

EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF OF GOOD SAMARITAN HOSPITAL PROPOSING TO ADD FIFTY ACUTE CARE BEDS TO THE EXISTING HOSPITAL

PROJECT DESCRIPTION

Good Samaritan Hospital (GSH) is a Washington State non-profit hospital located at 407 14th Avenue Southeast in the city of Puyallup, within Pierce County. GSH is currently a provider of Medicare and Medicaid acute care services to the residents of central and east Pierce County and surrounding areas. The hospital is licensed for 225 acute care beds, holds a three-year accreditation from the Joint Commission on Accreditation of Healthcare Organizations, and is designated as a level III trauma hospital and a level I adult trauma rehabilitation hospital. Additionally, GSH is one of four level I pediatric trauma rehabilitation hospitals in Washington State. The hospital also is approved to operate a level II neonatal intensive care unit and level II obstetric services. [CN historical files, DOH Office of Health Care Survey, and Application, p2]

GSH, as a corporation, has Good Samaritan Community Healthcare (GSCH) as its sole corporate member. In August of 2006, GSCH finalized an affiliation with MultiCare Health Systems. MultiCare currently operates two additional hospitals in Washington¹. As part of the affiliation, MultiCare became the sole corporate member of GSCH and the parent company of all of the GSCH subsidiaries, including GSH. GSH continues to operate under the original corporate structure and retains a local Board of Directors. [Application, p1 & 4]

This application proposes to add 50 acute care beds to the existing 225 acute care beds at the hospital, for a facility total of 275 acute care beds. The 50 beds would be added in two phases in compliment to an updated Campus Master Plan for GSH, which is described below.

Phase One

Construction of a patient care tower will begin in December 2008. By November 2010, the emergency department will be expanded, operating suites will be added and space will be made for imaging and support services. Two patient floors will be added to the top of the tower with each floor designed to accommodate 32 acute care beds in private rooms. In Phase 1, only the first of the two patient floors will become operational coinciding with the removal of 14 beds from service in other areas of the hospital. The result, at the end of Phase 1, will be a net gain of 18 beds or 243 total beds. [Application, p8 & 11]

Phase Two

With the completion of the new patient tower, the remaining 32 beds will be made operational in the additional floor. Phase two would be complete and operational by January 2013. The total number of acute care beds would then be 275.

The total cost of the patient tower is calculated to equal \$245,361,000. Of that total, the portion of the estimated capital expenditure associated with the establishment of the patient floors subject to CN review is \$30,636,523. [Application p32] Of the total costs under review, 71% is

¹ Tacoma General Hospital/Allenmore Hospital and Mary Bridge Children's Hospital

related to construction; 14% is related to equipment; 7% is allocated to Washington State sales tax; and the remaining 8% is related to applicable fees. The totals are outlined below.

Evaluation Breakdown Of ECE	Total	% of Total
Construction	\$21,700,000	71%
Equipment (fixed/Moveable)	\$4,340,000	14%
Taxes	\$2,291,517	7%
Fees	\$2,305,006	8%
Total Estimated Capital Costs	\$30,636,523	100%

APPLICABILITY OF CERTIFICATE OF NEED LAW

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

APPLICATION CHRONOLOGY

- September 28, 2006 Letter of Intent Submitted
- March 19, 2007 Application Submitted
- March 20, 2007 through August 29, 2007 Department’s Pre-Review Activities
 - 1st screening activities and responses
- August 30, 2007 Department Begins Review of the Application
 - Public comments accepted throughout review
- October 4, 2007 End of Public Comment / No Public Hearing held
- December 3, 2007 Department’s Anticipated Decision Date
- December 21, 2007 Department’s Actual Decision Date

AFFECTED PARTIES

There were no parties that qualified for affected person status under WAC 246-310-010:

SOURCE INFORMATION REVIEWED

- Good Samaritan Hospital’s Certificate of Need Application received March 19, 2007
- Good Samaritan Hospital’s supplemental information dated August 23, 2007
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Financial feasibility and cost containment evaluation prepared by the Department of Health's Office of Hospital and Patient Data Systems (November 21, 2007)
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2004, 2005, and 2006 summaries)

- Population data obtained from the Office Financial Management based on year 2000 census published January 2007.
- Licensing and/or survey data provided by the Department of Health's Office of Health Care Survey
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Data obtained from Good Samaritan Hospital's website
- Information obtained from the internet regarding Good Samaritan Hospital's project
- Certificate of Need Historical files

CRITERIA EVALUATION

To obtain Certificate of Need approval, Good Samaritan Hospital must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment), and portions of the 1987 State Health Plan as it relates to the acute care bed methodology.²

CONCLUSION

For the reasons stated in this evaluation, the Certificate of Need application submitted on behalf of Good Samaritan Hospital to add 50 acute care beds to the hospital is consistent with the Certificate of Need review criteria, and a Certificate of Need should be approved.

The approved capital costs for this project equal \$30,636,523.

² Each criterion contains certain sub-criterion. The following sub-criteria are not discussed in this evaluation because they are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

A. Need (WAC 246-310-210)

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

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

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. Because data from the applicant was relied on in generating the department's forecasts, GSH's project is discussed in the evaluation of need below.

As stated in the project description portion of this evaluation, GSH proposes to add 50 acute care beds to its existing 225 acute care beds. The 50 beds would be added incrementally during each of the two phases. Given that this application involves construction, GSH anticipates it to be complete and operational by January 2013; with a facility total of 275 beds. [Application, p11]

GSH provided three different versions of the numeric methodology: the first two, submitted as part of the original application, were prepared using 1996-2005 historical CHARS data. The first scenario was formulated according to the 12-step need projection utilized by the Department. The second scenario adjusted to account for the applicant's assertion that a shift of a portion of the MultiCare patients currently leaving the service area for the Tacoma hospitals would return to the hospital in their resident service area. The third, submitted by GSH as part of the August 23, 2007 screening responses, was prepared using 1997-2006 data which was released after submission of the original application. For purposes of this evaluation, only the third version will be reviewed and 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 and is consistent with the recommendations within the state health plan which states, "For most purposes, bed projections should not be made for more than seven years into the future." Further, a seven year forecast is consistent with most projects for hospital bed additions reviewed by the CN Program. At the time this methodology was submitted, the anticipated seven-year projection year was 2013. Although, a review of the GSH summary indicates that the planning horizon extended beyond what the department considers the correct planning horizon. As a result, the department will focus on the target year 2013, which is seven years after the most recent data (2006); however, in some areas of this evaluation, the year 2015 may be referenced in relation to submissions from the applicant.

In the final need method submitted in response to the department’s screening questions; GSH based its projections on hospital discharges for years 1997 - 2006. This version resulted in a projected total of 55,181 patient days in year 2007; which increases for years 2008 through 2013. Year 2013 projections show 67,612 patient days. Using this version, GSH determined a surplus of beds in the planning area through year 2008, with a need for 7 beds in year 2009, and 15 beds in year 2010. By the end of year 2013, this version calculated a need for 40 beds in the planning area. A complete summary of the applicant’s projections are shown below in Table 1. [August 23, 2007 Screening Responses, p25]

Table 1
Summary of GSH Need Methodology for East Pierce Planning Area

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Patient Days	53,330	55,181	57,119	59,149	61,224	62,716	65,754	67,612	69,542	71,411
Bed Currently in Planning Area	225	225	225	225	225	225	225	225	225	225
Adjusted Gross Need	209	216	224	232	240	245	257	265	272	279
Adjusted Net Need *	-16	-9	-1	7	15	20	32	40	47	54

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

The Department’s Determination of Numeric Need:

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

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

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

The completed methodology is presented as a series of appendices to this evaluation. 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)³, and planning area. The planning area for this evaluation is the East Pierce planning area located in HSA 1. State Health Planning and Development Agency documents from 1981 describe the three planning areas in Pierce County as follows:

“The Central Pierce planning area contains the City of Tacoma and surrounding communities of Fircrest, South Tacoma, and Fife, as well as the lower Kitsap peninsula which lies in Pierce County...

“West Pierce includes Steilacoom, Lakewood and Parkland, and the Fort Lewis and McChord Military installations...

The East Pierce planning area covers the remainder of Pierce County east to the Cascades, and includes the Milton, Puyallup, Sumner, and Orting...”

The planning area descriptions above were accompanied by a list of 23 contiguous Pierce County zip codes. Because some zip codes have changed, have been eliminated, or have been added since the creation of the planning area descriptions, GHS provided a list of 26 zip codes that it believes currently meet the description of the East Pierce planning area. In examining GSH’s interpretation of East Pierce, the department notes that two of the original zip codes no longer exist and five additional zip codes have been created within the original East Pierce planning area. GSH recognized these changes in preparing its methodology..

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, developed January 2007⁴. These forecasts are not, however, available for any area smaller than an entire county. As a result, the department generally relies upon sub-county population projections provided by applicants, provided they are obtained from a reliable source. In this application, GSH provided sub-county population projections developed by Claritas, Inc., a recognized source of demographic information.

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 GSH 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 proceeding the base year.

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

⁴ Found on the World Wide Web at <http://www.ofm.wa.gov/pop/estimates.asp> and at <http://www.ofm.wa.gov/pop/poptrends/default.asp> and compiled internally by DOH

For this step, attached as Appendix 1, the department obtained utilization data for 1997 through 2006 from the Department of Health's Office of Hospital and Patient Data Systems' CHARS (Comprehensive Hospital Abstract Reporting System) database. Total patient days were identified for the East Pierce Planning Area, HSA #1, and Washington State 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. Normal newborn days (DRG 391) were excluded because the normal newborn patients (babies) do not occupy a licensed acute care bed. The mothers of the normal newborns are included in the patient days (MDC 14 and DRG 370-384).

GSH followed this step as described above with no deviations.

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

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

GSH also followed this step as described above with no deviations.

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

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

GSH followed this step as described above with no deviations.

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

The resulting trend lines from the ten-year history, 1997-2006, of rates uniformly exhibit an upward slope in all three computations. This conclusion is generally supported by increasing utilization reported by hospitals throughout the state in recent years, and may be indicative of a growing population. More significant than overall population growth is the fact that the state's population is growing older as the number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations. GSH followed this step as described with no deviations.

GSH appears to have followed this step as described above; however, GSH's graph indicates a mild downward slope for the planning area, the result of the slightly different population projections used by GSH and department for the East Pierce planning area in Step 3. The graph submitted with the screening methodology contained the trend lines, but does not

contain the numerical values. As a result, it is unclear what slope values were calculated by GSH, but later calculations indicate a flatter trend line than that utilized by the Department.

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

The previous four steps of the methodology involved data identified by the planning area where care was provided. In order to determine the need for services for residents of a given planning area, patient days must be identified, instead, by the area where the patients live. Step 5, included as Appendix 5, identifies referral patterns in and out of the East Pierce planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also uses hospital discharge data obtained from the Oregon Department of Human Services to identify patient days for Washington residents obtaining health care in Oregon (the department is not aware of similar data for the state of Idaho). The last available Oregon data was for 2003/04, and without any more current information available, this same data was included as to have some accounting to the out migration.

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

GSH omitted a copy of this step of the methodology in the version provided in screening. Based on subsequent steps, indications are that GSH also followed this step as described above, but details are unavailable.

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 2006, as defined in Step 3, for the East Pierce planning area and for the rest of the state. GSH omitted a copy of this step of the methodology in the version provided in screening.

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 1997-2006 to reflect the use patterns of Washington residents. The 2006 use rates determined in Step 6 were multiplied by the slopes of both the planning area’s ten-year use rate trend line and by the slope of the statewide ten-year use rate trend line for comparison purposes. For the East Pierce planning area, the planning area trend is a lower rate of increase (an annual increase of

1.1725) than the statewide rate of increase (an annual increase of 2.6973). As directed in Step 7A, the department applied the planning area trend to project future use rates.

GSH applied this portion of step 7 with no apparent modifications. With the omission of the steps containing these calculations in the screening submission as detailed above, it is unclear the degree which this trend differs from the department, but the net effect is that the applicant calculates the need in the area on a different growth rate than that of the Department

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 2006 for purposes of this analysis. Therefore, the target year for this analysis will be 2013.

GSH proposes adding a net 18 beds by November 2010 for a total of 243 acute care beds. Phase two of the project is scheduled to be operational in January 2013 with the addition of the remaining 32 beds, making the final bed count equal to 275. The Department prepared the bed need methodology to show the effect of implementing the entire project as proposed and detailed in Appendix 10b.

As previously stated, in its calculations, GSH appears to have applied an area trend other than that of the planning area rate that was utilized in the department’s calculations. GSH also provided projections through 2015.

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

Using the statewide forecasted use rate for the target year 2013 and population projections submitted by the applicant for the planning area, the department’s projected patient days for East Pierce planning area residents is illustrated in Appendix 8. As noted in Step 7 above, forecasts have been prepared for a series of years and are presented in summary in Appendix 10a & 10b as “Total East Pierce Res Days.”

GSH used this same approach in its projections.

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

Using the patient origin study developed for Step 5, Appendix 9 illustrates how the projected patient days for the East Pierce planning area and the remainder of the state were allocated from county of resident to the area where the care is projected to be delivered in the target year 2013. The results of these calculations are presented in Appendix 10a & 10b as “Total Days in East Pierce Hospitals.”

GSH prepared this step as above. Previously noted variations in the trend slopes and projected populations resulted in lower totals than those derived by the department.

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

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

1. beds which are currently licensed and physically could be set up without significant capital expenditure requiring new state approval;
2. beds which do not physically exist but are authorized unless for some reason it seems certain those beds will never be 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.

The SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information was gathered through CN and Facilities and Services Licensing records. There is currently only one acute care hospital in the East Pierce planning area—the applicant. [CN and OHCS files]

The weighted occupancy standard for a planning area is defined by the SHP as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected in the 1987 SHP are higher than can be maintained by hospitals under the current models for provision of care. As a result, the department has adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds). As a result of this change, the East Pierce planning area's weighted occupancy has been determined to be 70%. This is reflected in the line "Wtd Occ Std" in Appendix 10.

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

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

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

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

GSH 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.

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

Table 2
Department Methodology
Appendix 10A and 10B Summary

	2007	2008	2009	2010	2011	2012	2013	2014
Planning Area # of beds	225	225	225	225	225	225	225	225
Need/(Surplus) - Without Project (Appendix 10a)	(9.29)	2.00	13.35	24.78	36.28	47.85	59.50	71.21
Planning Area # of beds	225	225	225	243	243	243	275	275
Need/(Surplus) - With Project (Appendix 10b)	(9.29)	2.00	13.35	6.78	18.28	29.85	9.50	21.21

A negative number indicates a surplus of beds.

As shown in Table 2 above, for the current year 2007, Appendices 10a and 10b illustrate a planning area surplus of 9 beds. Appendix 10a indicates the planning area is projected to experience a shortage of 2 beds beginning in year 2008, or within one year from the writing of this evaluation. Without additional beds in the planning area, this shortage is projected to increase to more than 24 beds in year 2010 and 59.5 beds in 2013.

On the other hand, Appendix 10b illustrates the effect on the planning area of this project. By adding 18 beds in 2010, GSH decreases the need to 6.78 beds in the planning area. This continues to grow in the following years and continues to show a need for 9 plus additional beds in 2013, upon completion of Phase 2.

In summary, if this project is not implemented, the planning area is projected to experience a shortage of 2 beds beginning in year 2008, which increases to a shortage of nearly 60 beds by the end of year 2013. If this project is implemented, the planning area remain under bedded by 9.5 beds at the end of Phase 2.

As demonstrated by the methodology above, the East Pierce planning area is projected to need additional bed capacity as early as 2008. It is also clear that this project, as proposed, would not over-bed the planning area.

In addition to the numeric methodology above, the department must also determine whether existing providers are available and accessible in the planning area. The applicant is the only provider of acute care in the East Pierce planning area. During the course of this review, the department did not receive any comment support or opposition to the project.

Based on just the numeric need methodologies prepared by both the applicant and the department, GSH's proposal to add 50 acute care beds is reasonable. The department notes that GSH's patient day estimates are 6% to 7% lower than those returned by the department's need methodology in the years approaching project completion. This disparity is due to the differences in the 2006 population data used in Appendix 5 and the growth rate applied.

Based on the above evaluation, the proposal by GSH to add 50 acute care hospital beds is consistent with this sub-criterion of need.

- (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.

The department uses a facility's Medicare certification as the measure to determine whether elderly patients would have access to the proposed services. GSH is a participant in the Medicare program. [Application, p2] Medicare patients are expected to continue to have access to care if this project is approved. [Application, p26]

To demonstrate compliance with this sub-criterion, GSH provided copies of the following policies and procedures: Acute Care Patient Admit Process with Patient Rights and responsibilities clearly outlined and the Charity Care policy. [Application, Exhibits 6 and 7] The Admission policy confirms that all residents of the service area, regardless of race, color, sex, religion, age, national origin or immigration status are entitled to adequate access to the hospital or charitable care at the hospital.

GSH responded to this issue in the application by stating, "Admission to GSH's facilities and programs is based upon clinical need. Services are made available to all persons regardless of race, color, creed, sex, national origin, or disability". The applicant continues, "GSH exists to provide quality and accessible services to residents of the community. GSH's charity care policy ensures that no individual is denied care based on the individual's financial status or inability to pay for the full costs of services. The charity care policies provided in the application indicate that GSH's accept patients for treatment and care regardless of the patient's ability to pay.

For charity care reporting purposes, OHPDS divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. GSH is one of 18 hospitals located within the Puget Sound Region. According to 2004-2006 charity care

data obtained from OHPDS, GSH has provided a degree of charity care comparable to the Puget Sound regional average. GSH's most recent three-year (2004-2006) charity care percentages for gross and adjusted revenues are 1.99% and 4.23%, respectively. Incomplete 2006 financial data for the other regional hospitals makes a direct year-to-year comparison inaccurate.

Although, review of the applicant's charity care reports for the 2003-2005 range are available and calculate a rate equal to 2.05% of gross and 4.24% of adjusted revenue. The average for the Puget Sound Region during the same period is 2.02% for gross revenue and 4.15% for adjusted revenue. GSH's proforma and current charity care policy both indicate that the hospital will continue to provide charity care at a comparable level. [OHPDS 2004-2006 Year End Reports, Application, p27]

Based on the above information, the department concludes that the applicant has effectively demonstrated that all residents of the service area currently have adequate access to the health services at GSH. Further, the information demonstrates that the additional 50 beds would not negatively affect this access, and patients would continue to have access to the health services at GSH. This sub-criterion is met.

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

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

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

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

Good Samaritan Hospital capital expenditure for the certificate of need portion is projected to be \$30,636,523 while the overall project is projected to be \$245,361,000. OHPDS provides a summary in Table 3 of the balance sheets from the application.

**Table 3
Good Samaritan Hospital & MultiCare Balance Sheets**

Good Samaritan Hospital FYE 2006			
Assets		Liabilities	
Current	\$ 50,536,000	Current	\$ 31,722,000
Board Designated	\$ 175,151,000	Long Term Debt	\$ 53,463,000
Property/Plant/Equipment	\$ 138,896,000	Other	\$ 3,487,000
Other	\$ 4,653,000	<i>Equity</i>	\$ 280,564,000
Total	\$ 369,236,000	Total	\$ 369,236,000
MultiCare Audited FYE 2005			
Assets		Liabilities	
Current	\$ 240,278,000	Current	\$ 87,549,000
Board Designated	\$ 218,991,000	Long Term Debt	\$ 280,596,000
Property/Plant/Equipment	\$ 368,753,000	Other	\$ 42,279,000
Other	\$ 87,616,000	<i>Equity</i>	\$ 505,214,000
Total	\$ 915,638,000	Total	\$ 915,638,000

The percentages of the certificate of need expenditure compared to various assets of Good Samaritan 2006 fiscal year end is summarized below in Table 4.

**Table 4
Good Samaritan Hospital / MultiCare Asset Ratios**

	Good Samaritan - 50 Beds Project Only	MultiCare Total Project
Capital Expenditure	\$ 30,636,523	\$ 245,361,000
Percent of Total Assets	8.30%	26.80%
Percent of Board Designated Assets	17.49%	112.04%
Percent of Equity	10.92%	48.57%

GSH indicates that it intends to use hospital reserves for the costs of the project. The hospital is committing a good portion of the hospitals assets on this project. Reserves are accumulated mainly from prior year profits or prior debt acquisition. However Good Samaritan also has the financial backing of its parent, MultiCare which has the assets to protect this project. GSH expands upon this issue by stating, “The capital for the larger Tower project will come from a combination of reserves, bonds and net operating revenues”. [Application, p33]

OHPDS also reviewed various ratios’ that can give a snapshot of the financial health of Good Samaritan Hospital as of 2006. Detailed below are the first five years of projections for the bed addition portion of the hospital project. State 2005 ratios are included as a comparison and are calculated from all community hospitals in Washington State whose fiscal year ended in 2005. The data is collected by the Washington State Dept. of Health Hospital and Patient Data section of the Center for Health Statistics. Table 5 below displays the results.

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 5
Good Samaritan Hospital Projected Financial Ratios**

Good Samaritan 50 Beds		State						
Ratio Category	Trend	2005	GSH2005	CNyr1	CNyr2	CNyr3	CNyr4	CNyr5
Long Term Debt to Equity	B	0.540	0.191	0.350	0.316	0.284	0.253	0.224
Current Assets/Current Liabilities	A	2.049	1.593	2.183	2.172	2.161	2.149	2.138
Assets Funded by Liabilities	B	0.432	0.231	0.293	0.273	0.254	0.234	0.214
Operating Expense/Operating Revenue	B	0.956	0.964	0.926	0.915	0.903	0.893	0.883
Debt Service Coverage	A	4.774	0.691	5.919	6.373	6.849	7.305	7.769
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, 2015 fiscal year end ratios (CoN year 5) for Good Samaritan Hospital are all better than the State average.

Review of the financial and utilization information show that the immediate and long-range capital expenditure as well as the operating costs can be met. Based on the information reviewed, the department concluded 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.

As previously stated, GSH is currently constructing a new patient tower, of which, the two top floors would be used to house the 32 beds each to be added in by completion of Phase 2 of the project. GSH indicates that the larger Tower project will be undertaken regardless of CN approval. The capital expenditure for the CN reviewable portion of patient tower project is estimated to be \$30,636,523. A breakdown of the capital costs is outlined in Table 6. [Application, p14]

**Table 6
Good Samaritan Hospital Patient Tower Capital Costs**

Item	Cost	% of Total
Land Purchase	\$0	0%
Utilities to Lot Line	\$0	0%
Land Improvements	\$0	0%

Building Purchase	\$0	0%
Residual Value of Facilities	\$0	0%
Building Construction	\$21,700,000	70.83%
Fixed Equipment	\$0	0%
Moveable Equipment	\$4,340,000	14.17%
Architect/Engineer Fees	\$1,953,000	6.37%
Consulting Fees	\$0	0%
Site Preparation	\$0	0%
Supervision and Inspection	\$0	0%
Costs Associated with Financing	\$0	0%
Sales Tax	\$2,291,517	7.48%
Other Project Costs - review fees	\$352,006	1.15%
Total Estimated Capital Costs	\$30,636,523	100 %

By OHPDS standards, the costs of the project are the costs and charges the patients and community are billed for. GSH rates are calculated in Table 7 below:

Table 7
Good Samaritan Hospital Patient Charge Forecast

Good Samaritan 50 Beds	2011	2012	2013	2014	2015
Rate per Various Items	CONyr1	CONyr2	CONyr3	CONyr4	CONyr5
Patients	15,070	15,578	16,133	16,601	17,059
Patient Days	63,293	65,427	67,759	69,725	71,649
Gross Revenue	663,527,000	685,899,000	710,346,000	730,956,000	751,127,000
Deductions From Revenue	433,711,000	448,335,000	464,314,000	477,786,000	490,970,000
Net Patient Billing	229,816,000	237,564,000	246,032,000	253,170,000	260,157,000
Other Operating Revenue	897,000	897,000	897,000	897,000	897,000
Tax Revenue	-	-	-	-	-
Net Operating Revenue	230,713,000	238,461,000	246,929,000	254,067,000	261,054,000
Operating Expense	213,691,000	218,142,000	223,049,000	226,929,000	230,641,000
Operating Profit	17,022,000	20,319,000	23,880,000	27,138,000	30,413,000
Other Revenue	15,474,000	17,454,000	19,576,000	21,978,000	24,615,000
Net Profit	32,496,000	37,773,000	43,456,000	49,116,000	55,028,000
Operating Revenue per Patient	\$ 15,309	\$ 15,308	\$ 15,306	\$ 15,304	\$ 15,303
Operating Expense per Patient	\$ 14,180	\$ 14,003	\$ 13,826	\$ 13,670	\$ 13,520
Net Profit per Patient	\$ 2,156	\$ 2,425	\$ 2,694	\$ 2,959	\$ 3,226
Operating Revenue per Patient Day	\$ 3,645	\$ 3,645	\$ 3,644	\$ 3,644	\$ 3,644
Operating Expense per Patient Day	\$ 3,376	\$ 3,334	\$ 3,292	\$ 3,255	\$ 3,219
Net Profit per Patient Day	\$ 513	\$ 577	\$ 641	\$ 704	\$ 768
Operating Revenue per Adj Admissions	\$ 10,141	\$ 10,141	\$ 10,141	\$ 10,141	\$ 10,141
Operating Expense per Adj Admissions	\$ 9,429	\$ 9,312	\$ 9,194	\$ 9,090	\$ 8,991
Net Profit per Adj Admissions	\$ 1,434	\$ 1,612	\$ 1,791	\$ 1,967	\$ 2,145
Operating Revenue per Adj Pat Days	\$ 2,415	\$ 2,415	\$ 2,415	\$ 2,415	\$ 2,415
Operating Expense per Adj Pat Days	\$ 2,245	\$ 2,217	\$ 2,189	\$ 2,164	\$ 2,141
Net Profit per Adj Pat Days	\$ 341	\$ 384	\$ 426	\$ 468	\$ 511

Good Samaritan Hospital’s rates are similar to the Washington statewide averages. [OHPDS Analysis, p4] The department concludes the project is not expected to have an unreasonable impact on the cost and charges. This sub-criterion is met.

(3) The project can be appropriately financed.

The Bed addition project will use hospital reserves. OHPDS states, “The CN project is part of a larger construction project. The overall project was budgeted at \$245 million. Good Samaritan Hospital will have the resources of MultiCare, the parent corporation to complete the project. Good Samaritan Hospital has the board reserves to cover the certificate of need portion of the project”. The analysis continues, “The use of cash is a very appropriate and inexpensive financing method since the only constraint would be the question, is this the best use of the cash. [OHPDS Analysis, p4]

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

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

Based on the source information reviewed, the department determines that the applicant has 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.

GSH provided estimates that the addition of 50 acute care beds to the hospital will require an increase of approximately 38 FTEs, including employed and contract staff, between 2010 and the first year of phase two with 275 acute care beds (year 2013). In short, with implementation of both phases of the project, almost 58 FTEs are anticipated to be added at GSH and is depicted in the table below. [August 23, 2007 Supplemental Information, p9]

**Table 8
Good Samaritan Hospital FTE Forecast**

	2010	2011	2012	2013	2014	2015
	Phase 1			Phase 2		
RN	11.20	0.00	0.00	24.15	0.00	0.00
LPN	0.00	0.00	0.00	0.00	0.00	0.00
Nursing Asst.	5.60	0.00	0.00	9.80	0.00	0.00
Support/Tech/Clerical	2.10	0.00	0.00	2.80	0.00	0.00
Clerical	0.00	0.00	0.00	0.00	0.00	0.00
Management/Admin	1.00	0.00	0.00	1.00	0.00	0.00
Total	19.90	0.00	0.00	37.75	0.00	0.00

GSH indicates that they have taken numerous steps intended to mitigate any potential shortages in available qualified staff. A brief listing of the type of strategies being pursued to facilitate the necessary recruitment includes:

- On-site career counseling. WorkSource provides on-site services designed to provide the current staff with the opportunity for additional training to qualify for internal advancement;
- GSH participates in the Pierce County Health Services Careers Council to expand educational opportunities for interested parties;
- Tuition assistance in exchange for minimum service commitments coupled with a loan forgiveness program;
- Educational programs such as the Healthcare Careers Camp to facilitate high school students interested in job shadowing health care professionals;
- A Competitive wage, benefit and retirement program in conjunction with a targeted staff recognition program;
- Management and leadership development courses to minimize turnover; and
- A new RN Residency Program which provides a 12 week training course in return for a two year service commitment at the hospital upon completion of the residency.

In addition, the recent affiliation with MultiCare has allowed for the ability to leverage resources to benefit area recruitment and retention. [Application, p39]

Based on the information provided in the application, the department concludes that GSH can have a reasonable assurance that it can recruit staff necessary for the proposed project. This sub-criterion is met.

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

GSH states that “As GSH currently operates all of the ancillary and support departments needed to support an acute care institution; GSH has determined that existing Hospital support departments will be more than adequate to meet the additional demands resulting from the bed addition.” The department concludes that, since this application proposes an increase in bed capacity of approximately 22%, and that no new specialty services or significant changes in healthcare delivery are expected to result from this bed addition, GSH’s assertions that current support services are sufficient to support the project are reasonable. [Application, p39]

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

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

GSH will continue to provide Medicare and Medicaid care services to the residents of the service area. GSH is listed by Joint Commission of Accreditation of Healthcare Organizations (JCAHO) as in full compliance with all applicable standards.⁵

In the spring of 2005, GSH requested suspension of review of a previously submitted bed expansion project. This request was precipitated by a survey of the facility by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). During the survey, GSH provided JCAHO with information that a staff member had supplied JCAHO with inaccurate information and forged signatures. As GSH notes in related responses, this inaccurate and forged information automatically resulted in a preliminary recommendation that accreditation be denied. In April, 2006, GSH provided the department with the results of JCAHO's follow-up survey. That final survey recommended full accreditation. The department notes that this level of accreditation is superior to the level of accreditation received in the 1996, 1999 and 2002 surveys, which recommended accreditation with requirements for improvement. The department, on examination of the current survey document, concludes that the cause of the initial recommendation that accreditation be denied has been corrected.

In addition to the surveys performed by JCAHO, the department's Office of Health Care Survey most recently conducted a complaint survey of GSH in September 2007. In that survey, department staff investigated a complaint against the facility. While deficiencies were identified as a result of the complaint investigation, GSH prepared a plan of correction that was approved by the department.

In addition to acute care services, GSH also provides Medicare certified home health and hospice services in Pierce and King Counties. GSH also operates an ambulatory surgery center. [CN historical files] Since 2002, the Department of Health's Office of Health Care Survey (OHCS) has completed two compliance surveys for Good Samaritan In-Home Service⁶ and one survey of Good Samaritan Surgery Center. Each of the compliance surveys revealed minor deficiencies typical for the type of facility and GSH submitted a plan of corrections and implemented the required corrections. [Compliance survey data provided by Office of Health Care Survey]

Based on GSH's hospital, home health, hospice and ASC 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.

⁵ <http://www.qualitycheck.org/qualityreport.aspx?hcoid=9609>

⁶ Surveys completed in 2002, 2003 and 2005.

- (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.

In its application, GSH noted that additional acute care capacity would enable it to serve the community better by accommodating the projected increase in patient days. Further, as an existing provider in the planning area, any current relationships with the medical and provider community are expected to continue after the expansion of the bed capacity [Application, p40]

The department concludes that there is reasonable assurance that addition of the 50 beds requested in this project would assist in GSH's ability to continue to promote continuity of care. Further, GSH's relationships within existing health care system would continue and not result in an unwarranted fragmentation of services. This sub-criterion is met.

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

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

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

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

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

The applicant notes 3 options that were considered;

1. Do nothing,
2. Continuing with the 30 bed expansion requested in the 2004 certificate of need
3. This application – expand at current site..

Good Samaritan Hospital addresses do nothing by explaining that population increase, sole hospital in service area and high midnight census make it unrealistic to continue as is. The applicant notes that adding outpatient beds does not make their hospital more flexible and does nothing to alleviate census and diversion issues. The hospital says continuing with the 30 bed application is reasonable but no longer optimal. Due to these issues the hospital elected for the third option, or this application, where 50 beds will be added.

The Department is satisfied that adding 50 licensed beds is an appropriate option. This criterion is satisfied.

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

Staff from OHPDS examined the construction costs of this project and provided the following analysis, “The costs of the project are the cost for construction, planning and process”. Good Samaritan Hospital projections are outlined in Table 9 below.

Table 9
Good Samaritan Hospital Construction Projections

Good Samaritan 50 Beds	
Total Capital	\$ 30,636,523
Construction Cost	\$ 25,914,606
Gross Square Footage	33,000
Beds/Stations/Other (Unit)	50
Total Capital per Gross Square Foot	\$ 928.38
Total Const. per Gross Square Foot	\$ 785.29
Total Capital per Unit	\$ 612,730.46

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. Good Samaritan Hospital is building in a facility it currently occupies for healthcare services and will construct the new area to the latest energy and hospital standards. [OHPDS Analysis, p5]

The Department is satisfied the applicant plans are appropriate. This criterion is satisfied.

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

Staff is satisfied that adding 50 licensed beds to a facility which is the only hospital in the planning area and where the population is growing in number and age will not have an unreasonable impact of the costs and charges to the public of providing services by other persons.

OHPDS staff is satisfied the project is appropriate. This criterion is satisfied.

(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.

OHPDS provided the following discussion of this criterion:

“Good Samaritan Hospital notes that this project will improve system efficiency for the hospital and patients as the new beds will be in private rooms which 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 building new. [OHPDS Analysis, p6]

The Department is satisfied the project is appropriate and needed. This criterion is satisfied.

APPENDICES