16 ICN level II bassinets are modeled and consolidated in one location. [Application, p13]

The phased implementation for both projects is outlined in Table 1.

**Table 1
Description of Sacred Heart's Phased Implementation**

| Year | Additional Acute Care Beds | ICN-level II Bassinets | Total Licensed Beds |
|--------------|-----------------------------------|-------------------------------|----------------------------|
| 2009 | | 5 | 628 |
| 2010 | | | 628 |
| 2011 | 21 | 16 | 665 |
| 2012 | 36 | | 701 |
| 2013 | 32 | | 733 |
| 2014 | 33 | | 766 |
| 2015 | 30 | | 796 |
| Total | 152 | 21 | 796 |

If only the 152 acute care bed addition project is approved, Sacred Heart's licensed beds would increase to 775 (623 + 152). If only the ICN-level II project is approved, Sacred Heart's licensed beds would increase to 644 (623 + 21). If both projects are approved as submitted, Sacred Heart's licensed bed count would increase to 796 (623 + 152 + 21). Except for the initial five level II bassinets,

construction is necessary for space to accommodate the additional beds and to consolidate the neonatal bassinets. The schedule for construction of the new space is detailed in Table 2. [February 20, 2009 Supplemental Information, p3]

Table 2
Sacred Heart Hospital's Construction Schedule

| Floor | Project | Construction Contract Awarded | Construction Complete | Licensure Approval | Occupancy or Offering of Service |
|--------------|----------------|--------------------------------------|------------------------------|---------------------------|---|
| 3 West | level II | April, 2010 | June, 2011 | July, 2011 | August, 2011 |
| 4 West | Acute Care | June, 2010 | June, 2011 | July, 2011 | August, 2011 |
| 6 West | Acute Care | October, 2010 | June, 2012 | July, 2012 | August, 2012 |
| 7 West | Acute Care | October, 2010 | June, 2012 | July, 2012 | August, 2012 |
| 8 West | Acute Care | October, 2011 | June, 2013 | July, 2013 | August, 2013 |
| 3 South | Acute Care | November, 2012 | June, 2013 | July, 2013 | August, 2013 |
| 6 South | Acute Care | November, 2013 | June, 2014 | July, 2014 | August, 2014 |
| 6 North | Acute Care | November, 2014 | June, 2015 | July, 2015 | August, 2015 |

As shown in the timetable above, the ICN-level II project is anticipated to be complete by the end of August, 2011. Under that timeline, calendar year 2012 is the first full calendar year of operation with ICN-level II services, and 2014 would be the third full calendar year of operation.

The 152 acute care beds are projected to be implemented in multiple phases. The initial 21 beds would become available in August, 2011. The last 30 beds would become operational in August, 2015. Under that timeline, calendar year 2016 would be Sacred Heart's first full calendar year of operation with an additional 152 acute care beds, and 2018 would be full year three. If both projects are approved as submitted, including all phases of the acute care bed addition, Sacred Heart would be operating as a 796 bed hospital in the fall of 2015.

Sacred Heart submitted this application with a total project cost of \$133,612,230. The portion of these costs related to the proposed phased expansion relevant to the CoN application equals \$84,673,217. The estimated capital expenditure for each of the two projects is broken down in Table 3. [Application, p5; February 20, 2009 Supplemental Information, p19]

Table 3
Estimated Capital Costs for Proposed Projects

| Item | Acute Care Beds | level II Bassinets | Total |
|-------------------------|------------------------|---------------------------|---------------------|
| Building Construction | \$51,241,254 | \$2,250,000 | \$53,491,254 |
| Fixed Equipment | \$3,352,000 | \$0 | \$3,352,000 |
| Moveable Equipment | \$13,494,044 | \$1,494,000 | \$14,988,044 |
| Architect/Engineer Fees | \$5,212,755 | \$337,500 | \$5,550,255 |
| Consulting Fees | \$160,920 | \$10,000 | \$170,920 |
| Sales Tax | \$5,941,808 | \$325,736 | \$6,267,544 |
| Other Project Costs | \$0 | \$853,200 | \$853,200 |
| Total | \$79,402,781 | \$5,270,436 | \$84,673,217 |

As shown above, Sacred Heart anticipates that the intermediate care nursery portion of the project would be approximately 6.2% of the total estimated capital costs. The acute care bed addition would make up the remaining 93.8% of the capital costs [Application, p60]

To avoid confusion in this evaluation, beginning with the Need review criteria, each of the two projects proposed by Sacred Heart will be addressed separately. Pages 6 through 29 and Appendices 1 through 10 will address the acute care bed addition project; pages 30 through 44 will address the ICN-level II project criteria.

APPLICABILITY OF CERTIFICATE OF NEED LAW

Acute Care Bed Addition

The acute care bed addition portion of this application is subject to Certificate of Need review as the change in bed capacity of a 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).

Intermediate Care Nursery level II Bassinette Addition (Reconciliation)

The intermediate care nursery ICN-level II obstetric bassinette reconciliation is subject to review as the change in bed capacity of a health care facility under RCW 70.38.105(4)(e) and WAC 246-310-020(1)(c).

APPLICATION CHRONOLOGY

| | |
|---|--|
| September 5, 2008 | Letter of Intent Submitted |
| October 23, 2008 | Application Submitted |
| October 24, 2008 through February 25, 2009 | Department's Pre-Review Activities <ul style="list-style-type: none">• 1st screening activities and responses |
| February 26, 2009 | Department Begins Review of the Application <ul style="list-style-type: none">• public comments accepted throughout review |
| April 2, 2009 | Public Hearing Conducted/End of Public Comment |
| April 17, 2009 | Rebuttal Documents Submitted to Department |
| June 2, 2009 | Department's Anticipated Decision Date |
| June 19, 2009 | Department's Actual Decision Date |

AFFECTED PERSONS

During the review of this application, three entities sought or received affected person status under WAC 246-310-010. The three entities are listed below.

- Deaconess Medical Center—an acute care hospital located in the city of Spokane, within Spokane County;
- Valley Hospital and Medical Center— an acute care hospital located in the city of Spokane Valley, within Spokane County;
- SEIU Healthcare 1199NW – a labor union representing approximately 1,200 members that reside in the applicants planning area.
- Primera Blue Cross – A Health Insurance carrier within eastern Washington.

SOURCE INFORMATION REVIEWED

- Sacred Heart Medical Center and Children's Hospital Certificate of Need application submitted October 23, 2008
- Sacred Heart Medical Center and Children's Hospital supplemental information dated February 20, 2009
- Sacred Heart Medical Center and Children's Hospital supplemental information dated March 9, 2009
- Department of Health's Office of Hospital and Patient Data Systems (HPDS) financial feasibility and cost containment analysis dated May 19, 2009
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Public comment received during the course of the review
- Documents submitted during the public hearing on April 2, 2009
- Acute care bed capacity surveys submitted by Deaconess Medical Center, Providence Holy Family, Providence Sacred Heart Medical Center and Children's Hospital, St. Luke's Rehabilitation Institute, and Valley Hospital and Medical Center
- Sacred Heart Medical Center and Children's Hospital rebuttal comments dated April 17, 2009
- Deaconess and Spokane Valley Hospital's rebuttal comments dated April 17, 2009
- SEIU Healthcare 1199NW rebuttal comments dated April 17, 2009
- Population data obtained from the Office Financial Management based on year 2000 census published November 2007
- Population estimates and forecasts obtained from the Claritas, Inc.
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Washington State Perinatal Levels of Care Criteria adopted by the Perinatal Advisory Committee-- February 2005, used as guidance
- Information cited on the Providence Health & Services website (www.providence.org)
- Mileage data obtained from Map Quest via the internet (www.mapquest.com)
- Certificate of Need Historical files
- Department of Health's Investigation and Inspection's Office (IIO) files

CRITERIA EVALUATION

To obtain Certificate of Need approval, Sacred Heart must demonstrate compliance with the applicable 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).¹ For the acute care bed addition portion of this project, Sacred Heart must demonstrate compliance with portions of the 1987 State Health Plan as it relates to the methodology for acute care beds.

¹ Each criterion contains certain sub-criteria. The following sub-criteria are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

CONCLUSIONS

ACUTE CARE BED ADDITION PROJECT

For the reasons stated in this evaluation, the Certificate of Need application submitted on behalf of Sacred Heart Medical Center and Children's Hospital to add 152 acute care beds to the hospital is not consistent with the Certificate of Need review criteria, and a Certificate of Need is denied.

LEVEL II - INTERMEDIATE CARE BASSINETTE ADDITION PROJECT

For the reasons stated in this evaluation, Sacred Heart Medical Center and Children's Hospitals proposal to recognize the inclusion of 21 ICN-level II bassinets to the existing neonatal program within space at the Children's hospital is consistent with application criteria of the Certificate of Need Program. This approval will allow for reconciliation of the number of bassinets currently used at the facility and will result in the hospital being approved for 21 ICN-level II and 40 NICU level III bassinets for a facility total of 644 licensed beds. This approval is based on Sacred Heart Medical Center and Children's Hospital agreement to the following condition:

Condition

1. Sacred Heart will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent policies reviewed and approved by the Department of Health. Sacred Heart will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Eastern Washington Region. Currently, this amount is 3.37% of adjusted revenue. Sacred Heart will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

The approved capital expenditure for this project is \$5,270,436.

ACUTE CARE BED ADDITION PROJECT

A. Need (WAC 246-310-210)

Based on the source information reviewed, the department determines that the application is not consistent with the applicable 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.*

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.

Summary of Sacred Heart's Numeric Methodology

As previously stated in the project description portion of this evaluation, Sacred Heart is currently licensed for 623 beds at the hospital. Of this bed compliment, 551 are classified as acute care beds, with the remaining 72 beds allocated for psychiatric care. Sacred Heart proposes to add 152 acute care beds to its existing capacity in multiple phases. Given that this proposal involves extensive construction, Sacred Heart intends to begin the construction project in June, 2010. The first 21 beds would be added in year 2011, resulting in 572 acute care beds at Sacred Heart. Between 2012 and 2015, Sacred Heart would add the remaining 131 beds as additional floors are completed, resulting in 703 acute care beds at completion. Under this timeline, 2018 would be Sacred Heart's third year of operation with 703 acute care beds, or a total compliment of 775 licensed beds. [February 20, 2009 Supplemental Information, p3, Sacred Heart Rebuttal, p4]

Sacred Heart is located within the Spokane County planning area. For its numeric demonstration of need for additional beds, Sacred Heart provided three separate versions of the numeric methodology, all relying on different assumptions and modifications, resulting in considerably different results. For purposes of this discussion, the three versions will be referred to as the Application version, the Screening version, and the Rebuttal version.

In the "Application" version, supplied with the initial application, Sacred Heart applied the numeric methodology to the Spokane planning area. The Application version uses the appropriate planning area patient days and follows each step as prescribed, but includes a different set of current capacity figures in Step 10 than that used in subsequent versions. As a result, Sacred Heart computed a surplus of beds from 2007 through 2011. The first indication of need for additional beds is apparent in 2012 (12 beds) and increases to equal a need for 76 additional beds by the end of year 2014. [Application, Exhibit 15]

In the second "Screening" version, Sacred Heart applied the numeric methodology to the Spokane planning area as before, but excluded level II and level III bassinets and the corresponding patient days from the relative calculations. Within this version, Sacred Heart determined a surplus of 178 beds in year 2007, decreasing to a surplus of 16 beds in 2012. The need increases to 48 in 2014. [February 20, 2009 Supplemental Information, Exhibit 33]

In the final “Rebuttal” version supplied with the applicant’s rebuttal documents, Sacred Heart again applied the numeric methodology to the Spokane planning area as prescribed, inclusive of neonate data, but applied an updated set of capacity figures in Step 10a. As a result of these final changes, Sacred Heart continued to demonstrate a surplus of beds from 2007 through 2011. The first indication of need for additional beds is again apparent in 2012 (1 bed) and increases to a need for 68 beds by the end of year 2014. [Sacred heart Rebuttal, Exhibit Q]

The department reviewed the circumstances of each version of the Sacred Heart bed need methodologies, and ultimately rejected both the Screening and Rebuttal versions. The Department acknowledges that there a logical premise to excluding the neonate data as done in the Screening methodology, but in this instance, the results are less supportive of the proposed project. Further, revisions of previously supplied data cannot be evaluated when received during the prescribed rebuttal period. Public comment produced by the public, interested, or affected parties does not provide an opportunity for an applicant to revise or update documents previously submitted prior to beginning of review. As a result, the department will only address Sacred Heart’s “Application” methodology for this evaluation of the proposed expansion. Sacred Heart’s “Application” version is explained in greater detail within the step-by-step portion of the numeric methodology explanation below.

A seven-year horizon for forecasting acute care bed projections will be used in this evaluation which is consistent with the recommendations within the state health plan that 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 application was submitted, the seven-year projection year is 2014. As a result, the department will set the target year as 2014, which is seven years after the most recent data (2007). However, in some areas of this evaluation, years 2015 or 2018 may be referenced for specific discussion purposes.

In summary, the Application method submitted by Sacred Heart based its projections on planning area resident hospital discharges for years 1998-2007. This resulted in a projected total of 280,863 patient days in year 2008; increasing through 2014. Year 2014 projections show 325,582 patient days. Sacred Heart determined a surplus of beds in the planning area through year 2011, with a need for 12 beds arising in 2012. Continuing the forecast through 2014, the applicant calculates a need for approximately 76 beds. A complete summary of the applicant’s projections are shown in Table 4. [Application, Exhibit 15]

**Table 4
Summary of Sacred Heart Application Need Methodology for Spokane Planning Area**

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---------------------|---------|---------|---------|---------|---------|---------|---------|
| Patient Days | 280,863 | 286,764 | 292,773 | 300,638 | 308,722 | 317,034 | 325,582 |
| Planning Area Beds | 1,168 | 1,168 | 1,168 | 1,168 | 1,168 | 1,168 | 1,168 |
| Adjusted Gross Need | 1,074 | 1,096 | 1,119 | 1,150 | 1,180 | 1,212 | 1,244 |
| Adjusted Net Need | (94) | (72) | (49) | (18) | 12 | 44 | 76 |

* Negative number indicates a surplus of beds. All numbers are rounded.

The Department’s Determination of Numeric Need:

The department uses the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP) 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. 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 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. 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)², and planning area. The planning area for this evaluation is the Spokane planning area.

The Spokane planning area is described in State Health Coordinating Council documents from 1987 as all of the zip codes within Spokane County and select zip codes from neighboring Stevens, Lincoln, and Whitman counties³. Zip codes are assigned by the US Postal Service for mail delivery purposes and do not necessarily correspond to fixed areas over long periods of time. Zip codes may also be added or deleted in an area as necessary. Because some zip codes have been added in Spokane County in the intervening years and some zip code boundaries have changed, the 1987 list of zip codes no longer corresponds with the geographic area intended to be considered the

² The state is divided into four HSA’s 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.

³ Described in 1981 Eastern Washington Health Systems Agency documents as all zip codes for Spokane County and select zip codes from neighboring counties including—99008, 99013, 99017, 99029, 99032, 99033, 99040, 99110, 99148, and 99170.

Spokane planning area. Changes and updates were considered in the compilation of the patient day and population totals.

When preparing acute care bed need projections, the department relies upon population forecasts published by the Washington State Office of Financial Management (OFM). OFM publishes a set of forecasts known as the “intermediate-series” county population projections, based on the 2000 census, updated November 2007⁴. However, OFM figures are not available for any area smaller than an entire county. Because OFM does not provide population estimates at the level necessary for inclusion of the necessary parts of Spokane’s neighboring counties, the department relied upon estimates and projections developed by Claritas, Inc. for the applicable zip code populations in Stevens, Lincoln, and Whitman counties. [Exhibit A of this evaluation, Population appendix]

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 Sacred Heart 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 planning area resident utilization data for 1998 through 2007 from the Department of Health Office of Hospital and Patient Data Systems’ CHARS (Comprehensive Hospital Abstract Reporting System) database. Total resident patient days were identified for the Spokane Planning Area, HSA 4, and the State of Washington as a whole, excluding psychiatric patient days (Major Diagnostic Category (MDC) 19) and normal newborns (Diagnostic Related Group (DRG) 391), according to the county in which care was provided.

Sacred Heart followed this step as described above with no deviations.

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

While this step was partially accomplished by limiting the data obtained for Step 1, 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.

Sacred Heart followed this step as described above with no deviations. Though, a nominal number of psychiatric patient, not identified by the Department, were included. No information was provided to interpret the source of these figures, but their inclusion provides for some minor variance in the calculated trend lines produced in Step 4.

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. For the purposes of this application, the average use rate was also determined for the state

⁴ The November 2007 series was the most current data set available during the production of the state acute care methodology following the release of the 2007 CHARS data and can be found at <http://www.ofm.wa.gov/pop/estimates.asp> and compiled internally by DOH

and the Spokane planning area and is attached as Appendix 3. Actual and projected population figures for this analysis were derived from the combination of State of Washington Office of Financial Management (OFM) “medium-series” county population projections and Claritas data as described above.

Sacred Heart followed this step as described. Although, the Spokane planning area population figures used by Sacred Heart exceed those used by the Department due in part to growth rate computations using population growth data from 1990 through 2007 and forecasted through 2020. A notable difference also appears in the population totals for the Stevens County resident zip codes. A complete comparison of relevant years used in the production of the Department’s methodology is included in the population data detail attached at the end of Exhibit A of this evaluation. [Application, p34, Table 21, Exhibit 15; Deaconess Comment, p7]

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 department has computed trend lines for the state, HSA 4, and the Spokane planning area based upon the trends in use rates from these ten years and has included them as Appendix 4. The resulting trend lines uniformly exhibit a mild upward slope. This conclusion is supported by increasing utilization reported by hospitals throughout the state in recent years, and is indicative of a growing population. More significant than overall population growth is the fact that the state’s population is growing older as the large 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.

Sacred Heart followed this step as described above with no deviations. Use of differing population values produces slightly different, but comparable, results.

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 utilizes data particular to the residents of the Spokane planning area. In order to forecast the availability of services for the residents of a given region, patient days must also be identified for the facilities available within the planning area. Step 5, included as Appendix 5, identifies referral patterns in and out of the Spokane 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 used discharge data for Washington residents that receive health care in Oregon. This data was obtained from the Oregon Department of Human Services (the department is not aware of similar data for the State of Idaho).

As has been noted earlier, the original purpose for this methodology was to create comprehensive, statewide resource need forecasts. For purposes of this evaluation, the state was broken into only two planning areas—Spokane and the state as a whole minus Spokane. Appendix 5 illustrates the age-specific patient days for residents of the Spokane planning area and for the rest of the state, identified here as “WA – Spokane.”

Sacred Heart followed this step as described above. The patient days for the facilities appear to include data recorded for St. Luke's Rehabilitation Institute. This will effect comparable computations explained further in step 9.

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 defined in Step 3, for the Spokane planning area and for the rest of the state.

Sacred Heart followed this step as described above with no deviations. Though, the use of larger population projections in Step 5 led to lower overall use rates than that of the Department. This will impact the results in future steps within the methodology

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. The State has a lower projected rate (an annual increase of 2.9379) than the HSA trend rate of 4.3345. 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.

Sacred Heart applied this portion of step 7 with one apparent modification. Rather than using the current use rates to project out to the target year of 2014, Sacred Heart initially projects out to 2010. The data is then continued with use rate projections in 5-year increments; including 2015, 2020, and 2025. No direct comparison can be made between the applicant's results and those of the Department due to the combined affect of the differing population values and projection years.

[Exhibit A; Application, Exhibit 15, p164]

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 forecasted use rate for the target year 2014 and population projections, projected patient days for Spokane planning area residents are 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 10 as "Total Spokane Res Days."

Sacred Heart applied this step with projections for 2010, 2015, and 2020.

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 Spokane planning area and the remainder of the state were allocated from county of residence 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 10 as “Total Days in Spokane Hospitals.”

Sacred Heart applied this step with no deviations and with differing in-migration percentages. Due primarily to the inclusion of St. Luke’s patient days, the applicant determined a higher in-migration to produce the “Total Days in Spokane Hospitals” values. In the 65+ age cohort, the applicant adjusts the patient day up by a factor of 34%. In contrast, the Department established a rate of 18%. The factor for the <64 age cohort was also lower in the Departments values after removing the St. Luke’s patient days in the calculations from step 5. [Exhibit A, Appendix 9]

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 available beds in the planning area was identified in accordance with the SHP standard 12.a., which identifies:

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 built;
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.

SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information was gathered through a capacity survey of the state hospitals, inclusive of the Spokane County hospitals. For those hospitals that do not respond to the department’s capacity survey, the information is obtained through the Department of Health’s Office of Hospital and Patient Data Systems records.

For this project, there are six hospitals considered in the Spokane planning area. Below is a summary of these facilities and the Department’s determination of the capacity values used in the production of the acute care bed methodology. Each of the hospitals currently operating in the Spokane planning area have completed and returned a survey for use in the establishment of the available bed capacity.

Deaconess Medical Center

Deaconess Medical Center (Deaconess) is located at 800 West Fifth Avenue in Spokane. Deaconess is licensed for 388 acute care beds. Of the 388 beds, Deaconess reports 283 set up and available and 11 additional beds assignable for a total of 294. Deaconess also reports 40 ICN-level

II bassinets which are considered part of their acute care bed compliment. In total, Deaconess will be recorded to have a total capacity of 334 beds. [Deaconess Utilization Survey, March 31, 2009 Survey Correction]

Deer Park Hospital

This community hospital was located at 1015 East 'D' Street in Deer Park and was licensed for 25 acute care beds. Effective March 4, 2008, Deer Park Hospital chose to close and remove all 25 beds from service in the planning area. Therefore, 2007 will be the last year these 25 beds will be counted in the acute care bed supply. [CN Facility Records]

Providence Holy Family

This facility is located at 5633 North Lidgerwood Street in Spokane and is licensed for 272 acute care beds. Although, Holy Family only reports that 182 acute care beds are set up and assignable. Survey responses also report 9 ICN-level II bassinets. This data results in a total capacity of 191 licensed beds. [Holy Family Utilization Survey]

Providence Sacred Heart Medical Center and Children's Hospital

The applicant facility is located at 101 West Eighth Avenue in Spokane and is licensed for 623 acute care beds. Of the 623 acute care beds set up and available, including the 40 level III bassinets. It is necessary to remove the 72 beds that are dedicated to psychiatric patients, resulting in 551 licensed beds. [Sacred Heart Utilization Survey]

St. Luke's Rehabilitation Institute

This facility is located at 711 South Cowley Street in Spokane. St. Luke's reports 72 set up and available and 24 additional beds assignable for a total capacity of 102 licensed beds. This facility is an acute care hospital that specializes in rehabilitation rather than general acute care services. No capacity or patient days attributable to St. Luke's will be included in the production of the need methodology [St Luke's Utilization Survey]

Valley Hospital and Medical Center

This facility is located at 12606 East Mission Avenue in Spokane Valley and is licensed for 123 acute care beds. Of the 123 beds, Valley reports 94 are currently set-up available and the remaining 29 are assignable. [Valley Hospital Utilization Survey]

While the methodology states that short-stay psychiatric beds should be included in the above totals, 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. There are no psychiatric hospitals located in the Spokane planning area. However, dedicated psychiatric beds within Sacred Heart's facility were excluded. In summary, among the four hospitals which remained open in the Spokane planning area, the Department has determined that there are 1,199 available licensed beds.

In contrast, Sacred Heart counted a total of 1,168 available licensed beds remaining in the Spokane planning area. Sacred Heart provided the following statements regarding how it believes the Department should determine the current bed supply. [Sacred Heart Rebuttal, p5]

- 1) Use the bed counts supplied by Community Health Systems (CHS) in the 2008 Certificate of Need applications reviewed as part of the acquisition of Deaconess and Valley hospitals rather than the subsequent acute care bed surveys. The applicant believes the survey totals are

inaccurate and misleading and are submitted in an effort to increase the bed count for the region and eliminate any projected need in a acute care bed forecast;

- 2) Adjust the bed need model to recognize Sacred Heart’s position as a regional tertiary provider of services unavailable in community hospitals such as Valley;
- 3) Use the occupancy adjustments⁵ that resulted from work performed at Sacred Heart by a nationally recognized bed need planning expert, and;
- 4) Use a planning horizon of project completion of plus three years, or 2018, for the bed need methodology to reflect the relatively long timeline for bringing the Sacred Heart beds into service.

The bed tally ultimately used in this evaluation can be found in Sacred Heart’s Application methodology and a comparison is shown in Table 5. [Application, Exhibit 15, Appendix 10a; Sacred Heart Rebuttal, p6 & 91]

Table 5
Spokane Planning Area Acute Care Bed Capacity Totals

| Hospital | Sacred Heart Total | Department Total |
|--|---------------------------|-------------------------|
| Deaconess Medical Center | 270 | 334 |
| Providence Holy Family | 182 | 191 |
| Providence Sacred Heart Medical Center | 551 | 551 |
| Valley Hospital and Medical Center | 93 | 123 |
| Applicable Hospital Capacity | 1,096 | 1,199 |
| St. Luke’s Rehabilitation Institute | 72 | 0 |
| Applied Methodology Capacity | 1,168 | 1,199 |

The disparity between capacities applied in the methodologies appears small. However, when reconciled to exclude St. Lukes, the applicant calculates a capacity in the planning area that is 103 beds less than the Department’s total. The capacity represented by the applicant for Deaconess and Holy Family account for nearly all of the disparity.

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 expected 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 hospitals under the current models for provision of care. As a result, the department adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds). The Department considered the request of Sacred Heart to alter these standards further. After this consideration, the standards were not altered further as requested by the applicant.

As a result of this change, the Spokane planning area’s weighted occupancy, after removing Deer Park, has been determined to be 71.80%. The weighted occupancy standard assumptions detailed above, is reflected in the line “Wtd Occ Std” in Appendix 10a and 10b.

⁵ Sacred Heart applied an Adjusted Average Daily Census to both the acute care bed expansion and the NICU expansion described in more detail later in this evaluation.

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.

Sacred Heart 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. Sacred Heart’s adjustments were all described within its methodology.

The results of the department’s methodology are available in Exhibit A as Appendices 10A and 10B attached to this evaluation. Appendix 10A calculates the Spokane planning area bed need without the proposed project. Appendix 10B demonstrates the impact of adding 152 additional beds to Sacred Heart in multiple phases. A summary of those appendices is shown in Table 6. Though the forecast period is through 2014, figures through 2015 are included to allow for comparison through the completion of the multiple phased implementations. [Exhibit A]

**Table 6
Department Methodology
Appendix 10A – Without Project - Summary**

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|--|-------|-------|-------|-------|-------|-------|-------|-------|
| Planning Area # of beds | 1199 | 1199 | 1199 | 1199 | 1199 | 1199 | 1199 | 1199 |
| Adjusted Gross Need | 987 | 1,008 | 1,029 | 1,057 | 1,086 | 1,115 | 1,144 | 1,173 |
| Need/(Surplus) – Without Project (Appendix 10a) | (212) | (191) | (170) | (142) | (113) | (84) | (55) | (26) |

Appendix 10B – With Project (Phases in Bold) – Summary

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|-------|-------|-------|-------------|-------------|-------------|-------------|-------------|
| Planning Area # of beds | 1199 | 1199 | 1199 | 1220 | 1256 | 1288 | 1321 | 1351 |
| Adjusted Gross Need | 987 | 1,007 | 1,029 | 1,056 | 1,084 | 1,112 | 1,140 | 1,168 |
| Need/(Surplus) - With Project (Appendix 10b) | (212) | (191) | (170) | (164) | (172) | (176) | (181) | (183) |

As shown in Table 6 above, for current year 2008, Appendices 10A and 10B illustrate a planning area net surplus of 212 beds. Appendix 10A shows without the addition of 152 beds to the planning area, the surplus would decline but maintain a surplus through 2015. No need materializes until 2016 as detailed in the attached methodology. [Exhibit A, Appendix 10a]

Appendix 10B illustrates the effect on the planning area if Sacred Heart begins to add 152 acute care beds to the planning area beginning in year 2011. The net surplus increases in year 2011 to 163.58 beds with the inclusion of the first 21 beds, and then maintains this level of surplus throughout the phased implementation ending in 2015. Under these projections, no need would appear until after 2020 as detailed in the attached methodology. [Exhibit A, Appendix 10b]

In comparison, the results of Sacred Heart’s application of the methodology are stated in Table 7. The applicant’s projections for 2015 have been added for comparison. [Application, Exhibit 15]

Table 7
Applicant’s Acute Care Need Methodology Summary – Including 2015

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---------------------|-------|-------|-------|-------|-------|-------|-------|-------|
| Planning Area Beds | 1,168 | 1,168 | 1,168 | 1,168 | 1,168 | 1,168 | 1,168 | 1,168 |
| Adjusted Gross Need | 1,074 | 1,096 | 1,119 | 1,150 | 1,180 | 1,212 | 1,244 | 1,279 |
| Adjusted Net Need | (94) | (72) | (49) | (18) | 12 | 44 | 76 | 111 |

* Negative number indicates a surplus of beds. All numbers are rounded.

As shown in Table 7 above, Sacred Heart’s application of the methodology illustrates a decreasing planning area surplus for years 2008 through 2011. A need of 12 beds that appears in 2012, increase to 111 by 2015. Sacred Heart did not provide a table showing the effect on the planning area if an additional 152 beds were phased in as proposed.

As demonstrated by the department’s methodology summarized in Table 6 above, the Spokane planning area currently does not show a need for additional acute care bed capacity until beyond the 7-year projection period. In total, the addition of 152 beds to the Sacred Heart facility over beds the planning area by as much as 181 beds in 2014, and the surplus is not exhausted until 2020. [Exhibit A, Appendix 10b]

During the review of this application, the department received numerous letters of support before and during the April 2, 2009 public hearing. The letters of support were submitted by residents of the planning area as well as elected representatives from the United States Senate, the United States House of Representatives, the Washington State Senate, and the Washington State House of Representatives. In addition, local trade unions, a variety of physician groups located within the planning area, regional hospitals and health districts also provided comment supporting the proposed project. All letters of support expressed concerns with overcrowding at Sacred Heart, long waits in the emergency room before being admitted, or the increased population growth within the community. [Public comment provided during the review]

The Applicant supplemented the public comment by contending that Sacred Heart is the ‘hospital to other hospitals’ for the regions sickest patients, providing services which are not otherwise available in the Spokane planning area. The comment continues, “Because of the rapidly increasing demand for Sacred Heart services, caused in part by a growing and aging population, and in part by a shortage of specialists at community hospitals, Sacred Heart has filled its current licensed bed capacity”. Further, these beds are necessary in order to maintain an efficient balance

and to eliminate bottlenecks at a hospital that has been nationally recognized as a low cost, high quality provider. [Sacred Heart Rebuttal, p3]

Likewise, the department also received letters in opposition to this expansion project. Comment received from Premier Blue Cross states, “We encourage the Department to carefully consider the alternative scenarios in determining the need for this project at the scope included in the application. Unneeded beds add cost to a health care system that is already financially strained”. This concern is also expressed in comment received from a local physician group, which maintains, “Deaconess has both unused capacity and shelved space that can quickly and efficiently be made operational. Deaconess’ new owner has committed to investing \$100 million in capital into Deaconess and Valley over the next five years”.

These comments are buttressed with comment submitted from the Chief Executive Officers for Deaconess Medical Center and Valley Hospital. Their comments note, “A correct accounting of supply negates any need for new beds”. The comments continue in expressing concerns over the production of the Applicant’s methodology and population values concluding, “Altogether, SHMC has overstated the need by well more than 100 beds. [Deaconess & Valley Hospital Public comment, p3]

In conclusion, though the proposed 152 bed addition to Sacred Heart has gained the support of many in the community, the planning area’s capacity in alternate hospitals and the Department’s bed need methodology do not support the requested acute care bed expansion. Sacred Heart has not demonstrated that the Spokane planning area population 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 conclusion is supported by the department’s numeric methodology summarized in Table 6. This sub-criterion is not 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.

Sacred Heart 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, Sacred Heart 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, Sacred Heart provided a copy of its current Admission Policy that would continue to be used at the hospital. The policy outlines the process/criteria that Sacred Heart will use to admit patients for treatment or care at the hospital. The applicant states that any patient requiring care will be accepted for treatment at Sacred Heart without regard to “race, color, national origin, sex, marital status, or on the basis of disability”. [Application Exhibit 18]

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.

Sacred Heart currently provides services to Medicare and Medicaid eligible patients. Documents provided in the application demonstrate that Sacred Heart intends to maintain this status. For this project, a review of the policies and data provided for Sacred Heart identifies the facility’s financial pro forma includes both Medicare and Medicaid revenues [Application, p20; February 20, 2009 Supplemental Information, Exhibit 10]

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.

Sacred Heart 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, Sacred Heart included a ‘charity care’ line item as a deduction from revenue within the pro forma financial documents for Sacred Heart. [Application, Exhibit 16; February 20, 2009 Supplemental Information, Exhibit 10]

For charity care reporting purposes, the Department of Health’s Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Sacred Heart is located in Spokane and is one of 21 hospitals located within the Eastern Washington Region. According to 2005-2007 charity care data obtained from HPDS, Sacred Heart has historically provided more than the average charity care provided in the region. Sacred Heart’ most recent three years (2005-2007) percentages of charity care for gross and adjusted revenues are detailed in Table 8. [HPDS 2005-2007 charity care summaries]

**Table 8
Sacred Heart Charity Care Comparison**

| | 3-Year Average for Eastern WA Region | 3-Year Average for Sacred Heart |
|------------------------------|---|--|
| % of Gross Revenue | 1.36 % | 1.90 % |
| % of Adjusted Revenue | 3.37 % | 4.97 % |

Historical reports indicate that Sacred Heart has previously provided charity care above the regional average of 1.36% of gross revenue and 3.37% of adjusted revenue. A review of the applicant’s pro forma show they are predicted to exceed the gross revenue percentages. However the rate for Adjusted Revenue is only 2.10%. Because Sacred Heart does propose to meet or exceed the regional average as identified above, a charity care condition for the hospital is necessary to approve the project. [February 20, 2009 Supplemental Information, Exhibit 10]

Sacred Heart will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Sacred Heart will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Eastern Washington Region. Currently, this

amount is 3.37% of adjusted revenue. Sacred Heart will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

With the applicant's agreement to this condition, the department concludes that all residents, including low income, racial and ethnic minorities, handicapped, and other under-served groups would have access to the services provided by the hospital. This sub-criterion is met.

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

Based on the source information reviewed, the department determines that the application is not consistent with the applicable 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, the department 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 typically analyzed 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 coverage ratio. If a project's ratios are within the expected value range, the project can be expected to be financially feasible. Additionally, HPDS reviews a project's three-year projected statement of operations.

The reported capital expenditure for the 152 addition is projected to be \$79,402,781. Also included in this portion of the review is the reported capital expenditure for the 21 ICN-level II beds of \$5,270,436. The reviewable total for this project is \$84,673,217. HPDS provides a summary of the balance sheets from the application in Table 9.

Table 9
Sacred Heart Medical Center Historical Balance Sheets
Providence Sacred Heart Fiscal Year End 2008 in 000's

| Assets | | Liabilities | |
|----------------------|----------------|----------------|----------------|
| Current | 159,953 | Current | 71,857 |
| Board Designated | 222,058 | Long Term Debt | 186,848 |
| Property/Plant/Equip | 326,255 | Other | 10,552 |
| Other | 55,963 | Equity | 494,972 |
| Total | 764,229 | Total | 764,229 |

Above figures from CN application

Providence Sacred Heart Fiscal Year End 2018 in 000's

| Assets | | Liabilities | |
|----------------------|------------------|----------------|------------------|
| Current | 175,240 | Current | 77,526 |
| Board Designated | 496,146 | Long Term Debt | 290,894 |
| Property/Plant/Equip | 442,603 | Other | 10,552 |
| Other | 56,216 | Equity | 791,233 |
| Total | 1,170,205 | Total | 1,170,205 |

Above figures from CN application

Providence Health & Service December 2008 in 000's

| Assets | | Liabilities | |
|----------------------|------------------|----------------|------------------|
| Current | 2,136,508 | Current | 1,726,556 |
| Board Designated | 1,896,245 | Long Term Debt | 1,148,619 |
| Property/Plant/Equip | 3,666,673 | Other | 1,128,256 |
| Other | 214,960 | Equity | 3,910,955 |
| Total | 7,914,386 | Total | 7,914,386 |

Above figures from a report on the Providence Health & Services website

This project is part of a larger construction project. The overall project was budgeted at \$133,612,230 million. Sacred Heart Medical Center will use long-term debt allocated from debt held by its parent corporation Providence Health and Services (PHS) and accumulated reserves. The un-audited Balance Sheet for PHS does show that the funds are available and that the cost of this project will not harm PHS or SHMC. The program compiled an analysis for the cost of this entire construction project in relation to designated reserves and other Asset classes from Providence's 2008 fiscal year end. The results are summarized in Table 10. [HPDS Analysis, p2]

Table 10
Providence Health & Services Asset Ratios

| | SHMC – All Phases |
|------------------------------------|-------------------|
| Total Capital Expenditure | \$ 133,612,230 |
| Percent of Board Designated Assets | 7.04 % |
| Percent of Equity | 3.41 % |
| Percent of Total Assets | 1.69 % |

As mentioned above, HPDS also compared the financial health of the Sacred Heart for December 31, 2007 to the statewide year 2007 financial ratio guidelines for hospital operations. Given that the proposed project is phased to extend through 2015, HPDS compared the financial ratios for current year 2008 through 2018—or three years after project completion. Table 11 summarizes the comparison provided by HPDS. [HPDS analysis, p3]

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.

**Table 11
Sacred Heart Hospital’s Current and Projected Financial Ratios**

| Ratio Category | Trend | State07 | Sacred Ht 08 | 2009 CONy1 | 2010 CONy2 | 2011 CONy3 | 2012 CONy4 |
|-------------------------------------|--|------------|--------------|------------|------------|-------------|------------|
| Long Term Debt to Equity | B | 0.523 | 0.377 | 0.592 | 0.565 | 0.539 | 0.513 |
| Current Assets/Current Liabilities | A | 2.135 | 2.226 | 2.199 | 2.218 | 2.227 | 2.232 |
| Assets Funded by Liabilities | B | 0.419 | 0.339 | 0.419 | 0.408 | 0.398 | 0.387 |
| Operating Expense/Operating Rev. | B | 0.950 | 0.922 | 0.925 | 0.921 | 0.922 | 0.925 |
| Debt Service Coverage | A | 6.041 | 9.142 | 7.480 | 7.923 | 8.221 | 8.502 |
| | 2013 CONy5 | 2014 CONy6 | 2015 CONy7 | 2016 CONy8 | 2017 CONy9 | 2018 CONy10 | |
| Long Term Debt to Equity | 0.487 | 0.463 | 0.439 | 0.415 | 0.391 | 0.368 | |
| Current Assets/Current Liabilities | 2.239 | 2.244 | 2.248 | 2.252 | 2.258 | 2.260 | |
| Assets Funded by Liabilities | 0.375 | 0.364 | 0.352 | 0.340 | 0.327 | 0.315 | |
| Operating Expense/Operating Rev. | 0.926 | 0.927 | 0.926 | 0.923 | 0.962 | 0.915 | |
| Debt Service Coverage | 7.255 | 5.732 | 5.948 | 6.338 | 4.857 | 6.935 | |
| Definitions | | | | | | | |
| Long Term Debt to Equity | Long Term Debt/Equity | | | | | | |
| Current Assets/Current Liabilities | Current Assets/Current Liabilities | | | | | | |
| Assets Funded by Liabilities | Current Liabilities + Long term Debt/Assets | | | | | | |
| Operating Expense/Operating Revenue | Operating Expense/Operating Revenue | | | | | | |
| Debt Service Coverage | Net Profit + Depr and Interest Exp/Current Mat. LTD and Interest Exp | | | | | | |

As shown above, fiscal year end ratios for 2008 through 2018 (CON year 10) for Sacred Heart Medical Center are better than the State average of the state in 2007. [HPDS analysis, p3]

Though, these future assets are based upon revenue that is not supported in the planning area need. Based upon the need methodology, the resulting surplus of beds may not allow the projected revenues to materialize. The department concludes that Sacred Heart would not be able to meet its short and long term costs of the project with an additional 152 acute care beds relying upon the projected patient days. This sub-criterion is not 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.

Sacred Heart proposes to add the 152 acute care beds in multiple phases, beginning in year 2011. The estimated capital expenditure for this portion of the project is \$79,402,781, and of that amount, 64% is related to construction costs; 20% is related to equipment (both fixed and moveable); 7% is

related to development fees; and the remaining 7% is related to state sales tax. A breakdown of the total capital costs by for each phase is detailed in Table 12. [Application, p5; February 20, 2009 Supplemental Information, p19]

Table 12
Breakout of 152 Acute Care Bed Expansion

| Item | 152 Bed Addition | % of Total |
|-------------------------|-------------------------|-------------------|
| Building Construction | \$51,241,254 | 64.53 % |
| Fixed Equipment | \$3,352,000 | 4.22 % |
| Moveable Equipment | \$13,494,044 | 16.99 % |
| Architect/Engineer Fees | \$5,212,755 | 6.56 % |
| Consulting Fees | \$160,920 | 0.20 % |
| Sales Tax | \$5,941,808 | 7.48 % |
| Total | \$79,402,781 | 100 % |

To assist the department in its evaluation of this sub-criterion, HPDS provides a summary of the reasonableness of building construction costs in relation to the potential impact on revenue and charges. The following page contains a summary of the HPDS review. [HPDS analysis, p4]

Table 13
HPDS Analysis of Forecasted Rates at Sacred Heart Hospital

| Sacred Heart | 2009 | 2010 | 2011 | 2012 | 2013 |
|--------------------------------------|-----------|-----------|-----------|-----------|-----------|
| Rate per Various Items | CONyr1 | CONyr2 | CONyr3 | CONyr4 | CONyr5 |
| Admissions | 31,611 | 32,376 | 32,866 | 33,430 | 34,966 |
| Adjusted Admissions | 42,621 | 43,717 | 44,510 | 45,365 | 47,082 |
| Patient Days | 162,257 | 166,182 | 169,532 | 172,645 | 180,814 |
| Adjusted Patient Days | 218,772 | 224,392 | 229,593 | 234,282 | 243,467 |
| Gross Revenue (in 1,000's) | 1,596,955 | 1,637,982 | 1,685,015 | 1,722,326 | 1,810,191 |
| Deductions From Revenue | 992,215 | 1,019,655 | 1,051,633 | 1,076,262 | 1,135,425 |
| Net Patient Billing | 604,740 | 618,327 | 633,382 | 646,064 | 674,766 |
| Other Operating Revenue | 52,519 | 52,519 | 52,519 | 52,519 | 52,519 |
| Net Operating Revenue | 657,259 | 670,846 | 685,901 | 698,583 | 727,285 |
| Operating Expense | 608,292 | 617,985 | 632,606 | 645,933 | 673,141 |
| Operating Profit | 48,967 | 52,861 | 53,295 | 52,650 | 54,144 |
| Net Profit | 48,967 | 52,861 | 53,295 | 52,650 | 54,144 |
| Operating Revenue per Admission | \$ 20,792 | \$ 20,720 | \$ 20,870 | \$ 20,897 | \$ 20,800 |
| Operating Expense per Admission | \$ 19,243 | \$ 19,088 | \$ 19,248 | \$ 19,322 | \$ 19,251 |
| Net Profit per Admission | \$ 1,549 | \$ 1,633 | \$ 1,622 | \$ 1,575 | \$ 1,548 |
| Operating Revenue per Patient Day | \$ 4,051 | \$ 4,037 | \$ 4,046 | \$ 4,046 | \$ 4,022 |
| Operating Expense per Patient Day | \$ 3,749 | \$ 3,719 | \$ 3,731 | \$ 3,741 | \$ 3,723 |
| Net Profit per Patient Day | \$ 302 | \$ 318 | \$ 314 | \$ 305 | \$ 299 |
| Operating Revenue per Adj Admissions | \$ 15,421 | \$ 15,345 | \$ 15,410 | \$ 15,399 | \$ 15,447 |
| Operating Expense per Adj Admissions | \$ 14,272 | \$ 14,136 | \$ 14,213 | \$ 14,239 | \$ 14,297 |
| Net Profit per Adj Admissions | \$ 1,149 | \$ 1,209 | \$ 1,197 | \$ 1,161 | \$ 1,150 |
| Operating Revenue per Adj Pat Days | \$ 3,004 | \$ 2,990 | \$ 2,987 | \$ 2,982 | \$ 2,987 |
| Operating Expense per Adj Pat Days | \$ 2,780 | \$ 2,754 | \$ 2,755 | \$ 2,757 | \$ 2,765 |
| Net Profit per Adj Pat Days | \$ 224 | \$ 236 | \$ 232 | \$ 225 | \$ 222 |
| Sacred Heart | 2014 | 2015 | 2016 | 2017 | 2018 |
| Rate per Various Items | CONyr6 | CONyr7 | CONyr8 | CONyr9 | CONyr10 |
| Admissions | 36,543 | 37,100 | 38,629 | 39,485 | 40,076 |
| Adjusted Admissions | 48,858 | 49,721 | 51,556 | 52,722 | 53,654 |
| Patient Days | 189,101 | 192,076 | 200,074 | 204,663 | 207,800 |
| Adjusted Patient Days | 252,829 | 257,420 | 267,029 | 273,275 | 278,203 |
| Gross Revenue (in 1,000's) | 1,899,986 | 1,939,729 | 2,019,073 | 2,073,335 | 2,115,185 |
| Deductions From Revenue | 1,195,625 | 1,222,040 | 1,274,618 | 1,310,664 | 1,338,471 |
| Net Patient Billing | 704,361 | 717,689 | 744,455 | 762,671 | 776,714 |
| Other Operating Revenue | 52,519 | 52,519 | 52,519 | 52,519 | 52,519 |
| Net Operating Revenue | 756,880 | 770,208 | 796,974 | 815,190 | 829,233 |
| Operating Expense | 701,559 | 713,409 | 735,589 | 748,144 | 758,655 |
| Operating Profit | 55,321 | 56,799 | 61,385 | 67,046 | 70,578 |
| Net Profit | 55,321 | 56,799 | 61,385 | 67,046 | 70,578 |
| Operating Revenue per Admission | \$ 20,712 | \$ 20,760 | \$ 20,631 | \$ 20,646 | \$ 20,692 |
| Operating Expense per Admission | \$ 19,198 | \$ 19,229 | \$ 19,042 | \$ 18,948 | \$ 18,930 |
| Net Profit per Admission | \$ 1,514 | \$ 1,531 | \$ 1,589 | \$ 1,698 | \$ 1,761 |
| Operating Revenue per Patient Day | \$ 4,003 | \$ 4,010 | \$ 3,983 | \$ 3,983 | \$ 3,991 |
| Operating Expense per Patient Day | \$ 3,710 | \$ 3,714 | \$ 3,677 | \$ 3,655 | \$ 3,651 |
| Net Profit per Patient Day | \$ 293 | \$ 296 | \$ 307 | \$ 328 | \$ 340 |
| Operating Revenue per Adj Admissions | \$ 15,491 | \$ 15,490 | \$ 15,458 | \$ 15,462 | \$ 15,455 |
| Operating Expense per Adj Admissions | \$ 14,359 | \$ 14,348 | \$ 14,268 | \$ 14,190 | \$ 14,140 |
| Net Profit per Adj Admissions | \$ 1,132 | \$ 1,142 | \$ 1,191 | \$ 1,272 | \$ 1,315 |
| Operating Revenue per Adj Pat Days | \$ 2,994 | \$ 2,992 | \$ 2,985 | \$ 2,983 | \$ 2,981 |
| Operating Expense per Adj Pat Days | \$ 2,775 | \$ 2,771 | \$ 2,755 | \$ 2,738 | \$ 2,727 |
| Net Profit per Adj Pat Days | \$ 219 | \$ 221 | \$ 230 | \$ 245 | \$ 254 |

As shown, the net profit by adjusted patient day ranges could range from a low of \$219 to a high of \$254. Because, the projected revenues are based upon patient stays that are not supported in the planning area forecasts and costs for care may be adjusted up to meet construction debt. The Department concludes that costs of the project to add 152 acute care beds may have an unreasonable impact upon the costs and charges for health services. This sub-criterion is not met.

(3) The project can be appropriately financed.

The HPDS review of the financing of this project states, “The CN project is part of a larger construction project. The overall project was budgeted at \$133,612,230 million. Sacred Heart Medical Center will use long-term debt allocated from debt held by its parent corporation Providence Health and Services (PHS) and accumulated reserves. The un-audited Balance Sheet for PHS does show that the funds are available and that the cost of this project will not harm PHS or SHMC”.

Further, HPDS concurs with the applicant that the use of parent corporation debt and accumulated reserves is an appropriate financing method and that it is an appropriate business financing practice.

Based on the source information reviewed for the bed addition project at Sacred Heart and the review performed by HPDS above, the department concludes that the proposed financing is the most prudent approach, and would not negatively affect Sacred Heart Medical Center or Providence Health and Services’ total assets, total liability, or general financial health. 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 application is not consistent with the applicable structure and process 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.

If this project is approved, Sacred Heart anticipates adding FTEs (full time equivalents) to Sacred Heart in specific staffing areas of nursing, technicians, and patient care beginning in 2011 to prepare for the phased increases. Table 14 shows the breakdown of Sacred Heart’s proposed incremental FTEs for the proposed acute care bed expansion. [February 20, 2009 Supplemental Information, Exhibit 28]

Table 14
Sacred Heart Hospital Projected Incremental FTE Totals – 152 Acute Care Bed Project

| Acute Care FTEs | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|-----------------|-------|-------|-------|--------|--------|--------|--------|--------|
| Tech | 13.95 | 21.30 | 62.53 | 95.27 | 108.04 | 145.52 | 159.6 | 172.94 |
| RN | 16.41 | 25.03 | 73.49 | 111.97 | 129.99 | 171.06 | 187.62 | 302.31 |

As shown above, Sacred Heart anticipates recruiting staff beginning in year 2011, and most of the increase in staff would occur between 2013 and 2016. By the end of year 2018, Sacred Heart expects to greatly expand pertinent staff at Sacred Heart, with the majority of the increase in direct patient care staff.

Sacred Heart states it expects no difficulty in recruiting staff for the additional 152 beds for a variety of reasons, including: [Application, p69, Exhibit 22]

- the excellent reputation and history of Sacred Heart in the community;
- competitive wage and benefits package;
- Sacred Heart facilities offer training programs through partnerships with educational institutions throughout eastern Washington, northern Idaho, and western Montana; and
- tuition reimbursement programs for advancement of health care related education and internal residency programs.

In addition, the applicant reports that the Spokane area has received funding which has led to increases in the slots available for health care training at Washington State University and other area community colleges. Separate funding was also used to expand the physician training program coordinated with the University of Washington and the WSU Spokane Campus. [Application, p70]

Based on the information provided in the application, the department concludes that Sacred Heart provided a comprehensive approach to recruit and retain staff necessary for the additional 152 acute care beds at Sacred Heart. As a result, the department concludes that qualified staff can be recruited and retained. 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.

Sacred Heart currently provides health care services to the residents of Spokane and the surrounding areas. The applicant states that “Sacred Heart’s Master Site and Facility Plan provides for the expansion of Sacred Heart’s ancillary and support services to meet the additional demand resulting from the addition of acute care beds...”. [Application, p70] Sacred Heart also asserts that current support services are sufficient to support the proposed project. There is no indication that these relationships would not be able to expand related services to accommodate the proposed expansion.

Therefore, the department concludes that there is reasonable assurance that Sacred Heart will continue its relationships with ancillary and support services within and associated with the hospital and this project would not negatively 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.

Sacred Heart will continue to provide Medicare and Medicaid services at the hospital to the residents of Spokane County and the surrounding communities. Sacred Heart contracts with the Joint Commission to survey and accredit the quality of service provided. The Joint Commission lists Sacred Heart Hospital in full compliance with all applicable standards following the most recent on-site survey in August 2008.⁶ The Joint Commission also lists certification of advanced programs in care for Stroke and Ventricular Assist devices.

⁶ <http://www.qualitycheck.org>

Complementing reviews performed by the Joint Commission, are the surveys conducted by the Department's Investigation and Inspection's Office. Records indicate that the department has completed two compliance surveys for Sacred Heart⁷ between 1999 and 2008. Each compliance survey revealed deficiencies which are typical for the type of facility and Sacred Heart submitted a plan of corrections and implemented the required corrections. [Compliance survey data provided by Investigation and Inspection's Office]

Based on Sacred Heart compliance history, the department concludes that there is reasonable assurance that the hospital would continue to operate in conformance with state and federal regulations with the additional acute care beds. 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.

Sacred Heart states that the additional beds would greatly assist in promoting continuity of care at hospital. Reported increases in demand for inpatient critical care currently exceed the licensed capacity. The applicant goes on to state, "The proposed modernization and expansion project will greatly assist Sacred Heart in promoting continuity of care and enhance its ability to carry out its mission of providing compassionate care to all in need, including the poor and vulnerable". [Application, p72]

Sacred Heart's assertions and impetus for adding acute care bed capacity at Sacred Heart are reasonable. Sacred Heart has been providing health care to the residents of Spokane County and surrounding communities for many years and participates in relationships with community facilities to provide a variety of post acute care services. Approval of this project will not change the relationships in place with the existing health care providers in the service area. [Application, p72]

In the need section of this evaluation, the department concluded that the existing providers are both available and accessible to adequately provide current and future need in the county. The promotion of continuity of care and unwarranted fragmentation of services does not require nor is it intended to have a single facility provide each and every service a patient might require. If that was the intent, there would be no concern about unnecessary duplication of services. The application guidelines provide guidance regarding the intent of this criterion. These guidelines ask for identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health services and resources serving the applicant's primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreement, and transfer agreements. Expansion of a hospital in the Spokane planning area, when no immediate or long-term need has been demonstrated, has the potential to increase the cost of care for all providers if the number of patients is not sufficient to support the bed capacity of the areas hospitals.

Therefore, the department concludes that approval of 152 additional beds in a planning area currently over bedded would have the potential of future fragmentation of care within the service area, and this sub-criterion is not met.

⁷ Surveys of hospital completed in September, 1999 and January, 2008

- (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 determined to be met.

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

Based on the source information reviewed, the department determines that the application is not consistent with the applicable cost containment criteria in WAC 246-310-240.

- (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable. Before submitting this application to add 152 beds to Sacred Heart Hospital, Sacred Heart considered and rejected four alternatives. The alternatives and Sacred Heart's rationale for rejection is summarized below. The applicant cites the following decision making criteria by order of importance [Application, p76]

1. Maximizing quality of patient care, including creating available bed capacity
2. Minimizing capital and operating costs, including considerations for operating efficiencies
3. Optimizing community and regional access to tertiary and quaternary services at Sacred Heart
4. Optimizing Sacred Heart's intermediate and long-term strategic growth opportunities

Alternative #1 – Do nothing

This alternative was ruled out for several reasons, though it is acknowledged that it is the least expensive in terms of capital expenditures. Efforts to increase hospital efficiencies have been successfully incorporated, but are seen as limited without modernization and expansion. This alternative is not viewed as sufficient to meet any potential need for the planning area and does nothing to alleviate the congestion for some services currently observed at the hospital. The applicant cites possible upgrades and replacement projects which do not require CN review, but expansion of the revenue base is seen as necessary to allow repayment of the expenditures. [Application, p76, February 20, 2009 Supplemental Information, p47]

Alternative #2 – Modernize and expand Sacred Heart in areas beyond those proposed in this application

This alternative was evaluated in conjunction with alternative #3. In addition to the criteria detailed above, the applicant considered other renovations included in their Master Plan, the ability to add capacity to meet demand over the next 10 years, consistency with CN rules, and cost effectiveness. Consideration was given to build a completely new hospital tower, with underground parking and power plant replacement. But, with an estimated cost approaching \$1 billion dollars, was determined to be cost prohibitive.

Further consideration was made regarding intermediate alternatives to this proposal ranging from \$250 million to \$465 million in capital costs. These projects included additional upgrades to hospital facilities and modernization of existing equipment beyond those necessary to accommodate the necessary expansion. Both of these projects were dismissed in favor of the project proposed in this application. [February 20, 2009 Supplemental Information, p48]

Alternative #3 – Transition services from Sacred Heart to Holy Family

This alternative considered transitioning either women's and children's services or the adult inpatient psychiatric services to Holy Family. This option would allow Sacred Heart to back-fill the vacated space at the hospital with services that remained on campus. This option was dismissed because the transition would either remove acute care services from that region of the planning area (with a Women's and children's specialty hospital), or require additional construction to accommodate the addition needs of the psychiatric services. [February 20, 2009 Supplemental Information, p48]

Alternative #4 – Build on a new site, a women's and Children's hospital, or a new general community hospital

This alternative included three possibilities which were all dismissed. The costs for each option still approached \$153 million to \$450 million depending on the focus and configuration of the new site. Further, the new construction would have required on site support services that would duplicate services currently provided at the Sacred Heart facility. This duplication would largely eliminate many of the efficiency programs that the hospital has been successful in implementing in recent years. [February 20, 2009 Supplemental Information, p50]

In summary, the Applicant determined that these alternatives either led to increases in capital costs or negatively affected operational efficiencies that have already benefited the hospital. As a result, Sacred Heart has developed and submitted the phased expansion as proposed in this application.

As addressed in detail above, the planning area is currently experiencing a surplus of bed capacity and the decision to do nothing may have been appropriate. The Sacred Heart application reports occupancy of up to 66% for 2007 in the 551 available beds. This would leave approximately 189 beds available at Sacred Heart each day [Application, p30, Table 16]. In addition, Deaconess Medical Center's year-end report (2007) figures produce an average daily census of 215 patients, leaving 55-119 unused beds, depending upon what capacity figures are applied. This would indicate that, as recently as 2007, there was, on average, 244 to 308 available beds in the current capacity of just these two hospitals. Considering all the hospitals, and their respective occupancy and capacity, the average number of beds available may exceed 370.

Further, the removal of the beds at the Deer Park facility does not appear to immediately change the current or short-term surplus. Since Sacred Heart dismissed the do nothing option and there is no apparent planning area need in the applicable, or extended (yr. 2018), projection period, this sub-criterion is not met.

(2) In the case of a project involving construction:

(a) The costs, scope, and methods of construction and energy conservation are reasonable;

Staff from HPDS examined the construction costs of this project and provided the following analysis. [HPDS Analysis, p6]

Table 15
Sacred Heart Medical Center Total Project Construction Projections

| Acute Care/ICN-level II Expansion | Totals |
|--|------------------|
| Total Capital | \$ 133,612,230 |
| Beds/Stations/Other (Unit) | 173 ⁸ |
| Total Capital per Unit | \$ 772,325.03 |

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. Sacred Heart Medical Center 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, p6]

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

(b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

This sub-criterion is also evaluated within the financial feasibility criterion under WAC 246-310-220(2) and has not been met.

(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.

As HPDS observes, “Sacred Heart Medical Center notes that this project will improve system efficiency for the hospital and patients as the new beds and ICN-level II nursery will give more flexibility and makes it much easier to place patients in the most appropriate clinical level. The hospital also notes several other system improvements that they will be able to do because of increasing beds and building new”. [HPDS Analysis, p6]

The Department acknowledges that newly constructed facilities may make moves toward current care standards (i.e.: single patient rooms, cohesive program efficiencies). The standards have the potential to increase the quality of care while reducing overall costs to the hospital. This sub-criterion is met.

⁸ Including the entire proposal of 152 acute care bed as and 21 level II bassinettes

INTERMEDIATE CARE NURSERY-LEVEL II BASSINET PROJECT

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.

ICN-level II neonatal services are considered tertiary services as defined by WAC 246-310-020(1)(d)(i)(B). For some tertiary services, such as open heart surgery, the department uses an established methodology to assist in its evaluation of need for the services. For other tertiary services, including ICN-level II services, no such methodology exists. The bassinets in which ICN-level II and NICU level III care is provided are licensed beds within the hospital.

Currently, Sacred Heart reports 40 level III bassinets as part of their 623 licensed beds and this application proposes accounting for 21 ICN-level II bassinets that are currently in use by the hospital in their efforts to account for volume within their neonate program. [Sacred Heart Survey Response, DOH License files]

In this instance, Sacred Heart has received prior approval to provide NICU level III intensive care neonatal services⁹. Sacred Heart was providing ICN-level II care prior to the award of the CN for NICU level III services. As a result, the Department will review this portion of the application as an attempt to reconcile the total number of bassinets at the hospital. Specifically, correcting the hospital's licensed capacity of 623 beds to equal 644 licensed beds. This total would be comprised of 511 acute care beds, 72 psychiatric beds, 40 NICU level III bassinets, and 21 ICN-level II bassinets. The review will consist of the applicant's reported planning area and the current utilization of the Sacred Heart NICU program.

Department's Evaluation of Applicant's Defined Planning Area

For this project, Sacred Heart established a planning area which included all of Spokane County and specific surrounding counties from both Washington and Idaho for which they currently record admits¹⁰. To assist in its review of the ICN-level II portion of this project, the department reviewed Sacred Heart's historical patient discharge data for years 2003 through 2007 for MDC #15.¹¹

For years 2003 through 2007, Sacred Heart recorded a five-year combined total of 2,863 patients under the combined ICN-level II DRGS for MDC #15¹² originating from the planning area provided by the applicant. Table 17 identifies the originating county and corresponding number of patient's who received care at Sacred Heart. [Application, Exhibit 6]

⁹ CN 383-332 was issued May 8, 1978 to Sacred Heart and Deaconess for the establishment of the Inland Perinatal Services to provide neonatal intensive care services

¹⁰ Included as 'Other' are the combined totals for counties outside Washington.

¹¹ As of the writing of this evaluation, year 2008 CHARS data is not available.

¹² Discharges are a sum of DRG 388/792 and 389/793 totals combined with 75% of 387/791 and 25% of 390/794 totals

Table 17
Sacred Heart Hospital CHARS ICN-level II Patients
2003-2007 Combined

| County | 5-yr # of patients |
|--------------|--------------------|
| Adams | 25 |
| Asotin | 11 |
| Columbia | 5 |
| Ferry | 18 |
| Grant | 88 |
| Lincoln | 33 |
| Okanogan | 43 |
| Other | 229 |
| Pend Oreille | 20 |
| Spokane | 2,248 |
| Stevens | 102 |
| Whitman | 41 |
| Total | 2,863 |

To further assist in review of the proposed planning area, the Department considered records and survey returns which indicate that Holy Family and Deaconess Medical Center are currently providing ICN-level II services and are located within Spokane County. The Department searched 2007 discharge data of all the MDC #15 ICN-level II and NICU level III classifications for the other hospitals for comparison. The results are tabulated in Table 19.

Table 19
Record of 2007 ICN-level II and NICU level III Discharges by Originating Counties

| | Sacred Heart | Deaconess | Holy Family |
|--------------|---------------------|------------------|--------------------|
| Adams | x | x | x |
| Asotin | x | x | |
| Columbia | x | | |
| Ferry | x | x | x |
| Grant | x | x | x |
| Lincoln | x | x | x |
| Okanogan | x | x | x |
| Other | x | x | x |
| Pend Oreille | x | x | x |
| Spokane | x | x | x |
| Stevens | x | x | x |
| Benton | x | x | |
| Chelan | x | x | |
| Douglas | x | x | x |
| Franklin | x | x | |
| Kittitas | x | | |
| King | x | x | x |
| Skagit | x | | |
| Walla Walla | x | x | |
| Whitman | x | x | x |

The chart above depicts all of the originating counties in which Sacred Heart reported patient discharges. Those listed above the black line show the counties the applicant has defined as its primary planning area. The other ICN-level II providers show similar trends for their admissions into their respective neonatal programs. In conclusion, reviewing Sacred Heart’s ICN-level II project, using the planning area defined by the applicant, is reasonable.

Sacred Heart’s Neonate Program Utilization

The Department completed a review of the discharge data for the most current year, across all levels of neonate care, for the Sacred Heart program. The results are represented in Table 21.

Table 21
Spokane level II Area Hospital Neonatal Discharge Totals - 2007

| DRG | Corresponding Level of Care | Discharges |
|-----------------------|------------------------------------|-------------------|
| 789 | level III | 23 |
| 790 | level III | 162 |
| 791 | levels II or III | 98 |
| 792 | level II | 149 |
| 793 | level II | 218 |
| 794 | levels I or II | 365 |
| 795 | level I | 1957 |
| Facility Total | | 2,972 |

As shown, Sacred Heart does appear to have been supplying ICN-level II care as part of the current neonate program. However, through a series of misunderstandings, not entirely the fault of the hospital, the under-reporting of ICN-level II bassinets has occurred. In this instance, these bassinets are currently in the bed supply for the Spokane level II planning area and appear to be necessary for the continuum of care provided within the hospital. An acknowledgement of their existence will allow for a correction to be applied to Sacred Heart’s current license of 623 beds and provide for complete accounting of the capacity for Sacred Heart. The result would not be an actual increase in current capacity, but simply a reconciliation of what is currently being operated.

On the basis of this information, the department concludes that Sacred Heart has appropriately applied a planning area to the population served and can demonstrate the use of the space that it has been operating outside the reported licensed capacity. A Certificate of Need citing the correct bed count of 644 beds, inclusive of 21 ICN-level II and 40 level III bassinets is appropriate to facilitate the necessary reconciliation. This sub criterion is 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.

As previously stated, Sacred Heart 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, Sacred Heart 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, Sacred Heart provided a copy of its current Admission Policy that would continue to be used at the hospital. The policy outlines the process/criteria that Sacred Heart will use to admit patients for treatment or care at the hospital. The applicant states that any patient requiring care will be accepted for treatment at Sacred Heart

without regard to “race, color, national origin, sex, marital status, or on the basis of disability”. [Application Exhibit 18]

To determine whether low-income residents would have access to the proposed services, the department uses the facility’s Medicaid eligibility as the measure to make that determination.

Sacred Heart currently provides services to Medicaid eligible patients. Documents provided in the application demonstrate that Sacred Heart intends to maintain this status. For this project, a review of the policies and data provided for Sacred Heart identifies the facility’s financial resources as including Medicaid revenues [Application, p20; February 20, 2009 Supplemental Information, Exhibit 10]

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.

Sacred Heart 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, Sacred Heart included a ‘charity care’ line item as a deduction from revenue within the pro forma financial documents for Sacred Heart. [Application, Exhibit 16; February 20, 2009 Supplemental Information, Exhibit 10]

For charity care reporting purposes, the Department of Health’s Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Sacred Heart is located in Spokane and is one of 21 hospitals located within the Eastern Washington Region. According to 2005-2007 charity care data obtained from HPDS, Sacred Heart has historically provided more than the average charity care provided in the region. Sacred Heart’ most recent three years (2005-2007) percentages of charity care for gross and adjusted revenues are detailed in Table 22. [HPDS 2005-2007 charity care summaries]

Table 22
Sacred Heart Charity Care Comparison

| | 3-Year Average for Easter WA Region | 3-Year Average for Sacred Heart |
|------------------------------|--|--|
| % of Gross Revenue | 1.36 % | 1.90 % |
| % of Adjusted Revenue | 3.37 % | 4.97 % |

Historical reports indicate that Sacred Heart has previously provided charity care above the regional average of 1.36% of gross revenue and 3.37% of adjusted revenue. Although, review of the applicant’s pro forma accounting for the ICN-level II exceed the gross revenue percentages but only indicate a rate of 2.10% of adjusted revenue. Because Sacred Heart does propose to meet or exceed the regional average as identified above, a charity care condition for the hospital is necessary to approve the project. [February 20, 2009 Supplemental Information, Exhibit 10]

Sacred Heart will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed

and approved by the Department of Health. Sacred Heart will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Eastern Washington Region. Currently, this amount is 3.37% of adjusted revenue. Sacred Heart will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

With the applicant's agreement to this condition, the department concludes that all residents, including low income, racial and ethnic minorities, handicapped, and other under-served groups would have access to the services provided by the hospital. 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.

The review performed by HPDS of the proposed 152 acute care bed expansion included the costs associated with the proposed ICN-level II project. The information indicated that the funds are available and that the cost of this project will not harm Providence or Sacred Heart. An analysis for the cost of the construction project in relation to asset classes the financial health of the organization also result in acceptable ratios.

With the ICN-level II neonatal patient days supported by the use rate of the neonate program and that the operating costs are likely to be met. The Department's concludes that this sub-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.

Sacred Heart proposes to construct space to accommodate all the programs ICN-level II and NICU level III bassinets. As previously stated, Sacred Heart is currently operating these bassinets as an overflow unit, thus some costs not affiliated with construction for the new unit have already been incurred. The estimated capital expenditure for this portion of the project is \$5,270,436, and of that amount, 64% is related to construction costs; 28% is related to movable equipment; 7% is related to development fees. A breakdown of the total capital costs by for each phase is detailed in Table 23. [Application, p5; February 20, 2009 Supplemental Information, p19]

**Table 23
Breakout of 21 ICN-level II Bassinette Construction Project**

| Item | level II Bassinettes | % of Total |
|-------------------------|-----------------------------|-------------------|
| Building Construction | \$2,250,000 | 63.17 % |
| Moveable Equipment | \$1,494,000 | 28.35 % |
| Architect/Engineer Fees | \$337,500 | 6.40 % |
| Consulting Fees | \$10,000 | 0.19 % |
| Sales Tax | \$325,736 | 6.18 % |
| Other Project Costs | \$853,200 | 16.19 % |
| Total | \$5,270,436 | 100 % |

To assist the department in its evaluation of this sub-criterion, HPDS provided a summary of the reasonableness of building construction costs above in Table 23 and was compiled with the costs of the ICN-level II project factored in. Based on the information provided here and above in the review of the acute care bed expansion, the Department concludes that the costs of the ICN-level II project will probably not result in an unreasonable impact on the costs and charges for health services. This sub-criterion is met.

(3) The project can be appropriately financed.

In the above discussion of the proposed 152 acute care bed expansion, the Department concluded that the applicant had met the sub-criterion described in WAC 246-310-220(3). The review performed by HPDS regarding the appropriateness of the proposed financing of the project included the costs associated with the ICN-level II project. There was no additional information provided during this review of the ICN-level II project that would change the Department’s conclusion regarding this sub-section of Financial Feasibility. Therefore, 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 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.

If this project is approved, Sacred Heart anticipates adding FTEs (full time equivalents) to Sacred Heart in specific staffing areas of nursing, technicians, and patient care beginning after the addition of the remaining 16 bassinettes in 2011. Table 24 shows the breakdown of Sacred Heart’s proposed incremental FTEs for the proposed neonatal project. As shown, Sacred Heart anticipates recruiting the additional FTEs in 2012 when the consolidation of the ICN-level II and NICU level III is complete, and maintains these staffing levels through the remaining review period. [February 20, 2009 Supplemental Information, Exhibit 28]

**Table 24
Sacred Heart Hospital Projected Incremental FTE Totals – 21 ICN-level II Bassinette Project**

| Acute Care FTEs | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Tech | 5.98 | 17.93 | 17.93 | 17.93 | 17.93 | 17.93 | 17.93 | 17.93 |
| RN | 7.03 | 21.09 | 21.09 | 21.09 | 21.09 | 21.09 | 21.09 | 21.09 |

Sacred Heart states it expects no difficulty in recruiting FTEs for the additional 21 bassinets in for a variety of reasons. In addition to a strong community reputation, competitive wage and benefits package, and continuing education programs, the applicant reports a waiting list of current staff awaiting positions to open up in the Children's Hospital. Efforts to continue to participate in internship and residency programs specializing in pediatric and neonatal care are also viewed as a means to attract the necessary staff to reach the expected staffing levels. [Application, p70, Exhibit 22]

Based on the information provided in the application, the department concludes that Sacred Heart provided a comprehensive approach to recruit and retain staff necessary for the 21 ICN-level II bassinets at Sacred Heart. As a result, the department concludes that qualified staff can be recruited and retained. This sub-criterion is met.

Washington State Perinatal Levels of Care Guidelines

In addition to the structure and process of care criteria found under WAC 246-310-230, the department uses the standards of care guidelines outlined in the Washington State Perinatal Levels of Care Criteria as guidance in evaluating this project. The guidelines, adopted by the Perinatal Advisory Committee on February 2005, offer recommendations on facility and staffing standards for ICN-level II services. Within the guidelines, ICN-level II services are separated into A and B, with A being the least intensive of ICN-level II services and B as the most intensive.

The circumstances of this application are that Sacred Heart has been providing ICN level II services for many years and is also delivering the higher acuity level III neonatal intensive care to the necessary newborns. Therefore, the program is already meeting the categories outlined in the Perinatal Guidelines regarding level III intensive care neonatal service and capabilities, medical staffing and ratios, support, and lab services at a level exceeding the recommendations prescribed for level IIA and level IIB intermediate care. [Application, p71]

Based on the information provided by Sacred Heart in the application and the fact that the program currently operates and staffs a ICN Level II and NICU Level III, the Department concludes that approval of this reconciliation project will continue to meet the Washington State Perinatal Levels of Care guidelines. As a result, 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 sub-criterion was extensively evaluated within the sub-criterion above and is determined to be 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.

In the above discussion of the proposed 152 acute care bed expansion, the Department concluded that the applicant had met the sub-criterion described in WAC 246-310-230(3). There was no additional information provided during this review of the ICN-level II neonatal project that would change the Department's conclusion regarding this sub-section addressing conformance with applicable licensing and participation conditions. Therefore, 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.

Sacred Heart states that the types of patients currently being cared for within the neonatal program within the Children's Hospital are receiving the appropriate intensity and level of care. Additionally, discharge considerations are extensive and are initiated at time of admission to facilitate appropriate planning in the care of the newborn baby and their mother. A full needs assessment relating to home health care support and any other resources needs are considered and completed for each patient discharged from the NICU. The program currently employs full-time case managers, full-time therapy specialists, and lactation and respiratory support for the mothers and families of the discharged newborns [Application, p71]

Based on the information provided by Sacred Heart, the department concludes that there is reasonable assurance that approval of this project will promote continuity in the provision of ICN-level II services at Sacred Heart. Additionally, the project will continue to have the appropriate relationships to the service area's existing health care system. Further the project is not likely to result in an unwarranted fragmentation of ICN-level II services in relation to the current capacity in the planning area. 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 determined to be 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.

Before submitting this application to add 152 beds to Sacred Heart Hospital, Sacred Heart considered and rejected three alternatives. The alternatives and Sacred Heart's rationale for rejection is summarized below. The applicant cites the following decision making criteria by order of importance [Application, p76]

1. Maximizing quality of patient care, including creating available ICN-level II bed capacity.
2. Minimizing capital and operating costs, including considerations for operating efficiencies.
3. Optimizing community and regional access to neonatal tertiary and quaternary services at Sacred Heart.

Alternative #1 – Do nothing

This alternative was ruled out for several reasons, though it is acknowledged at the least expensive in terms of capital expenditures. The other justifications cited to warrant the dismissal of this option relate to the reported high occupancy of the current available space and the relatively low number of other available capacity. Though, no consideration was made in relation to the available capacity at Deaconess or the use of the existing 21 over-flow bassinets later discovered. [Application, p77]

Alternative #2 – Other bed sizing options as compared to the 21 bassinets proposed in this application

Little was supplied to substantiate the dismissal of this option that was not addressed above in relation to the current occupancies at Sacred Heart and the lack of alternative capacity in the area. No alternative number to the 21 bassinets was described, but reference was made to the efficiencies that would be maintained through the proposed project. [Application, p77]

Alternative #3 – Undertake the project proposed in this application

This alternative was chosen due to its ability to most effectively address the criteria outlined above. Specifically, the ability to add this capacity is believed to allow for a level of coverage to meet the potential need for the next 10 years; its consistency with certificate of need rules; and the relative cost effectiveness. [Application, p77]

In summary, the Applicant determined that these alternatives did not sufficiently address the need they surmised was seen in the planning area or negatively affected operational efficiencies that have already benefited the hospital. As a result, Sacred Heart has developed and submitted the 21 bassinette ICN-level II project as proposed in this application.

As addressed in detail above, the circumstances of this proposal address the need to reconcile the number of bassinets utilized by the hospital with the number reported on their hospital's license. The decision to accept this construction proposal and properly account for the current use of the 21 bassinets becomes an acceptable option. The result will be to record Sacred Heart as having 21 ICN-level II bassinets in addition to the 40 NICU level III intensive care beds, for a total of 61. Therefore, this sub-criterion is met.

(2) *In the case of a project involving construction:*

- (a) *The costs, scope, and methods of construction and energy conservation are reasonable; and*
- (b) *The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.*

This sub-criterion is addressed in the financial feasibility criteria above and is determined to be met.

(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 assurances and cost effectiveness.*

In the discussion of the proposed 152 acute care bed expansion, the Department concluded that the applicant had met the sub-criterion described in WAC 246-310-240(3). The review performed by HPDS considered the efficiencies associated with the proposed NICU project. There was no additional information provided during this review of the ICN-level II neonatal project that would

change the Department's conclusion regarding this sub-section of Cost Containment. Therefore, this sub-criterion is met.

Exhibit A

Acute Bed Need Methodology