STATE OF WASHINGTON

DEPARTMENT OF HEALTH

*Olympia, Washington 98504*

November 29, 2016

CERTIFIED MAIL # 7008 1830 0002 8022 0762

Richard Petrich, Vice President
Planning and Business Development
CHI Franciscan Health
1145 Broadway, #1000
Tacoma, Washington 98402

RE: Certificate of Need Application #16-39

Dear Mr. Petrich:

We have completed review of the Certificate of Need application submitted by CHI Franciscan Health proposing to add acute care bed capacity to St. Anthony Hospital in Gig Harbor, within Pierce County. Enclosed is a written evaluation of the application.

For the reasons stated in the enclosed decision, the application is consistent with the applicable criteria of the Certificate of Need Program, provided CHI Franciscan Health agrees to the following in its entirety.

**Project Description**

St. Anthony Hospital currently operates 80 acute care beds. This certificate approves the addition of 32 acute care beds. At project completion, St. Anthony Hospital will license and operate a total of 112 acute care beds. The approved bed breakdown is shown below.

| Type | Total # of Beds |
|---|---|
| Medical Surgical | 112 |
| **Total** | **112** |

**Conditions**

1. Approval of the project description as stated above. CHI Franciscan Health further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. CHI Franciscan Health shall finance the project using cash reserves from CHI Franciscan Health as described in the application.

3. St. Anthony Hospital will provide charity care in compliance with its charity care policies reviewed and approved by the Department of Health, or any subsequent policies reviewed and approved by the Department of Health. St. Anthony Hospital 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 Puget Sound Region. Currently, this amount is 1.87% gross revenue and 4.70% of adjusted revenue. St. Anthony Hospital will maintain records documenting the amount of charity care provided and demonstrating its compliance with its charity care policies.

**Approved Costs**

The approved capital expenditure for the 32-bed addition is $15,601,740.

Please notify the Department of Health within 20 days of the date of this letter whether you accept the above project description, conditions, and capital costs for your project. If you accept these in their entirety, your application will be approved and a Certificate of Need sent to you.

If you reject any of the above provisions, your application will be denied. The department will send you a letter denying your application and provide you information about your appeal rights.

Send your written response to the Certificate of Need Program, at one of the following addresses.

Mailing Address:
Department of Health
Certificate of Need Program
Mail Stop 47852
Olympia, WA 98504-7852

Physical Address:
Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, WA 98501

If you have any questions, or would like to arrange for a meeting to discuss our decision, please contact Janis Sigman with the Certificate of Need Program at (360) 236-2955.

Sincerely,

Bart Eggen, Acting Director
Community Health Systems

Enclosure

**EVALUATION DATED NOVEMBER 29, 2016, FOR THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY CHI FRANCISCAN HEALTH PROPOSING TO ADD ACUTE CARE BEDS TO ST. ANTHONY HOSPITAL IN GIG HARBOR**

## APPLICANT DESCRIPTION

Catholic Health Initiatives (CHI) is a not-for-profit health system and the parent company of Franciscan Health System. CHI, through its subsidiary CHI Franciscan Health System[1], owns or operates a variety of healthcare facilities under the "CHI Franciscan Health" name. CHI does not have direct ownership or management of any facilities in Washington State. [source: Application, p1] Throughout this evaluation, CHI Franciscan Health will be referenced as 'CHI Franciscan.'

In Washington State, CHI Franciscan operates a variety of healthcare facilities. Below is a listing of the eight hospitals, six dialysis centers, hospice care center, hospice agency, and two ambulatory surgery centers owned or operated by CHI Franciscan in Washington State. [source: CN historical files]

**Hospitals**
Harrison Medical Center, Bremerton
Highline Medical Center, Burien
Regional Hospital, Tukwila
St Anthony Hospital, Gig Harbor
St Clare Hospital, Lakewood
St Elizabeth Hospital, Enumclaw
St Francis Hospital, Federal Way
St Joseph Medical Center, Tacoma

**Ambulatory Surgery Centers**
Gig Harbor Ambulatory Surgery Center
Franciscan Endoscopy Center

**Dialysis Centers**
Franciscan Bonney Lake Dialysis Center[2]
Franciscan Eastside Dialysis Center
Franciscan South Tacoma Dialysis Center
Greater Puyallup Dialysis Center
St Joseph Medical Center
St Joseph Dialysis Center Gig Harbor

**Hospice Care Center**
FHS Hospice Care Center

**Hospice Agency**
Franciscan Hospice, Tacoma

In addition to the eight hospitals listed above, on August 24, 2016, Franciscan Specialty Care, LLC received Certificate of Need approval to establish a new, 60-bed level I rehabilitation hospital in Tacoma, within Pierce County. Franciscan Specialty Care, LLC is 51% owned by CHI Franciscan Health dba St Joseph Medical Center and 49% owned by RehabCare Development 4 – a 100% subsidiary of Kindred Healthcare, Inc. The new rehabilitation hospital is expected to be operational by the end of December 2018.[3]

[1] In year 2014 Franciscan Health System changed its name to CHI Franciscan Health. Portions of this evaluation reference past applications, but continue to reference the applicant as CHI Franciscan Health. The department acknowledges that before 2014, the applicant was known Franciscan Health System.
[2] Franciscan Bonney Lake Dialysis Center is recently approved and not yet operational.
[3] August 24, 2016, 'Intent to Issue a Certificate of Need.'

## BACKGROUND INFORMATION

This project focuses on St. Anthony Hospital (SAH) located at 11567 Canterwood Boulevard Northwest in Gig Harbor, within Pierce County. On August 12, 2003, CHI Franciscan submitted a Certificate of Need application proposing to establish a 112-bed acute care hospital in two phases. Phase 1 was the establishment of 80 beds; phase two was the addition of the remaining 32 beds. On May 26, 2004, the department issued an "Intent to Issue a Certificate of Need" for the establishment of an 80-bed hospital, or phase one only.[4] Once CHI Franciscan provided a copy of its final Environmental Impact Statement, the department issued CN #1332 on June 15, 2006.

The approved capital expenditure associated with CN #1332 was $94,563,078. The costs included the build-out of the entire hospital. Between the time of the initial approval in May 2004 and the date CN #1332 was issued in June 2006, CHI Franciscan underwent an extensive land use approval process required by the city of Gig Harbor. The city of Gig Harbor required CHI Franciscan to financially contribute to the cost of road improvement for traffic mitigation. As a result, the project's costs increased to $161,726,222—an additional 71% from the approved capital costs. On October 24, 2008, CN #1332A was issued to CHI Franciscan approving the increase in capital costs for the project to $161,726,333.[5] [source: CN historical files]

The initial application projected that the first 80 acute care beds—phase one—would be operational by July 2007. With the extensive land use approval required by the city of Gig Harbor the opening of SAH was delayed. On March 16, 2009, SAH was issued its initial hospital license. [source: ILRS data]

SAH is currently licensed for 80 acute care beds. The hospital provides a variety of general medical surgical services, including cardiac care, intensive care, and emergency services.[6] The hospital is currently a Medicare and Medicaid provider, holds a level IV adult trauma designation from the Department of Health's Emergency Medical Services and Trauma office[7], and holds a three-year accreditation from the Joint Commission[8]. [source: Application, p2 and CN historical files]

## PROJECT DESCRIPTION

This project proposes completion of 21,322 square feet on the fifth floor that was shelled-in when SAH was constructed. The space will be equipped and used as general medical/surgical space. Once the shelled in space is completed, 32 beds would be added, and SAH would be licensed and operating 112 acute care beds. [source: Application, p8]

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[4] Projected utilization, pro forma financial statements, and assumptions provided in the application supported only phase one of the project—80 bed hospital. As a result, the department was unable to approve a two-phase project for SAH.

[5] Under CN Program rules, if the capital costs of a project increase the greater amount of $50,000 or 12% above the approved costs, an amended CN is required.

[6] SAH does not provide elective percutaneous coronary interventions (PCI) services or obstetric services.

[7] A Level IV Trauma Center has demonstrated an ability to provide advanced trauma life support prior to transfer of patients to a higher level trauma center. It provides evaluation, stabilization, and diagnostic capabilities for injured patients. [source: American Trauma Society]

[8] The Joint Commission accredits and certifies more than 20,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. [source: Joint Commission website]

The capital expenditure associated with this project is $15,601,740. Of that amount, approximately 85% is related to construction necessary to complete the fifth floor and the purchase and installation of both fixed and medical equipment. [source: Application, p35]

CHI Franciscan Health proposes the new space will be completed and the additional 32 acute care beds would be licensed and operational by January 2018. [source: Application, p15 and August 12, 2016, screening response, Attachment 1]

## APPLICABILITY OF CERTIFICATE OF NEED LAW

CHI Franciscan's application is subject to review as the change in bed capacity of a health care facility which increases the total number of licensed beds under Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

## EVALUATION CRITERIA

WAC 246-310-200(1)(a)-(d) identifies the four determinations that the department must make for each application. WAC 246-310-200(2) provides additional direction in how the department is to make its determinations. It states:

*"Criteria contained in this section and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240 shall be used by the department in making the required determinations.*

*(a) In the use of criteria for making the required determinations, the department shall consider:*

*(i) The consistency of the proposed project with service or facility standards contained in this chapter;*

*(ii) In the event the standards contained in this chapter do not address in sufficient detail for a required determination the services or facilities for health services proposed, the department may consider standards not in conflict with those standards in accordance with subsection (2)(b) of this section; and*

*(iii) The relationship of the proposed project to the long-range plan (if any) of the person proposing the project."*

In the event WAC 246-310 does not contain service or facility standards in sufficient detail to make the required determinations, WAC 246-310-200(2)(b) identifies the types of standards the department may consider in making its required determinations. Specifically WAC 246-310-200(2)(b) states:

*"The department may consider any of the following in its use of criteria for making the required determinations:*

*(i) Nationally recognized standards from professional organizations;*

*(ii) Standards developed by professional organizations in Washington State;*

*(iii) Federal Medicare and Medicaid certification requirements;*

*(iv) State licensing requirements;*

*(v) Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to a proposed undertaking; and*

*(vi) The written findings and recommendations of individuals, groups, or organizations with recognized expertise related to a proposed undertaking, with whom the department consults during the review of an application."*

To obtain Certificate of Need approval, the applicant must demonstrate compliance with the criteria found in WAC 246-310-210 (need) including applicable portions of the 1987 Washington State Health

plan; 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); 246-310-240 (cost containment).

## TYPE OF REVIEW

This project was reviewed under the regular timeline outlined in WAC 246-310-160, which is summarized below.

## APPLICATION CHRONOLOGY

| Action | CHI Franciscan |
|---|---|
| Letter of Intent Submitted | December 22, 2015 |
| Application Submitted | June 7, 2016 |
| Department's pre-review activities | |
| • DOH 1st Screening Letter | June 28, 2016 |
| • Applicant's Responses Received | August 12, 2016 |
| • DOH 2nd Screening Letter | N/A |
| • Applicant's Responses Received | N/A |
| Beginning of Review | August 19, 2016 |
| End of Public Comment | |
| • Public comments accepted through end of public comment | September 26, 2016 |
| • Public hearing conducted | Not requested or conducted |
| Rebuttal Comments Received | October 11, 2016 |
| Department's Anticipated Decision Date | November 29, 2016 |
| Department's Actual Decision Date | November 29, 2016 |

## AFFECTED PERSONS

Washington Administrative Code 246-310-010(2) defines "affected person" as:

*"…an "interested person" who:*

*(a) Is located or resides in the applicant's health service area;*
*(b) Testified at a public hearing or submitted written evidence; and*
*(c) Requested in writing to be informed of the department's decision."*

WAC 246-310-010(2) requires an affected person to first meet the definition of an 'interested person.' WAC 246-310-010(34) defines "interested person" as:

*(a) The applicant;*
*(b) Health care facilities and health maintenance organizations providing services similar to the services under review and located in the health service area;*
*(c) Third-party payers reimbursing health care facilities in the health service area;*
*(d) Any agency establishing rates for health care facilities and health maintenance organizations in the health service area where the proposed project is to be located;*
*(e) Health care facilities and health maintenance organizations which, in the twelve months prior to receipt of the application, have submitted a letter of intent to provide similar services in the same planning area;*
*(f) Any person residing within the geographic area to be served by the applicant; and*

*(g) Any person regularly using health care facilities within the geographic area to be served by the applicant.*

During the review of this project, only MultiCare Health System sought affected person status.

MultiCare Health System

MultiCare Health System requested interested and affected person status and to be informed of the department's decision. MultiCare Health System operates an acute care hospital in Tacoma, within Pierce County. MultiCare Health System meets the definition of an "interested person" under WAC 246-310-010(34) and provided written public comments on the application. MultiCare Health System also meets the definition of an "affected person" for this project.

## SOURCE INFORMATION REVIEWED

- CHI Franciscan Health System's Certificate of Need application received June 7, 2016
- CHI Franciscan Health System's screening responses received August 12, 2016
- Public comments received by the department through the close of business on September 26, 2016
- CHI Franciscan Health System's rebuttal documents received October 11, 2016
- 1987 Washington State Health Plan
- Year 2006 through 2015 Comprehensive Hospital Abstract Reporting Systems [CHARS] data
- Office of Financial Management Population Data 2012
- Claritas population data obtained in year 2015
- Department of Health Hospital/Finance and Charity Care Program Analysis dated October 21, 2016
- Department of Health Integrated Licensing and Regulatory System database [ILRS]
- Licensing and/or survey data provided by the Department of Health's Investigations and Inspections Office
- Licensing data provided by the Medical Quality Assurance Commission, Nursing Quality Assurance Commission, and Health Systems Quality Assurance Office of Customer Service
- Department of Health's Emergency Medical Services and Trauma designation dated October 2015
- CHI Franciscan Health System's website at www.chifranciscan.org
- Joint Commission website at www.qualitycheck.org
- American Trauma Society website at www.amtrauma.org
- Certificate of Need historical files

## CONCLUSIONS

For the reasons stated in this evaluation, the application submitted by CHI Franciscan Health proposing to add 32 acute care beds to St. Anthony Hospital located in Gig Harbor within Pierce County is consistent with applicable criteria of the Certificate of Need Program, provided CHI Franciscan Health agrees to the following in its entirety.

### Project Description

St. Anthony Hospital currently operates 80 acute care beds. This certificate approves the addition of 32 acute care beds. At project completion, St. Anthony Hospital will license and operate a total of 112 acute care beds. The approved bed breakdown is shown below.

| Type | Total # of Beds |
|---|---|
| Medical Surgical | 112 |
| **Total** | **112** |

**Conditions:**

1. Approval of the project description as stated above. CHI Franciscan Health further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. CHI Franciscan Health shall finance the project using cash reserves from CHI Franciscan Health as described in the application.
3. St. Anthony Hospital will provide charity care in compliance with its charity care policies reviewed and approved by the Department of Health, or any subsequent policies reviewed and approved by the Department of Health. St. Anthony Hospital 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 Puget Sound Region. Currently, this amount is 1.87% gross revenue and 4.70% of adjusted revenue. St. Anthony Hospital will maintain records documenting the amount of charity care provided and demonstrating its compliance with its charity care policies.

**Approved Costs:**

The approved capital expenditure for the 32-bed addition is $15,601,740.

## CRITERIA DETERMINATIONS

### A. Need (WAC 246-310-210)

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that CHI Franciscan Health **met** 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.*

WAC 246-310 does not contain an acute care bed forecasting method. 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 baseline need for acute care beds.[9]

The 1987 methodology is a twelve-step process of information gathering and mathematical computation. This forecasting method is designed to evaluate need for additional capacity in general, rather than identify need for a specific project.

CHI Franciscan—Numeric Need Methodology

[source: Application, pp27-33 and Exhibit 7]

This project proposes to add 32 acute care beds to SAH located in Gig Harbor within Pierce County. CHI Franciscan provided an acute care bed methodology based on historical CHARS[10] data for years 2005 through 2014. Below are the assumptions and factors used in the numeric methodology.

- Hospital Planning Area – Central Pierce County
- CHARS data – Historical years 2005 through 2014
- Projected Population – Based on Claritas 2015 for central Pierce; Office of Financial Management medium series data for statewide. For both data sources historical and projected intercensal and postcensal estimates are calculated.
- Planning Horizon – Seven-year planning horizon beginning with the next year following the based year. The base year is 2014; year seven is 2021.
- Excluded MDCs and DRGs
  - MDC[11] 19 – patients, patient days, and DRGs for psychiatric.
  - DRG[12] 385-391/789-795 – patients, patient days, and DRGs for neonates
  - DRG 462/945-946 – patients, patient days, and DRGs for rehabilitation.
- Weighted Occupancy – Calculated consistent with the State Health Plan 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. CHI Franciscan's methodology calculated a weighted occupancy of 71.5%.

[9] The acute care bed methodology in the 1987 SHP divides Washington State into four separate HSAs that are established by geographic regions appropriate for effective health planning. Pierce County is located in HSA #1, which includes the following ten counties: Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Snohomish, and Whatcom.

[10] CHARS=Comprehensive Hospital Abstract Reporting System.

[11] MDC=Major Diagnostic Category

[12] DRG=Diagnosis Related Group

- Existing Acute Care Bed Capacity – Four acute care hospitals operate in the Central Pierce planning area. One of the hospitals—MultiCare's Mary Bridge Children's Hospital—is a dedicated children's hospital. CHI Franciscan did not count this facility in its methodology.

  To determine the number of beds to be counted for the planning area's remaining three acute care hospitals, CHI Franciscan provided the following excerpt from the 1987 State Health Plan.

  > *"The number of beds in the planning area was identified in accordance with the SHP standard 12.a, 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 use 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.'*

  CHI Franciscan based its methodology on the available beds in the planning area and counted 752 beds. The 752 beds represent only available medical/surgical acute care beds for the three hospitals. Not counted at the three hospitals are beds dedicated for: level II intermediate care nursery, level III neonatal intensive care nursery, psychiatric, and rehabilitation.

Table 1 below shows the results of CHI Franciscan's numeric methodology for years 2015 through 2021. [source: Application, p32]

**Table 1**
**CHI Franciscan Acute Care Bed Methodology**
**Projection Years 2015 through 2021**

| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| Gross Number of Beds Needed | 696 | 710 | 724 | 739 | 755 | 771 | **787** |
| Minus Existing Capacity | 752 | 752 | 752 | 752 | 752 | 752 | **752** |
| **Net Bed Need or (Surplus)** | **(56)** | **(42)** | **(28)** | **(13)** | **3** | **19** | **35** |

Using a seven-year planning horizon—year 2021—CHI Franciscan's methodology showed need for an additional 35 acute care beds at in the Central Pierce planning area.

Public Comment

- *"Update to Base Year 2015 for Acute Care Need Model*
  *In the case of acute care bed requests, the methodology used to estimate the need for future acute care beds is defined in a 12-step methodology in the Washington State Health Plan ("SHP"). Although the SHP was sunset in 1989, the Department of Health has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds, thus still uses this methodology consistently on all certificate-of-need decisions related to acute care bed requests. The methodology defines how data sets of total patient*

*days and population are created and how they are used mathematically to create bed need forecasts for a defined planning area--in this case, the Central Pierce Planning Area.*

*The data set used for examining patient day utilization in Washington State is the Comprehensive Hospital Abstract Reporting System ("CHARS"). In order to accurately reflect trends and utilization in the planning area, the most recent year available for CHARS is used in the need model; referred to as the 'base year.' This has important implications as the base year determines the scope of the analysis and potentially strongly impacts the use-rates and migrations statistics used throughout the forecast period to project demand for health services in planning area hospitals. These demand projections, in turn, are compared to bed supply and used to quantify the net need for additional beds in the planning area. For example, using 2014 CHARS as the base year means the applicant analyzes in Step 1 of the acute care need methodology patient days for the previous 10 years (i.e. 2005-2014), while 2015 CHARS would call for patient days occurring during the 2006-2015 time period. Additionally, Step 5 of the methodology is entirely limited in scope to the base year data. Step 5 serves as the basis for the migration statistics and use-rates at planning area hospitals for the entire forecast period. If significant changes occur between 2014 and 2015, then this could have potentially large impacts on the net need estimated for Central Pierce hospitals.*

*With respect to the SAH application, its acute care need model incorporated 2014 CHARS as the base year. This was the correct base year at the time the application was submitted because 2014 CHARS was the most recent data available at that time. However, since SAH's application submittal, the full calendar year 2015 CHARS data has become available. During the screening period subsequent to SAH's application, neither the Department nor SAH have asked/provided an updated acute care model that incorporates base year 2015 CHARS as required by the need methodology.* ***However, the Department should use an updated acute care bed need model that includes 2015 CHARS as the base year to determine net need in the Central Pierce Planning Area."*** [emphasis in original] [source: MultiCare Health System public comment, pp5-6]

- *"Rehabilitation Provider Exclusion*

  *When the Department uses an updated 2015 CHARS model for the Central Pierce Planning Area, we recommend a revision to the methodology to account for a change that occurred in 2015. In 4Q 2015, there was the transition from ICD9 to ICD10. The transition had a significant effect on the MS-DRGs ("DRGs") assigned for certain types of hospital stays. Most importantly, for the purposes of the acute care bed need model, the transition to ICD10 diagnosis codes significantly shifted the DRGs assigned for rehabilitation patients. Previously, DRGs 945-946 were used as a way to exclude rehabilitation utilization from the acute care model. Unfortunately, this no longer is an accurate designation. Table 3 below shows the rehabilitation providers' discharge mix by DRG. The table clearly demonstrates that DRGs 945 and 946 no longer can be used as the only factor to exclude rehab days from the model. By ignoring this change, the model will inaccurately assign patient days to acute care utilization and corresponding use rates, thereby artificially inflating net bed need. To correct for this reallocation of days from DRGs 945 and 946, beginning in Q4 2015, all patient day figures, regardless of DRG, from all Washington State designated rehabilitation units and St. Luke's Rehabilitation Institute, should be excluded from the acute care bed need model. This exclusion should be applied to every step of the methodology."* [source: MultiCare Health System public comment, pp7-8]

***Table 3 [of MultiCare Public Comments]***
***Discharge Mix at Rehab Unit Providers and***
***St. Luke's Rehabilitation Institute, CY2015***

| ***MS-DRG*** | ***Q1*** | ***Q2*** | ***Q3*** | ***Q4*** |
|---|---|---|---|---|
| *945* | *1,332* | *1,395* | *1,369* | *81* |
| *946* | *153* | *142* | *160* | *23* |
| *057* | *3* | *2* | *0* | *410* |
| *949* | *0* | *0* | *6* | *130* |
| *560* | *0* | *0* | *0* | *122* |
| *056* | *0* | *0* | *0* | *101* |
| *065* | *2* | *0* | *4* | *62* |
| *092* | *0* | *1* | *1* | *43* |
| *064* | *0* | *0* | *0* | *42* |
| *559* | *0* | *0* | *0* | *35* |
| *561* | *0* | *0* | *0* | *34* |
| *052* | *0* | *0* | *0* | *34* |
| *091* | *1* | *0* | *0* | *33* |
| *939* | *6* | *6* | *7* | *6* |
| *All Other MS-DRGs* | *5* | *9* | *11* | *368* |
| ***Total*** | ***1,502*** | ***1,555*** | ***1,558*** | ***1,524*** |

- *"Mary Bridge Hospital should be included as a planning area hospital*

  *The aim of the acute care bed need model is to ensure that there is a sufficient supply of beds to meet the demand for health services expected to take place in planning area hospitals. Therefore, a key designation within the acute care methodology is the proper assignment of planning area hospitals. In the case of the SAH acute care project, the planning area is Central Pierce. Accordingly, the following is a list of hospitals located inside of the Central Pierce Planning Area.*
  - *St. Anthony Hospital*
  - *St. Joseph Medical Center*
  - *Tacoma General/Allenmore Hospital*
  - *Mary Bridge Children's Hospital*

  *When the list of planning area hospitals above is compared to the bed supply list displayed in Step 10 of SAH's acute care need model, it is clear SAH decided to exclude Mary Bridge Children's Hospital from the list of planning area providers. SAH acknowledges they have chosen to exclude Mary Bridge and includes the following rationale:*

  > *"Mary Bridge is a children's hospital, and because SAH does not provide inpatient pediatric services, we do not believe that Mary Bridge is comparable. This conclusion would be consistent with past decisions of the CN Program, including its 2012 CN approval of additional beds at Mary Bridge."*

  *The fact that Mary Bridge is a children's hospital does not preclude it from being designated as a planning area hospital for the purposes of the SAH application, nor does the fact that SAH does not provide inpatient pediatric services. In fact, SAH's acute care model uses total patient day and population figures for all ages, including pediatrics. Given the Central Pierce acute care need model includes pediatric utilization and population forecasts, Mary Bridge should be included as a planning area hospital throughout the methodology, including the addition of its bed supply in Step 10.*

*In combination with the previous comments included thus far, SAH should include the following updates to its acute care need model:*

1. *Update to Base Year 2015*
2. *Exclude patient day utilization at rehabilitation providers*
3. *Include Mary Bridge Children's Hospital as a Central Pierce Planning Area Hospital"*

[source: MultiCare Health System public comment, pp8-9]

Rebuttal Comment

- *2015 CHARS data*

  *"The 32 Beds requested remain fully supported with the inclusion of 2015 CHARS. MHS identified several issues regarding the Washington State Acute Care Bed Need Methodology. First, it noted that because full year 2015 CHARS data is now available, it should be used to determine the bed need for this application.*

  *CHI Franciscan concurs. As we noted on page 28 of the SAH application, we are aware the CN Program uses the most recent ten full years of CHARS data. Full year 2015 was released after our CN application was submitted. We have updated the methodology with 2015, and as alluded to in our CN application, the need for beds with 2015 data grows exponentially.*

  *As suggested in our application, the utilization in Central Pierce, at least for the CHI Franciscan hospitals, was up significantly in 2015 (over 2014). The updated methodology, using a 7 year planning horizon—and holding bed need supply constant—demonstrates that 123 additional beds are needed by 2022. Table B summarizes key statistics found in the bed need methodology that account for the increase in the bed need:"*

***Table B** [of CHI Franciscan Rebuttal Comments]*
***Acute Care Bed Need Methodology, Key Statistics, 2014 and 2015***

| ***Step*** | ***Statistic*** | ***2014 Methodology*** | ***2015 Methodology*** | ***Percent Change Or Notes*** |
|---|---|---|---|---|
| *3* | *Central Pierce Planning Area Resident Days* | *120,992* | *130,959* | *+8.24%* |
| *4* | *Trend used to adjust use rates* | *-0.13* | *-0.09* | *Trend still negative but improving* |
| | *Central Pierce Provider Planning Area Patient Days* | *179,021* | *196,511* | *+9.8%* |
| *5* | *Use Rates* | *0-64: 248.71* | *0-64: 264.08* | *0-64: 6.2%* |
| | | *65+: 1,190.91* | *65+: 1,273.13* | *65+: 6.9%* |
| *5* | *Market Share* | *0-64: 69.03%* | *0-64: 70.74%* | *0-64: 2.5%* |
| | | *65+: 82.03%* | *65+: 81.46%* | *65+: 0.7%* |
| *5* | *In-migration to Central Pierce Providers* | *0-64: 4.36%* | *0-64: 4.53%* | *0-64: 3.90%* |
| | | *65+: 4.10%* | *65+: 4.13%* | *65+: 0.73%* |

- *Rehabilitation Patient Day and Provider Exclusion*

  *"For the record, this updated methodology (contained in Attachment 2) incorporates MHS' suggested methodology for exclusion of rehabilitation patient days for 2015 due to the change in coding as a result of the implementation of ICD-10. (*Footnote #1 provides the

following statement: *ICD-10 became effective on October 1, 2015, as such only 4th Q 2015 CHARS is impacted by the change in coding.)*

*As noted on page 30 of the application, the distinction between licensed and "set up" beds could be significant to this project. While the two CHI Franciscan hospitals (SJMC and SAH) currently set up and operate all of their respective beds (acute rehab, psychiatric and neonatal Level II and Level III are excluded), we are currently unclear about exactly how many of the licensed beds at the other Central Pierce hospital, MultiCare Tacoma General, currently has setup and available. In the bed need methodology included in Attachment 2, we have listed the count of available beds at MHS to be 385 (consistent with the bed need methodology included in the application). This is higher than the 373 listed in MHS' 2014 Year End Report (the 2015 report has not yet been filed) and is higher than the 309 available beds (as noted in the 2016 CN Program acute bed survey). The 2016 bed survey indicates that MHS' remaining licensed bed capacity is assignable but not set up (an additional 188 beds or 38% of MHS' existing licensed bed capacity). In MHS' year end reports and previous surveys, MHS has never indicated that all of its licensed bed capacity was set up or assignable but not set up. CHI Franciscan questions its ability to do so today. However, even if all 497 licensed beds are included, bed need for the SAH addition is supported in 9 years (by 2024) with the updated (2015) bed need methodology. And, as was discussed in the application, regardless of the bed count at MHS, there are numerous reasons that the exception language in the State Health Plan should be invoked; allowing for the approval of the bed addition at SAH."*

- *Mary Bridge Hospital is appropriately excluded as a Central Pierce hospital planning area hospital*

  *MHS has asserted that Mary Bridge should be included as an acute care facility as described in the methodology for the Central Pierce Planning Area. The record must reflect that it is MHS, beginning in 2010, that has requested that Mary Bridge be placed in a separate planning area (much like Seattle Children's) because it is a provider of tertiary pediatric services. MHS requested, and the CN Program concurred that the Planning Area for Mary Bridge is an 8 county planning area—not Central Pierce. In its 2010 CN application for beds, MHS wrote:*

  > *'Mary Bridge Children's Hospital is the only children's hospital in southwest Washington. It primarily serves patients from Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Pierce and Thurston counties. The planning area was defined based on the number of discharges and patient days from Mary Bridge Children's Hospital, as well as the Hospital's share of total county patient days for pediatric inpatients. [source: MultiCare Mary Bridge Certificate of Need Application Proposing to Add 25 Acute Pediatric Beds, July 2010, p16]'*

  *In 2011, the CN Program's 2011 evaluation of MHS' application to add 20 pediatric acute care beds, based on the above planning area, stated:*

  > *'Further, each applicant contended that* ***their respective hospitals would be the only capacity considered in step 10 of their supporting methodologies'***
  > *[emphasis in original]*

  *Although the above application was denied; the CN Program accepted the planning area used by MHS. In 2011, MHS submitted a 2nd application, based on the same 8 county planning area and received CN approval (in 2012). In neither case, did MHS base its bed*

*need methodology on the Central Pierce Hospital Planning area. Therefore, MHS' argument that Mary Bridge's utilization and capacity be included within the Central Pierce Planning Area is without merit and should be rejected by the CN Program."* [source: CHI Franciscan rebuttal comments, pp3-5]

Department Evaluation

The acute care bed methodology relies on 10 years of historical discharge data for Washington State hospitals. A variance in one of the years will affect projected years; however, generally not significantly.

The department concurs with both CHI Franciscan and MultiCare Health System that the most recent data available should be used for the acute care bed methodology. Year 2015 CHARS data became available during the first week of June 2016; this application was submitted in the first week of June 2016. During the screening period, the department should have requested CHI Franciscan provide an updated numeric methodology using base year 2015. The department did not request the revision; therefore, CHI Franciscan did not include an updated methodology in its screening responses.

CHI Franciscan provided the updated methodology in response to public comments from MultiCare Health System; however, the department does not accept new or updated information in rebuttal documents. CHI Franciscan's updated methodology, while appropriate for this review, cannot be used to evaluate this project. The methodology provided by CHI Franciscan in rebuttal will not be considered or further discussed in this evaluation.

Both CHI Franciscan and MultiCare Health System agree that the rehabilitation beds and patient days should be excluded from the CHARS data. The department concurs. For 2015 data, CHI Franciscan and MultiCare suggest that rather than relying on the rehabilitation days coded under DRGs 945/946, instead, the patients and patient days for all rehabilitation hospitals and designated rehabilitation units within acute care hospitals should be excluded. The department concurs with this approach.

For comparison purposes, the department calculated two separate numeric need methodologies for this project. The two methodologies are briefly described below.

Method #1

This methodology relied on CHARS data for years 2006 through 2015.
Exclusion of rehabilitation patients, patient days, and beds was completed similar to the process used in previous reviews—by excluding DRGs 945/946.

Method #2

This methodology also relied on 2006 through 2015 CHARS data.
Exclusion of rehabilitation patients, patient days was completed by excluding rehabilitation patients, patient days, and beds within rehabilitation hospitals and rehabilitation units within acute care hospitals. This process for exclusion was completed for all historical years, rather than just year 2015.

The results of the two methodologies are not significantly different; however, the department considered Method #2 to be more reliable based on the changes in ICD9 to ICD10 coding as previously discussed. Method #1 was calculated for comparison purposes and will not be further

discussed in this evaluation. Below is a more detailed description of the department's methodology [Method #2].

Below are the assumptions and factors used in its methodology. The numeric methodology is included in this evaluation as Attachment A.

- Hospital Planning Area – Central Pierce County
- CHARS data – Historical years 2006 through 2015
- Projected Population – Based on Claritas 2015 for central Pierce; Office of Financial Management medium series data released May 2012 for statewide. For both data sources historical and projected intercensal and postcensal estimates are calculated.
- Excluded MDCs and DRGs
  - MDC 19 – patients, patient days, and DRGs for psychiatric.
  - MDC 15 – patients, patient days, and DRGs for neonates.
  - Excluded rehabilitation hospitals and rehabilitation units.
- Weighted Occupancy – Calculated consistent with the State Health Plan. The department's methodology calculated a weighted occupancy of 70.08%.
- Existing Acute Care Bed Capacity –A total of 778 medical/surgical beds were counted. Further discussion on the 778 beds is under steps 10 through 12 below.

Below is a summary of the steps in the department's numeric methodology. In this evaluation, the department will not compare its methodology with CHI Franciscan because the differences in the data sets used by each are not conducive to a practical comparison.

Steps 1 through 4 of the methodology develop trend information on historical hospital utilization. In steps 1 through 4, the department focused on historical data for years 2006 through 2015 to determine the statewide and health service area [HSA] use trends for acute care services. The department computed a statewide and HSA use trend line. The HSA use trend line projected an increase in acute care use [1.0401] and the statewide trend line projected a slight decline in use [-0.0899]. The SHP requires use of either the statewide or HSA trend line "*whichever has the slowest change*." The HSA trend line, with the slight decline showed the slowest change and is considered more statistically reliable. The department applied the data derived from those calculations to the projection years in the following steps.

Steps 5 through 9 calculate a baseline non-psychiatric bed need forecasts.
For these steps, the department applied its use trend line to the projected population to determine a use rate broken down by population ages 0-64 and ages 65 and older. The department also multiplied the use rates derived from step 6 by the slopes of the HSA, central Pierce planning area, and statewide ten-year use rate trend line. This step is completed for comparison purposes, and showed the planning area use rate to be statistically most reliable. The department also determined the in-migration for residents who do not live within central Pierce County, but obtained acute care services at one of the hospitals in the planning area. The use rates, broken down by age group, and the in-migration ratio are each applied in future steps of this methodology.

Table 2 on the following page shows the use rates, broken down by age group, that MHS and the department each applied to the projected population.

**Table 2**
**Department Numeric Methodology**
**Use Rates Applied to Projected Population**

| | 0- 64 Age Group | 65 + Age Group |
|---|---|---|
| Department | 267.80/1,000 population | 1,269.54/1,000 population |

When the use rates are applied to the projected population, the result is the projected number of patient days for the planning area. The numeric 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 at least seven years from the last full year of available CHARS data. Using 2015 CHARS data, seven years is 2022; and ten years is 2025.

Steps 10 through 12 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. Step 12 is the adjustment phase where 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. These steps also allow psychiatric projections, which the department did not compute [step 11], and allow for other adjustments in population, use rates, market shares, out-of-area use and occupancy rates [step 12]. The department did not include any other adjustments than those described in the previous steps.

In steps 10 through 12, the department projected the number of acute care beds needed in the planning area, subtracted the existing capacity, resulting in a net need for acute care beds. During the review of this project, CHI Franciscan and MultiCare Health System disagreed on the facilities and the number of beds that should be counted in the planning area. There are four acute care hospitals in the central Pierce County planning area. Table 3 below shows each hospital and the counts identified by CHI Franciscan and the department.[13]

**Table 3**
**Central Pierce County Acute Care Bed Count**

| Hospital | CHI Franciscan | DOH | DOH Difference |
|---|---|---|---|
| St. Anthony Hospital (1) | 80 | 80 | 0 |
| St. Joseph Medical Center (1) | 287 | 276 | -11 |
| Tacoma General/Allenmore (2) | 385 | 337 | -48 |
| Mary Bridge Children's Hospital (2) | 0 | 82 | +82 |
| **Totals** | **752** | **775** | **23** |

**(1)** CHI Franciscan Health facility; **(2)** MultiCare Health System facility

As shown in Table 3, for existing capacity, CHI Franciscan subtracted 752 acute care beds and did not include any beds at Mary Bridge Children's Hospital. In its public comments, MultiCare Health System states that the acute care beds at Mary Bridge Children's hospital should be counted. However, the department concludes that the beds at Mary Bridge Children's Hospital should be counted for this project because SAH provides a full range of acute care services to all

[13] MultiCare Health System asserted that Mary Bridge Children's Hospital and its 82 beds should be counted in the numeric methodology, but did not provide comments on the number of beds identified by CHI Franciscan for Tacoma General/Allenmore.

ages of patients. Further, CHI Franciscan and the department both included patients of all ages [0-64 and 65+] in the calculations of the numeric methodology.

Below is a description of the difference in bed count by facility and the department's rationale for the count.

- St. Joseph Medical Center – CN #1425 was issued on August 2, 2010. The certificate approved the addition of a 23-bed dedicated psychiatric unit at the hospital and relocation of 16 psychiatric beds to medical/surgical use. The certificate identifies the number of general medical/surgical beds at project completion to be 276.
- Tacoma General/Allenmore – CN #1543 was issued on April 21, 2015. The certificate approved the conversion of 30 medical surgical beds to psychiatric use. The certificate identifies the number of general medical/surgical beds at project completion to be 337.
- Mary Bridge Children's Hospital – CN #1482 was issued on August 7, 2012. The certificate approved the addition of 10 acute care beds to the hospital, resulting in a facility total of 82 acute care beds.

Table 4 below shows the department's methodology calculations for years 2017 through 2022. Table 4 also shows the impact to the planning area if 32 acute care beds are added to SAH in year 2018.

**Table 4**
**Department of Health Methodology**
**Projection Years 2017 through 2025**

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2025 |
|---|---|---|---|---|---|---|---|
| Gross Number of Beds Needed | 869 | 884 | 898 | 913 | 928 | 942 | 986 |
| Minus Existing Capacity | 775 | 775 | 775 | 775 | 775 | 775 | 775 |
| **Net Bed Need (Surplus)** | **94** | **109** | **123** | **138** | **136** | **167** | **211** |
| Plus 32 Bed sat SAH-Year 2018 | 0 | 32 | 32 | 32 | 32 | 32 | 32 |
| **Net Bed Need or (Surplus)** | **94** | **73** | **87** | **102** | **117** | **131** | **175** |
| | | | | | | **7 years** | **10 years** |

Table 4 above shows that the addition of 32 beds in 2018 results in a need for 73 beds in year 2018, which increases to a need for more than 100 beds by the end of year 2020.

Based on the department's need methodology alone, need for additional acute care beds in central Pierce County is demonstrated. In addition to the numeric need, the department must determine whether other services and facilities of the type proposed are not or will not be sufficiently available and accessible to meet that need.

CHI Franciscan Health

*"According to the Washington State Health Plan's Acute Care Bed Need Projection Methodology, the midnight occupancy target for a hospital with 80 licensed acute care beds is 60%.*[14] *As depicted in Table 5 [below], in 2015, SAH's average midnight occupancy was 89% or 48% above this target. In fact, Table 5 [below] details that on more than 61% of the days, at midnight in 2015, the medical beds were above 90% occupancy. The surgical beds were at*

[14] The original SHP standard was 65%, but was reduced to 60% by the department in approximately 2004.

*or above 90% occupancy on 56% of the days. The 16 bed ICU exceed 90% occupancy on 40% of all days."* [source: Application, p17]

*"The current high inpatient census compromises access to timely care, results in extended holding time in the emergency department, delays initiation of care and results in lower patient satisfaction. In the emergency department, total boarding hours, defined as the number of hours between an inpatient bed request and the time the patient is admitted to a floor increased by 79% between 2014 and 2015. Importantly, the number of patients left without being seen (LWBS) more than tripled between 2014 and 2015."* [source: Application, p17]

***Table 5 [of CHI Franciscan Application]***
***2015 Daily Midnight Census***

| | ***4th Floor Medical*** | ***3rd Floor Surgical*** | ***ICU*** | ***All Acute Units*** |
|---|---|---|---|---|
| *Current Licensed/Set Up Beds* | *32* | *32* | *16* | *80* |
| *ADC at Midnight* | *29.5* | *28.5* | *13.4* | *71.4* |
| *Target Average Occupancy* | *60%* | *60%* | *60%* | *60%* |
| *Actual Average Occupancy* | *92%* | *89%* | *84%* | *89%* |
| ***Occupancy*** | ***Actual Days at or Above Given Occupancy*** | | | |
| *100%* | *98* | *69* | *71* | *85* |
| *95%* | *141* | *112* | *71* | *148* |
| *90%* | *223* | *206* | *147* | *215* |
| *85%* | *259* | *253* | *196* | *268* |
| *80%* | *320* | *302* | *239* | *309* |
| *75%* | *346* | *328* | *282* | *328* |
| *70%* | *350* | *336* | *284* | *352* |
| *65%* | *359* | *350* | *319* | *358* |
| ***Target Occupancy per SHP: 60%*** | ***362*** | ***354*** | ***339*** | ***363*** |

*Source: Applicant Internal Data. Includes all patients occupying inpatient beds at midnight.*
[source: Application, p18]

*"CHI Franciscan "ran" the CN Program's acute care bed projection methodology using the best currently available information and determined that there is need for an additional 35 beds in Central Pierce by 2021, or 7 years following the latest (2014) full year of CHARS data. More than 750 letters of support from Pierce County residents, representatives of the local fire districts, and law enforcement officials were submitted in support of the establishment of the hospital in 2003. Common themes within the letters of support included:*

- *concerns with patients having to travel over the traffic-congested Tacoma Narrows Bridge to receive routine medical care;*
- *concerns with patients having to travel over the bridge to receive emergent medical care; and*
- *concerns with the growing population in the Gig Harbor and Key Peninsula areas resulting in increased traffic in the future.*

*After reviewing the letters and analyzing all available information, in its approval of the 80 bed new hospital, the CN Program concluded that* ***"traffic congestion may be viewed as a barrier to provision of health care services for patients residing in the Gig Harbor/Key***

***Peninsula areas, as well as emergency transport vehicles".*** [emphasis in original] [source: Application, p18]

*"Today, traffic, but more importantly high census in Central Pierce hospitals (particularly those operated by CHI Franciscan) continues to provide a barrier for patients that are delayed in receiving care at SAH due to high census. Because of medical staff continuity, shared electronic medical record and higher tertiary-level resources, the preferred admission or diversion hospital from SAH is St. Joseph Medical Center (SJMC), but SJMC is rapidly approaching 90% average midnight occupancy. While Harrison Medical Center in Bremerton and Silverdale is an option, Gig Harbor area patients greatly prefer Tacoma to Bremerton or Silverdale.*

*Table 6 identifies the census of the 10 busiest (defined as occupancy on licensed beds) in Washington during the first three quarters of 2015. As can be determined from Table 6, five of the 10 hospitals—or 50%, are CHI Franciscan hospitals, including all three of our Pierce County hospitals. Unlike many other hospitals statewide, each of these hospitals has 100% of its licensed beds set-up and available for care, and does not have "banked" beds that can be used for expansion without prior CN review and approval.*

*As the data in Table 6 [below] shows, CHI can justify more beds at a large percentage of its hospitals, including the two in Central Pierce. This application seeks to immediately remedy the census concerns at SAH."* [source: Application, p19]

***Table 6 [of CHI Franciscan Application]***
***2015 Highest Occupancy Hospital in Washington State****

| | ***Hospital*** | ***Licensed Beds*** | ***SHP Target Occupancy*** | ***Occupancy (Licensed)*** |
|---|---|---|---|---|
| *1* | *Harborview Medical Center* | *328* | *75.0%* | *88.8%* |
| ***2*** | ***St. Joseph Medical Center*** | ***294*** | ***70.0%*** | ***86.1%*** |
| ***3*** | ***St. Anthony Hospital*** | ***80*** | ***60.0%*** | ***77.5%*** |
| *4* | *Seattle Cancer Care Alliance* | *20* | *60.0%* | *76.9%* |
| ***5*** | ***Regional Hospital for Respiratory & Complex Care*** | ***40*** | ***60.0%*** | ***76.3%*** |
| ***6*** | ***St. Clare Hospital*** | ***106*** | ***65.0%*** | ***74.6%*** |
| ***7*** | ***St. Francis Hospital*** | ***118*** | ***65.0%*** | ***74.5%*** |
| *8* | *MultiCare Good Samaritan Hospital* | *250* | *70.0%* | *71.8%* |
| *9* | *Providence Regional Medical Center Everett* | *453* | *75.0%* | *71.2%* |
| *10* | *PeaceHealth St. Joseph Medical Center* | *221* | *70.0%* | *68.1%* |

*Source: WA State CHARS Database, 2015 3Q annualized (Excludes MDC 15, 19, Rehab MSDRGs 945/946)*

***** Table 6 in the application showed CHI Franciscan Health facilities in italics. The department's re-creation of the table shows the CHI Franciscan Health facilities in bold.

*"While 2014 CHARS suggests that mathematical need for the beds exists, CHI Franciscan concurs with the CN Program's 2004 conclusion that the result of the mathematical calculation is not the sole measure of determining need. The State Health Plan's Criterion 2 identifies other scenarios under which providers can be awarded new beds, especially in Planning Areas where one or more hospitals are operating above capacity, but another may not be. The Hospital Bed Need Forecasting Method contained in Volume II of the 1987 State Health Plan states:*

*CRITERION 2: Need for Multiple Criteria*

*Hospital bed need forecasts are only one aspect of planning hospital services for specific groups of people. Bed need forecasts by themselves should not be the only criterion used to decide whether a specific group of people or a specific institution should develop additional beds, services or facilities. Even where the total bed supply serving a group of people or planning area is adequate, it may be appropriate to allow an individual institution to expand.*

*Standards:*

*b. Under certain conditions, institutions may be allowed to expand even though the bed need forecasts indicate that there are underutilized facilities in the area. The conditions might include the following:*

- *the proposed development would significantly improve the accessibility or acceptability of services for underserved groups; or*
- *the proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or*
- *the proposed development would allow expansion of a crowded institution which has good cost, efficiency or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.*

*In such cases, the benefits of expansion are judged to outweigh the potential costs of possible additional surplus.*

*In the highly unlikely event that the CN Program finds numeric need for less than the 32 beds we propose, SAH requests that its bed expansion be considered for approval based on our location and accessibility to residents and patients that historically had been underserved by virtue of geography. As the CN Program itself noted in its 2004 CN decision, "traffic congestion may be viewed as a barrier to provision of health care services for patients residing in the Gig Harbor/Key Peninsula areas, as well as emergency transport vehicles".* [source: Application, p20]

*"Further, the requested beds would allow for the expansion of a "crowded institution"—defined as a hospital operating at a midnight occupancy level nearly 50% higher than the target level identified in the State Health Plan. There are no underutilized facilities in the CHI Franciscan Health System in Central Pierce or even in Pierce County. As noted in Table 6, each of our Central Pierce hospitals as well as our 3rd Pierce County hospital operates significantly above its target midnight occupancy level on licensed beds. While MultiCare appears to have more licensed than set-up beds; it has operated below its licensed bed complement for decades; and according to various sources, it too operates at high occupancy levels on the number of beds it chooses to set-up.*

*A midnight occupancy level of 89% is not sustainable, nor is the fact that SAH exceeded 90% occupancy on 215 days or 59% of all days in 2015. The current high inpatient census compromises access to timely care, results in extended holding time in the emergency department, increases costs, delays initiation of care and results in lower patient satisfaction.*

*As note earlier in this application, boarding hours in the emergency department has greatly increased in the past several years and the number of patients left without being seen (LWBS) has also increased. As the sole inpatient provider on the Gig Harbor and Key Peninsulas, we are wholly aware that our high occupancy has consequences on the community's access. The 32 beds we are requesting should rectify this situation."* [source: Application, p21]

Public Comment

- *"St. Anthony cites Criterion 2 as support for its request, but it provides virtually no supporting documentation*

  *In its discussion of Need, SAH states the following:*

  *" ...CHI Franciscan concurs with the CN Program's 2004 conclusion that the result of the mathematical calculation is not the sole measure of determining need. The State Health Plan's Criterion 2 identifies other scenarios under which providers can be awarded new beds ...*

  *... In the highly unlikely event that the CN Program finds numeric need for less than the 32 beds we propose, SAH requests that its bed expansion be considered for approval based on our location and accessibility to residents and patients that historically had been underserved by virtue of geography. As the CN Program itself noted in its 2004 CN decision, "traffic congestion may be viewed as a barrier to provision of health care services for patients residing in the Gig Harbor/Key Peninsula areas, as well as emergency transport vehicles ...*

  *... Further, the requested beds would allow for the expansion of a "crowded institution" defined as a hospital operating at a midnight occupancy level nearly 50% higher than the target level identified in the State Health Plan."*

  *Criterion 2 is not well-defined in terms of agreed-upon, measurable criteria and standards with which to evaluate an applicant. It originated from the 1987 Washington State Health Plan and includes the following conditions where it might apply:*

  - *The proposed development would significantly improve the accessibility or acceptability of services for underserved groups; or*
  - *The proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has a wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or*
  - *The proposed development would allow expansion of a crowded institution which has good cost, efficiency, or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.*

  *St. Anthony Hospital states it is a "crowded institution," and provides occupancy statistics to show it is operating above the target level for a hospital of its size. We recognize there may be occupancy constraints at SAH. However, Criterion 2 requires supporting data and comparisons across providers. St. Anthony has not supported its request for Criterion 2 with any such required information. In our opinion, it cannot just assert Criterion 2 applies-it must demonstrate it with real data and provide required comparisons to meet Criterion 2 standards. For instance, what support can SAH provide to support its claim that potential geographic barriers exist for Gig Harbor/Key Peninsula area residents in accessing care? Until it*

*provides the required support, Criterion 2 cannot be used to support its request."* [source: MultiCare Health System public comment, pp9-10]

- *By way of background, from 2005 to 2011, I served on the Gig Harbor Planning Commission and was a part of the initial approval process for St. Anthony Hospital following Certificate of Need (CN) approval in May 2003. As a part of that process, I learned that SAH was originally designed for 112 beds but had only received CN approval to operate 80 beds. At the time, I was concerned that the 80 beds might not be sufficient for our growing and aging community. Therefore, it comes as no surprise to me that SAH is requesting additional beds.* [source: Jill Guernsey, Mayor of Gig Harbor public comment, p1]

- *Since the construction of the hospital and it's opening in 2009, its occupancy has consistently grown. It is an important service for those of us living in the Peninsula area, and that acceptance has meant that occupancy levels are now consistently full; and this includes the emergency area where patients often are required to wait for beds to become available in the hospital. It would appear that there is enough demand in the South Sound and the Peninsula to warrant these 32 beds to avoid unnecessary transfers to Seattle, Bellevue and Kirkland. Recently, two of my elderly neighbors were separately transferred to Swedish in Seattle and to Virginia Mason in Kirkland; this after a significant waiting period. Both of these locations were incredibly difficult for their various family members. Surely, this hospital can withstand some growth and expansion, both from the standpoint of the need of the local population (taking into account the demographics of the area) and from the potential to expand the footprint of the current facility. This is especially true, given the fact that the original construction prepared for this type of addition of facilities.* [source: Kathy Keele, past president of Auxiliary at St. Anthony's public comment, p1]

- *As a fellow not-for-profit organization with a mission for serving Gig Harbor residents, Heron's Key will provide a continuum of health care, including assisted living, memory care, rehabilitative services and skilled nursing. When finished in 2017, Heron's Key will have 184 independent living apartments, 10 cottages, 36 assisted living suites and 45 skilled nursing private rooms. A second phase will add apartments and cottages. Designed to accommodate residents' changing needs throughout the aging process, Heron's Key may rely heavily on accessibility and availability of beds at St. Anthony's Hospital.* [source: James Antonucci, Jr. PhD, Heron's Key Executive Director, public comment, p1]

<u>Rebuttal Comments</u>

- *<u>"Irrespective of bed need, SAH has compelling argument to add beds, and Criterion 2 allows for need when bed need is absent</u>.*
  *MHS (p. 9) states that Criterion 2 "is not well defined in terms of agreed upon, measureable criteria and standards…" Despite MHS' opinion a Health Law Judge (HLJ) and subsequently Washington's courts have determined that it is a valid means of approving bed projects. According to the HLJ:*

  > *'1.7 At hearing, in prehearing briefs, and in its closing brief, Petitioners argue that Criterion 2 of the State Health Plan cannot be used in CN evaluations, but they are incorrect. RCW 70.38.115(5) does give the Program discretion when applying the evaluative criteria. WAC 246-310-200(2)(a)(iii) and b(ii) allow the use of other standards and criteria. Criteria 2 is a balanced, logical approach to evaluating cases like this, and furthermore, is completely harmonious with the Washington Supreme*

*Court's opinion in Overlake Hosp. Assoc. v. Dept. of Health, Op. cit. , which promotes accessibility as one of the overriding purposes of the CN Program.'*

[Footnote #4 states: Findings of Fact, Conclusions and Initial Order, Master Case Nos: M2013-1393, M2013-1394, and M2013-1395, p47]

*"MHS had the opportunity to review our application and create a table with comparative data to challenge our assertion that we are a "crowded facility"; but they failed to do so. More importantly, MHS did not address or dispute the original condition identified by the CN Program in the 2004 decision, that traffic congestion may be viewed as a barrier to provision of health care services. This condition still exists as well. We would also note that conditions under Criterion 2 are not "and" but "or", only one condition needs to exist to satisfy this Criterion. We believe that SAH is unique in that it satisfies two of these conditions.*

*As we note in the application, the acute care bed need methodology suggests that mathematical need for the beds exists. We also concur with the CN Program's 2004 conclusion that the* ***result of the mathematical calculation is not the sole measure of determining need****. The State Health Plan's Criterion 2 identifies other scenarios under which providers can be awarded new beds, especially in Planning Areas where one or more hospitals are operating above capacity, but another may not be. In our case, the other scenario data is compelling.* [emphasis in original]

*Data provided in the application documented the census of the 10 busiest (defined as occupancy on licensed beds) in Washington during the first three quarters of 2015 (Table 6). This table has been revised to include occupancy data for the first six months of 2016. As depicted in the updated table (Table C) four of the CHI Franciscan hospitals are in the top 6, including all three in Pierce County. Unlike many other hospitals statewide, each of the CHI Franciscan hospitals has 100% of its licensed beds set-up and available for care, and does not have "banked" beds that can be used for expansion without prior CN review and approval.*

***Table C [of CHI Franciscan rebuttal comments]***
***2015 and 2016 Highest Occupancy Hospitals in Washington State****
***(CHI Franciscan hospitals are italicized)***

| | ***Hospital*** | ***Licensed Beds*** | ***SHP Target Occupancy*** | ***Occupancy (Licensed)*** |
|---|---|---|---|---|
| ***1*** | ***St. Joseph Medical Center*** | ***294*** | ***70.0%*** | ***88.2%*** |
| ***2*** | ***St. Francis Hospital*** | ***118*** | ***65.0%*** | ***86.5%*** |
| *3* | *Harborview Medical Center* | *328* | *65.0%* | *79.9%* |
| ***4*** | ***St. Clare Hospital*** | ***106*** | ***75.0%*** | ***78.3%*** |
| *5* | *Providence Regional Medical Center Everett* | *453* | *75.0%* | *78.1%* |
| ***6*** | ***St. Anthony Hospital*** | ***80*** | ***60.0%*** | ***77.5%*** |

*Source: WA State CHARS Database, 2015 3Q annualized*
*(Excludes MDC 15, 19, Rehab MSDRGs 945/946 and 2015 Rehab Units 2016 data)*

* Table C of the rebuttal comments showed CHI Franciscan Health facilities in italics. The department's re-creation of the table above shows the CHI Franciscan Health facilities in bold.

*Consistent with the information provided in the application on page 20 and, for reader ease, replicated below, census pressures at the CHI Franciscan hospitals continue. In the highly unlikely event that the CN Program finds numeric need for less than the 32 beds we propose,*

*SAH requests that its bed expansion be considered for approval based on our location and accessibility to residents and patients that historically have been underserved by virtue of geography. As the CN Program itself noted in its 2004 CN decision, "**traffic congestion may be viewed as a barrier to provision of health care services for patients residing in the Gig Harbor/Key Peninsula areas, as well as emergency transport vehicles**".* [emphasis in original]

*Further, the requested beds would allow for the expansion of a "crowded institution." As detailed in Table C, there are no underutilized facilities in the CHI Franciscan Health System in Central Pierce or even in Pierce County. While MultiCare appears to have more licensed than set-up beds; it has operated below its licensed bed complement for decades; and according to various sources, it too operates at high occupancy levels on the number of beds it chooses to setup. Contrary to the MHS public comment, CHI Franciscan believes that this data does document that SAH meets Criterion 2. In addition, as was documented in the 2014 and 2015 bed need methodologies, sufficient bed need exists to justify the beds requested in this application.*
[source: CHI Franciscan rebuttal comments, pp5-7]

Department Evaluation

CHI Franciscan states that SAH has capacity constraints that would be alleviated with additional beds. If 32 beds are approved, the new beds would be located in completed space on the fifth floor. The letters of support provided for this project focused on the need for additional acute care bed capacity at SAH. The excerpts above provide examples of the common theme throughout the letters.

CHI Franciscan provided documentation intended to demonstrate additional acute care beds are needed at SAH. MultiCare Health System states that it does not oppose this project, but takes issue with CHI Franciscan assertion that it should be approved under "*Criterion 2*" of the SHP. Based on the information provided in the application, the department concurs that CHI Franciscan did not demonstrate need for additional beds under Criterion 2.

The department also concludes that the numeric methodology and information provided in the application support the addition of 32 acute care beds to SAH. Further, the letters of support assist CHI Franciscan with this demonstration. The demonstration under Criterion 2 is not needed to approve this project. Based on the information received, the department concludes the existing capacity is not or will not be sufficiently available and accessible to meet the projected need.

Based on the results of the department's acute care bed methodology and the information discussed above, the department concludes that CHI Franciscan has demonstrated the need for an additional 32 beds at SAH. **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.*

To evaluate this sub-criterion, the department evaluates an applicant's admission policies, willingness to serve Medicare and Medicaid patients, and to serve patients that cannot afford to pay for services.

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 assurances regarding access to

treatment. The admission policy must also include language to ensure all residents of the planning area would have access to the proposed services. This is accomplished by providing an admission policy that states patients would be admitted without regard to race, ethnicity, national origin, age, sex, pre-existing condition, physical, or mental status.

Medicare certification is a measure of an applicant's willingness to serve the elderly. With limited exceptions, Medicare is coverage for individuals age 65 and over. It is also well recognized that women live longer than men and therefore more likely to be on Medicare longer.

Medicaid certification is a measure of an applicant's willingness to serve low income persons and may include individuals with disabilities.

Charity care shows a willingness of a provider to provide services to individuals who do not have private insurance, do not qualify for Medicare, do not qualify for Medicaid, or are under insured. With the passage of the Affordable Care Act, the amount of charity care is expected to decrease, but not disappear.

CHI Franciscan Health

CHI Franciscan provided copies of the following policies used at all of its hospitals, including SAH. [source: Application, Exhibits 6]

- Admission Policy-Approved March 2014
- Non-Discrimination Policy-Approved March 2014
- Uninsured / Underinsured Patient Discount (Charity Care) Policy-Approved January 2012

SAH is currently Medicare and Medicaid certified. CHI Franciscan provided its current and projected source of revenues by payer for SAH. A breakdown of both revenue sources is shown in Table 5 below. [source: Application, p10 and p41]

**Table 5**
**St. Anthony Hospital Payer Mix**

| Revenue Source | Current 80 beds | Projected 112 beds |
|---|---|---|
| Medicare | 48.1% | 49.0% |
| Medicaid | 17.1% | 16.9% |
| Commercial | 29.3% | 28.7% |
| Other | 5.5% | 5.4% |
| **Total** | **100.0%** | **100.0%** |

In addition to the policies and payer mix information, CHI Franciscan provided the following information related to uncompensated care provided by CHI Franciscan. [source: Application, pp22-23]

> *"In addition to charity care as measured by the department, CHI Franciscan provides numerous uncompensated services to the communities served. In fiscal year 2015 alone, CHI Franciscan's quantifiable Community Benefit (including the cost of charity care) total $142 million. A sampling of local CHI Franciscan education and community outreach programs*…[was provided in a table in the application].

Public Comments

- *"The Department's data shows SAH's historical provision of charity care has been below the Puget Sound regional average when measured as a percent of revenue. SAH's projected charity care is even lower than its historical rate-and just a fraction of the Puget Sound Regional average--as it has been adjusted, in SAH's words, for post-Medicaid expansion---driven off of 2015 actuals at SAH. However, as will be explained and demonstrated in this paper, the projected amount of charity care included by SAH in its proforma is significantly lower than what would be expected when compared to the forecasted charity care simulated based on alternative, and more reasonable standards. In order to ensure residents' access to charity care services, the Department should include a charity care requirement in the event it approves SAH's CN request."* [source: MultiCare Health System public comment, p3]

- *"Historically, the primary metric used to evaluate the sub-criterion above has been to examine the three-year charity care average by the applicant compared to the regional average. This charity care percentage is also incorporated into the applicant's pro forma to forecast and evaluate the financial feasibility of the project. Further, in the event that the Department grants an approval to issue a CN, but the applicant has not historically been above the regional charity care average, then a condition is often attached to the CN requiring the project to meet the regional charity care average when it becomes operational.*

- *In its application, Saint Anthony Hospital ("SAH") responds to the access sub-criterion discussed above by providing the historical average charity care for SAH and other CHl-FH hospitals in the region compared to the regional average, as well as an outline of Community Benefit provided in FY2015. The text featured in SAH's application regarding charity care, as well as the actual charity care percentage forecasted in its application, was used to construct Table 1 below.*

***Table 1 [of MultiCare Public Comments]***
***Charity Care Comparison***

| | ***% of Total Revenue (2012 – 2014)*** | ***% of Adjusted Revenue (2012-2014)*** | ***Forecasted Rate**** |
|---|---|---|---|
| *SAH-Historical* | *1.96%* | *4.14%* | |
| *CHI-FH Regional Hospitals* | *2.03%* | *5.09%* | |
| *Puget Sound Region* | *2.51%* | *6.05%* | |
| *SAH-Pro Forma* | | | *0.55%* |

*As evident by Table 1, both SAH and the CHl-FH regional hospitals are well below the Puget Sound Regional average for the 2012-2014 period. It is also apparent that SAH's forecasted rate of charity care (0.55%), provided in Exhibit 9 of its application, is significantly below the regional average (2.51 %). While SAH does not provide justification for why its historical charity care was below the regional average, it does comment on why its forecasted rate is so low:*

> *"Please note that the Department's charity care data is pre-Medicaid expansion. Since Medicaid expansion, system-wide our charity care has declined by more than 60% and by 78% at SAH. While we fully anticipate that our charity care will be at the Puget Sound Regional average, the amount we have included in our pro forma is not the 2012-2014 average, but rather reflects our current post-Medicaid expansion experience. "*

[source: MultiCare Health System public comment, p4]

*"Unfortunately, 2015 charity care data has yet to be released by the Department. However, in a recent CN decision in August 2016 regarding the question of what impact does the increase in healthcare coverage have on projected charity care for the purpose of CNs, the Department stated the following:*

> *"The Certificate of Need program recognizes that charity care in Washington State is expected to continue to decline as more individuals receive healthcare coverage under the ACA, but charity care is not expected to reach zero."*

*In the decision referenced above, the Department clearly did not agree with the applicant's (Tristate Memorial Hospital) low forecasted charity care rate (0.16%). Instead, the Department attached a condition that the project is required to continue its historical rate (1 .51 % of total revenue) into the future despite the recent expansion in healthcare coverage."* [source: MultiCare Health System public comment, p5]

*"Impact of Charity Care Revisions*
*While we believe the three-year regional average should remain the standard for all projects, we recognize alternatives may be appropriate as well that reflect recent CN decisions or other reasonable assumptions. In the case of SAH's project, we suggest the Department revises the charity care projections with any of the three following options (all percent of total revenue):*

1. *Puget Sound Regional Average for 2012-2014 (2.51 %)*
2. *SAH Average for 2012-2014 (1.96%)*
3. *Puget Sound Regional Average for CY2014 (1 .66%)*

*Option 1 above represents the standard that is consistent with how the Department has historically applied the charity care analysis in the past. Option 2 is an alternative that reflects the recent CN decision in August 2016 as applied to Tri-State Memorial Hospital in their ambulatory surgery center ("ASC") application. Option 3 is a novel alternative that continues in the same vein as the previous regional average standard, but shortens the analysis to only CY2014 to limit the gap between the previous regional average and the expected new set point that reflects recent healthcare expansions and associated drops in charity care. Table 2 below shows the findings from a sensitivity analysis of the alternative charity care projections simulated based the options discussed above."* [source: MultiCare Health System public comment, p5]

***Table 2 [of MultiCare Health System Public Comment]***
***Projected Charity Care by Option, 2016-2020***

| | | ***Charity Care ($,000)*** | | | | |
|---|---|---|---|---|---|---|
| | ***% Total Revenue*** | ***2016*** | ***2017*** | ***2018*** | ***2019*** | ***2020*** |
| ***Option 0: SAH Pro Forma*** | *0.55%* | *$ 3,329* | *$ 3,382* | *$ 3,438* | *$ 3,495* | *$ 3,554* |
| ***Option 1. Regional Average (2012-2014)*** | *2.51%* | *$ 15,244* | *$ 15,500* | *$ 15,506* | *$ 16,057* | *$ 16,347* |
| ***Option 2. SAH (2012-2014)*** | *1.96%* | *$ 11,904* | *$ 12,108* | *$ 12,319* | *$ 12,538* | *$ 12,765* |
| ***Option 3. Regional Average (2014)*** | *1.66%* | *$ 10,076* | *$ 10,248* | *$ 10,427* | *$ 10,613* | *$ 10,804* |

*"Based on findings from Table 2, SAH's forecasted charity care percentage of 0.55% is well below those projected regardless of which option it is compared against. The shortfall in SAH's projected charity care expenditures is millions of dollars in any forecast year under any of the options.*

***The goal of this public comment is not to argue against SAH's project as such, but where there are errors in the application, point them out, which under-forecasting charity care is***. [emphasis in original] *We encourage the Department to use a well-defined charity care standard, such as in the very recent Tri-State Memorial decision, noted above. We believe the findings presented above demonstrate that revisions should be made to the SAH financial projections, since they underestimate charity care expenditures, and overstate net income. We would also argue that if approved, the SAH CN request have a charity care condition included in the CN, as in the case of Tri-State Memorial's request."* [source: MultiCare Health System public comment, p6]

Rebuttal Comments

- *"CHI Franciscan and St. Anthony Hospital both enjoy a long and positive history of operating in conformance with Washington State charity care requirements.*
  *Under RCW 70.38.115(2)(j), Washington State hospitals are required to meet or exceed the regional average level of charity care. Each of CHI Franciscan's hospitals operates in full compliance with our Department of Health approved charity care policy. At SAH, due in part to both socioeconomics of the local community and the scope of services offered (Level IV ED, no Obstetrics, no pediatrics, no inpatient psych), our charity care—despite fully complying with our charity care policy—has been lower than that of other hospitals in the Puget Sound Region. Based on our actual experience, we projected future charity care at SAH to be approximately .67% of total revenue. MHS, in its public comment characterized our charity care calculations as "errors" sufficient enough that the CN Program should request that CHI Franciscan revise the financial forecast.*

  *CHI Franciscan finds these comments perplexing given the CN Program's consistent standard: in reviewing CN applications the CN Program first confirms that the Hospital operates with a Department of Health (Department) approved charity care policy, and then if the Hospital is operating below the calculated regional average, places a condition on the CN award requiring the hospital to use reasonable efforts to provide charity care at or above the regional average. MHS is well aware of this requirement because in at least five CN requests since 2011, the CN Program found that its applying hospital was below the regional average, and a condition was placed on the CN requiring that it (in this case, Mary Bridge): 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. Mary Bridge 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 Pierce County Region. A copy of the relevant pages from these recent MHS evaluations (included in Attachment 1) include:*

***Table A [of CHI Franciscan rebuttal comments]***
***MultiCare Certificate of Need Applications Submitted Wherein Its Charity Care Performance Was Below Regional Averages***

| ***Application*** | ***Evaluation Date*** | ***Charity Care (Above or Below Regional Average)*** | ***Outcome*** |
|---|---|---|---|
| *Mary Bridge –Add Pediatric Acute Care Beds* | *7/20/2012* | *Mary Bridge was below regional average.* | *Application approved. Charity care condition issued.* |
| *MHS –Tacoma General – Expanding Level III NICU Beds* | *3/28/2012* | *Tacoma General was below regional average.* | *Application approved. Charity care condition issued.* |
| *MHS Good Samaritan* | *12/5/2011* | *Good Sam was below regional average.* | *Application approved. Charity care condition issued.* |
| *MHS –Tacoma General – Expanding Level II NICU Beds* | *8/12/2011* | *Tacoma General was below regional average.* | *Application approved. Charity care condition issued.* |
| *Mary Bridge –Add Pediatric Acute Care Beds* | *3/15/2011* | *Mary Bridge was below regional average.* | *Application denied on need.* |

*Here, MHS is requesting the CN Program hold CHI Franciscan and SAH to a standard that the CN Program has not held other applicants to, including MHS.*

*Finally, we note for the record that charity care is one metric that the CN Program uses to determine compliance to access and availability to underserved populations. CHI-Franciscan has a 125 year legacy of providing access for all patients in the communities we serve, regardless of ability to pay and this is a practice we will proudly continue. If, as in the MHS approved decisions identified above, the CN Program determines it is appropriate to apply a condition related to providing charity care, CHI Franciscan is more than willing to accept such a condition."* [source: CHI Franciscan rebuttal comments, pp1-3]

Department Evaluation

CHI Franciscan has been providing healthcare services to the residents of King, Kitsap. and Pierce counties through its hospitals and medical clinics for many years. Healthcare services have been available to low-income, racial and ethnic minorities, handicapped and other underserved groups. [source: CHI Franciscan Health System website]

The Admission Policy describes the process CHI Franciscan uses to admit a patient into one of its hospitals and outlines rights and responsibilities for both CHI Franciscan and the patient. The Admission Policy includes language to ensure all patients would be admitted for treatment without regard to "*race, beliefs, age, ethnicity, religion, culture, language, physical or mental disability, socio-economic status, sex, sexual orientation, gender identity or expression and your ability to*

*pay for care. Be treated with dignity and respect including cultural and personal beliefs, values and preferences.*"

The Non-Discrimination Policy ensures that CHI Franciscan does not "*exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, religion, sexual orientation, physical , mental or other disability, economic status, citizenship, medical condition or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Franciscan Health System directly or through a contractor or any other entity with which Franciscan Health System arranges to carry out its programs and activities.*" The policy provides the process to be used to obtain assistance or disability services at any of the CHI Franciscan healthcare facilities.

For SAH, current Medicare revenues are approximately 48% of total revenues and CHI Franciscan anticipates a slight increase in the revenue percentages of Medicare if additional acute care beds are added. Additionally, financial data provided in the application shows Medicare revenues.

Focusing on Medicaid revenues, CHI Franciscan expects no change from the approximately 17% currently provided at SAH with the approval of 32 additional acute care beds. The financial data provided in the application also shows Medicaid revenues.

Commercial and other revenues are also expected to remain at essentially the same percentages with the additional 32 acute care beds.

The Uninsured/Underinsured Patient Discount Policy (Charity Care) provided in the application has been reviewed and approved by the Department of Health's Hospital/Finance and Charity Care (HFCC) Program. The policy outlines the process one would use to obtain financial assistance and is used in conjunction with the charity care policy. The policy was approved in January 2012 and has been updated since this application was submitted.[15]

The updated Financial Assistance Policy posted to the department's website has also been reviewed and approved by the Department of Health's HFCC Program. A comparison of the two policies reveals that they are the same, with the exception of references to Catholic Health Initiatives (CHI) rather than Franciscan Health System in some areas. The pro forma financial documents provided in the application include a charity care 'line item' as a deduction of revenue

Charity Care Percentage Requirement

For charity care reporting purposes, Washington State is divided into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. CHI Franciscan proposes additional acute care beds in Pierce County within the Puget Sound Region. Currently there are 19 hospitals operating within the region. Of the 19 hospitals, some did not report charity care data for years reviewed.[16]

[15] The policy recommends review every three years.

[16] For years 2013 and 2014, the following three hospitals did not report data: Forks Community Hospital in Forks; Whidbey General Hospital in Coupeville; and EvergreenHealth-Monroe [formerly Valley General Hospital, Monroe]. For years 2015, EvergreenHealth-Monroe did not report data. Additionally, in 2015, MultiCare Health System was late in reporting data for Auburn Medical Center Mary Bridge Children's Hospital, and Tacoma General/Allenmore. Charity care data for these three facilities were obtained from 2015 quarter reports.

Table 6 below compares the three-year historical average of charity care provided by the hospitals currently operating in the Puget Sound Region and SAH's historical charity care percentages for years 2012-2015. The table also compares the projected percentage of charity care. [source: Application, Exhibit 9 and HFCC Program's 2013-2015 charity care summaries]

**Table 6**
**Charity Care Percentage Comparisons**

| | Percentage of Total Revenue | Percentage of Adjusted Revenue |
|---|---|---|
| Puget Sound Region Historical Average | 1.87% | 4.70% |
| St. Anthony Hospital Historical Average | 1.36% | 3.03% |
| St. Anthony Hospital Projected Average | 0.55% | 1.60% |

As noted in Table 6 above, the three-year historical average shows SAH has been providing charity care below the regional average. For this project, CHI Franciscan projects that SAH would continue to provide charity care below the regional average.

CHI Franciscan has been providing health care services in central Pierce County for many years. SAH has been operational since March 2009. Charity care is health care provided through the hospital at no cost or reduced cost to low income patients. Charity care is a state-mandated and partially state-funded program that allows uninsured or underinsured people to receive inpatient and outpatient care at a reduced cost. Only people who meet certain income and asset criteria are eligible to receive charity care. Information provided in the application demonstrates that CHI Franciscan offers a variety of community outreach programs throughout Pierce and King counties. Outreach programs help offset costs for healthcare services in the communities, but it is not charity care and cannot be counted toward the percentage of charity care provided by a hospital under Certificate of Need rules.

The focus of this sub-criterion is charity care percentages specific to SAH. MultiCare Health System suggests different approaches to ensure SAH provides charity care at the regional average, rather than its projected percentage of 0.55% of gross revenues and 1.60% of adjusted revenues. Typically, the department does not change well-established practices during the course of a review without first notifying applicants of upcoming changes.[17] Without proper notification, a significant change in the way charity care percentages are calculated for an applicant during the review could be viewed as unfair.

In this case, the department would require SAH to provide charity care at a percentage consistent with the regional average.[18] CHI Franciscan must provide written agreement to the charity care condition stated below.

[17] One approach suggested by MultiCare Health System is to attach a condition similar to the condition attached to the August 4, 2016, ambulatory surgery center (ASC) project approved for Tri-State Memorial Hospital. There are significant differences between the Tri-State Memorial Hospital project and this acute care bed addition project proposed by CHI Franciscan. The circumstances that resulted in the department's charity care condition for the ASC project do not exist in this project.

[18] The condition related to the percentage of charity care and its impact on SAH's revenue and expense statement is addressed in the financial feasibility section of this evaluation.

St. Anthony Hospital will provide charity care in compliance with its charity care policies reviewed and approved by the Department of Health, or any subsequent policies reviewed and approved by the Department of Health. St. Anthony Hospital 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 Puget Sound Region. Currently, this amount is 1.87% gross revenue and 4.70% of adjusted revenue. St. Anthony Hospital will maintain records documenting the amount of charity care provided and demonstrating its compliance with its charity care policies.

Based on the information provided in the application and with CHI Franciscan's agreement to the condition, the department concludes t**his sub-criterion is met.**

*(3) The applicant has substantiated any of the following special needs and circumstances the proposed project is to serve.*

*(a) The special needs and circumstances of entities such as medical and other health professions schools, multidisciplinary clinics and specialty centers providing a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas.*

Department Evaluation
This sub-criterion is not applicable to this application.

*(b) The special needs and circumstances of biomedical and behavioral research projects designed to meet a national need and for which local conditions offer special advantages.*

Department Evaluation
This sub-criterion is not applicable to this application.

*(c) The special needs and circumstances of osteopathic hospitals and non-allopathic services.*

Department Evaluation
This sub-criterion is not applicable to this application.

*(4) The project will not have an adverse effect on health professional schools and training programs. The assessment of the conformance of a project with this criterion shall include consideration of:*

*(a) The effect of the means proposed for the delivery of health services on the clinical needs of health professional training programs in the area in which the services are to be provided.*

Department Evaluation
This sub-criterion is not applicable to this application.

*(b) If proposed health services are to be available in a limited number of facilities, the extent to which the health professions schools serving the area will have access to the services for training purposes.*

Department Evaluation
This sub-criterion is not applicable to this application.

*(5) The project is needed to meet the special needs and circumstances of enrolled members or reasonably anticipated new members of a health maintenance organization or proposed health maintenance organization and the services proposed are not available from nonhealth maintenance organization providers or other health maintenance organizations in a reasonable and cost-effective manner consistent with the basic method of operation of the health maintenance organization or proposed health maintenance organization.*

Department Evaluation
This sub-criterion is not applicable to this application.

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

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that CHI Franciscan met 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.*

WAC 246-310 does not contain specific WAC 246-310-220(1) financial feasibility criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what the operating revenues and expenses should be for a project of this type and size. Therefore, using its experience and expertise the department evaluates if the applicant's pro forma income statements reasonably project the proposed project is meeting its immediate and long-range capital and operating costs by the end of the third complete year of operation.

**CHI Franciscan**

The assumptions used by CHI Franciscan to determine the projected number of admissions, patient days, and occupancy of SAH are below. [source: Application, p9, p15, and p33]

- *The additional 32 beds would be licensed and operational by January 2018.*
- *Occupancy projections for calendar years 2018 through 2020 show 62.7%; 64.9% and 67.1% for the entire hospital with 112 acute care beds.*
- *SAH's average length of stay (ALOS) increased by 21% between years 2011 and 2015. For these projections, the ALOS is not expected to change from current (2015) of 4.3 days.*
- *SAH's average daily census [ADC] is projected at 70.2 in year 2018; 72.6 in year 2019; and 75.2 in year 2020.*
- *An annual inpatient growth rate of 3.5% was applied to the projected admissions and patient days for years 2016 through 2020. The growth rate is approximately one-half of the historical average annual growth rate for years 2011-2015.*
- *SAH is currently the largest provider of inpatient services to residents of the Gig Harbor Peninsula. The market share increased between 2009 and 2014. No market share increase was assumed.*

Using the assumptions stated above, CHI Franciscan projected the number of inpatient discharges, patient days, average length of stay, and occupancy percentages for SAH. The projections are shown in Table 7 on the following page. [source: Application, p33]

**Table 7**
**St. Anthony Hospital**
**Projections for Years 2016 through 2020**

| | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 |
|---|---|---|---|---|---|
| Total Licensed Beds | 80 | 80 | 112 | 112 | 112 |
| Total Discharges | 5,617 | 5,814 | 6,017 | 6,228 | 6,446 |
| Total Patient Days | 23,913 | 24,750 | 25,616 | 26,513 | 27,441 |
| Average Daily Census | 65.5 | 67.8 | 70.2 | 72.6 | 75.2 |
| Occupancy Percentages | 81.9% | 84.8% | 62.7% | 64.9% | 67.1% |

The assumptions CHI Franciscan used to project revenue, expenses, and net income for SAH for projection years 2018 through 2020 are below. [source: Application, p33, p41, and Exhibit 9]

- The hospital information includes both inpatient and outpatient revenues and expenses. The projections assume no changes in outpatient revenue.
- Payer mix is based on 2015 actuals and is expected to change slightly with the additional 32 beds. Current and projected hospital-wide payer mix is shown in Table 8 below.

**Table 8**
**Current and Projected Payer Mix**

| Revenue Source | Current 80 beds | Projected 112 beds |
|---|---|---|
| Medicare | 48.1% | 49.0% |
| Medicaid | 17.1% | 16.9% |
| Commercial | 29.3% | 28.7% |
| Other | 5.5% | 5.4% |
| **Total** | **100.0%** | **100.0%** |

- No inflation was assumed for gross revenues.
- Reimbursement percentages were based on actuals for 2015 and held constant throughout the projections years.
- Expenses include salaries and wages for FTEs.
- All costs associated with physician staffing are included.
- Expenses included a 'corporate services' line item which is allocated costs from CHI-Franciscan and CHI-National for information technology, accounting, human resources, legal, executive offices, patient financial services, and care management.
- Allocated costs for years 2018 through 2020 are approximately $14,350,000.

CHI Franciscan's projected revenue, expenses, and net income for SAH for projection years 2018 through 2020 are shown in Table 9 below. [source: Application, Exhibit 9 and August 12, 2016, screening responses, p2]

**Table 9**
**St. Anthony Hospital**
**Projected Years 2018 through 2020**

| | CY 2018 | CY 2019 | CY 2020 |
|---|---|---|---|
| Net Revenue | $ 146,475,000 | $ 149,170,000 | $ 151,962,000 |
| Total Expenses | $ 121,416,000 | $ 122,903,000 | $ 124,441,000 |
| **Net Profit / (Loss)** | $ 25,059,000 | $ 26,267,000 | $ 27,521,000 |

The 'Net Revenue' line item is gross inpatient and outpatient hospital revenue. The 'Total Expenses' line item includes all expenses related to hospital operations, including all staff salaries/wages and allocated costs from SAH to CHI Franciscan.

Public Comments
None

Rebuttal Comments
None

Department Evaluation
To evaluate this sub-criterion, the department first reviewed the assumptions used by CHI Franciscan to determine the projected number of admissions, patient days, and occupancy of SAH with 32 additional acute care beds. When compared to historical data [years 2014 and 2015] provided in the application, the department notes that overall admissions are expected to increase with the increase in beds. The occupancy percentages are expected to decrease in calendar year 2018 when the additional 32 beds are licensed and operational. In year 2018 – the first year of operation as a 112 bed hospital, SAH's projected occupancy is expected to be about 63%. By the end of year three (2020) SAH's occupancy is expected to increase to about 67%. After reviewing CHI Franciscan's admission and patient day assumptions for SAH, the department concludes they are reasonable.

CHI Franciscan based its revenue and expenses for SAH on the assumptions referenced above. CHI Franciscan also used its current operations as a base-line for the revenue and expenses shown in Table 9. Historical information shows that CHI Franciscan operates SAH at a profit. With an additional 32 medical/surgical beds, CHI Franciscan projected that SAH will continue operating at a profit.

In the 'need' section of this evaluation, the department discussed the low percentage of charity care projected at SAH and concluded that a charity care condition is necessary. The revenue and expense statement in Table 9 above is based on SAH's projections that charity care dollars and percentages would be below the regional average. Table 10 below shows the adjustments in charity care to be provided.

**Table 10**
**St. Anthony Hospital**
**Projected Charity Care Years 2018 through 2020**

| | CY 2018 | CY 2019 | CY 2020 |
|---|---|---|---|
| SAH Application | $ 3,438,000 | $ 3,495,000 | $ 3,554,000 |
| Department Calculation | $ 11,741,000 | $ 11,950,000 | $ 12,165,000 |
| **Increased Difference** | $ 8,303,000 | $ 8,455,000 | $ 8,611,000 |

As shown in Table 10 above, charity care dollars more than double based on the department's condition related to charity care percentages at SAH. Table 11 on the following page shows a recalculation of the SAH revenue and expense summary using the revised charity care dollars calculated in Table 10.

**Table 11**
**St. Anthony Hospital**
**Projected Years 2018 through 2020-Charity Care Revised**

| | CY 2018 | CY 2019 | CY 2020 |
|---|---|---|---|
| Net Revenue | $ 138,172,000 | $ 140,715,000 | $ 143,351,000 |
| Total Expenses | $ 121,416,000 | $ 122,903,000 | $ 124,441,000 |
| **Net Profit / (Loss)** | $ 16,756,000 | $ 17,812,000 | $ 18,910,000 |

As shown in Table 11 above, even with the increase in charity care dollars, SAH would operate at a profit as a 112-bed hospital.

To assist the department in its evaluation of this sub-criterion, staff from the Department of Health's HFCC Program [19] also provided a financial analysis. To determine whether CHI Franciscan would meet its immediate and long range capital costs, HFCC Program reviewed the 2015 historical balance sheet for SAH and the third year projected balance sheet for SAH. The information is shown in Table 12 below. [source: HFCC Program analysis, p2]

**Table 12**
**St. Anthony Hospital Balance Sheet for Year 2015**

| Assets | | Liabilities | |
|---|---|---|---|
| Current Assets | $ 66,391,000 | Current Liabilities | $ 9,920,000 |
| Board Designated Assets | $ 10,698,000 | Other Liabilities | $ 0 |
| Property/Plant/Equipment | $ 122,193,000 | Long Term Debt | $ 64,993,000 |
| Other Assets | $ 521,000 | **Equity** | **$ 124,890,000** |
| **Total Assets** | **$ 199,803,000** | **Total Liabilities and Equity** | **$ 199,803,000** |

**St. Anthony Hospital Balance Sheet for Year 2020**

| Assets | | Liabilities | |
|---|---|---|---|
| Current Assets | $ 206,888,000 | Current Liabilities | $ 12,732,000 |
| Board Designated Assets | $ 10,698,000 | Other Liabilities | $ 0 |
| Property/Plant/Equipment | $ 89,452,000 | Long Term Debt | $ 42,431,000 |
| Other Assets | $ 521,000 | **Equity** | **$ 252,396,000** |
| **Total Assets** | **$ 307,559,000** | **Total Liabilities and Equity** | **$ 307,559,000** |

After reviewing the balance sheet above, HFCC Program provided the following statement.

> *"St. Anthony's CN capital expenditure for the 32 acute care bed expansion is projected to be $15,601,740. The funding will come from existing reserves of CHI-West. …St. Anthony in 2015 and in the third year of the project balance sheet shows Board Designated Assets at the facility-level are not sufficient to fund this project, but the applicant stated that reserves of the parent entity, CHI Franciscan, would be used. A review of the parent organization's balance sheets indicate that it has the assets to fund this project from reserves."*

For hospital projects, HFCC Program provides a financial ratio analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios typically analyzed

[19] Effective July 1, 2016, the hospital financial and cost containment analyses are provided by the Hospital/Financial and Charity Care Program within the Department of Health's Office of Community Health Systems.

are **1)** long-term debt to equity; **2)** current assets to current liabilities; **3)** assets financed by liabilities; **4)** total operating expense to total operating revenue; and **5)** debt service coverage. Historical and projected balance sheet data is used in the analysis. SAH's 2015 balance sheet was used to review applicable ratios and pro forma financial information was used to review projected ratios. Table 13 below shows historical year 2015 and projected years 2018 through 2020. [source: HFCC Program analysis, p3]

**Table 13**
**Current and Projected Debt Ratios for St. Anthony Hospital**

| Category | Trend * | State 2015 | SAH 2015 | SAH 2018 | SAH 2019 | SAH 2020 |
|---|---|---|---|---|---|---|
| Long Term Debt to Equity | B | 0.533 | 0.520 | 0.262 | 0.211 | 0.168 |
| Current Assets/Current Liabilities | A | 2.701 | 6.693 | 11.869 | 14.095 | 16.249 |
| Assets Funded by Liabilities | B | 0.421 | 0.375 | 0.244 | 0.210 | 0.179 |
| Operating Expense/Operating Revenue | B | 0.948 | 0.837 | 0.8.29 | 0.824 | 0.819 |
| Debt Service Coverage | A | 5.048 | 4.842 | 5.161 | 5.272 | 5.387 |

| **Definitions:** | **Formula** |
|---|---|
| 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 expenses / operating revenue |
| Debt Service Coverage | Net Profit+Depr and Interest Exp/Current Mat. LTD and Interest Exp |

***** A is better is above the ratio; and B is better if below the ratio.

After reviewing the financial ratios above, staff from the HFCC Program noted that the current assets/current liabilities ratio is significantly higher than the 2015 average, and provided the following rationale and analysis.

> *"…very little debt is held at the hospital level. I note that the only debt carried on St. Anthony's balance sheet is notes and loans payable to parent. If there is little long-term debt, there isn't much to put into 'current portion of long term debt.' When looking at the other debt-related ratios, … St. Anthony is significantly better than the state average for those measures as well. A review of CHI's consolidated balance sheet gives ratios closer to the state averages. 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 above, the department concludes that the immediate and long-range operating costs of the project can be met. **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.*

WAC 246-310 does not contain specific WAC 246-310-220(2) financial feasibility criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what an unreasonable impact on costs and charges would be for a project of this type and size. Therefore, using its experience and expertise the department compared the proposed project's costs with those previously considered by the department.

CHI Franciscan

The capital expenditure associated with the addition of 32 acute care beds at SAH is $15,601,740. A breakdown of the capital expenditure is shown in Table 14 below. [source: Application, p35]

**Table 14**
**St. Anthony Hospital**
**Estimated Capital Expenditure Breakdown**

| Item | Cost |
|---|---|
| Construction Costs | $ 9,456,000 |
| Fixed Equipment | $ 729,000 |
| Moveable Equipment | $ 3,150,850 |
| Architect/Engineering/Consulting Fees | $ 927,976 |
| Other Costs: Permits/Fees/Signage | $ 127,656 |
| Sales Tax | $ 1,210,258 |
| **Total** | **$ 15,601,740** |

Since SAH is currently operational with 80 acute care beds, no start-up costs are required. CHI Franciscan provided a letter from 'Cumming' a contractor in Seattle attesting that the costs for construction, equipment, and fees identified above are reasonable. [source: Application, p35 and August 12, 2016, screening responses, Attachment 2]

CHI Franciscan stated that no changes in costs or charges for acute care services at SAH are anticipated. [source: Application, p36]

Public Comments

None

Rebuttal Comments

None

Department Evaluation

CHI Franciscan provided a letter from a contractor, attesting that the construction estimate within the application is reasonable. CHI Franciscan confirmed that SAH would continue full operations during the construction required to add 32 beds. As a result, no start-up costs are required.

In the financial review, HFCC Program confirmed that the rates proposed by CHI Franciscan for SAH are similar to Washington statewide averages. [source: HFCC Program analysis p3]

CHI Franciscan stated under WAC 246-310-220(1) that the payer mix is not expected to significantly change with the additional beds at SAH. Further, CHI Franciscan stated that all assumptions related to costs and charges are based on current rates at SAH with no proposed changes.

Based on the above information, the department concludes that the addition of 32 acute care beds at SAH would probably not have an unreasonable impact on the costs and charges for healthcare services in Pierce County. **This sub-criterion is met.**

*(3) The project can be appropriately financed.*

WAC 246-310 does not contain specific source of financing criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how a project of this type and size should be financed. Therefore, using its experience and expertise the department compared the proposed project's source of financing to those previously considered by the department.

CHI Franciscan

The capital expenditure associated with the addition of 32 acute care beds at SAH is $15,601,740. [source: Application, p35]

CHI Franciscan intends to fund the project using cash reserves and provided a letter of financial commitment from the CHI Franciscan's chief financial officer. In addition to the financial commitment letter, CHI Franciscan provided its audited financial statements for fiscal years 2013 and 2014 to demonstrate it has sufficient reserves to finance the project. [source: Application, Exhibit 8 and Appendix 1]

Public Comments

None

Rebuttal Comments

None

Department Evaluation

After reviewing the balance sheet, the HFCC Program concluded that SAH's board designated assets are not sufficient to fund the $15,601,740 required for this project. CHI Franciscan, the parent of SAH, intends to fund the project. The HFCC Program reviewed SAH's parent organization's balance sheets and concluded that it has the assets to fund this project from reserves. [source: HFCCP analysis, p2]

If this project is approved, the department would attach a condition requiring CHI Franciscan to finance the project consistent with the financing description in the application. With the financing condition, the department concludes **this sub-criterion is met.**

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

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that CHI Franciscan Health met 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.*

WAC 246-310 does not contain specific WAC 246-310-230(1) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what specific staffing patterns or numbers of FTEs that should be employed for projects of this type or size. Therefore, using its experience and expertise the department concludes that the planning would allow for the required coverage.

CHI Franciscan

SAH currently provides acute care services with 80 licensed beds. With the addition of 32 acute care beds, SAH would be licensed and operating as a 112-bed acute care hospital beginning in January 2018. [source: Application, p8 and p15]

Table 15 below provides a breakdown of current and projected FTEs [full time equivalents] for the hospital. Current year is 2015. Projected years begin with 2016 through 2020, which is the third year following completion of this project. [source: Application, p42]

**Table 15**
**St. Anthony Hospital**
**Current and Proposed FTEs for Years 2015-2020**

| FTE by Type | CY 2015 Current | CY 2016 Increase | CY 2017 Increase | CY 2018 Increase | CY 2019 Increase | CY 2020 Increase | Total FTEs |
|---|---|---|---|---|---|---|---|
| Nursing FTEs | 176.1 | 5.2 | 5.4 | 6.6 | 5.8 | 6.0 | **205.1** |
| Ancillary/Support FTEs | 316.0 | 4.1 | 4.3 | 4.4 | 4.6 | 4.7 | **338.1** |
| **Total FTEs** | **492.1** | **9.3** | **9.7** | **11.0** | **10.4** | **10.7** | **543.2** |

CHI Franciscan provided the following description of the FTEs referenced in the table.

- Nursing FTEs = nursing managers, RNs, patient care assistants, and support staff
- Ancillary/Support FTEs = ancillary/support managers, RNs, patient care assistants, technicians, and support staff

[source: Application, p42]

In addition to the table above, CHI Franciscan provided the following statements related to this sub-criterion. [source: Application, pp43-44]

*"For an organization the size of CHI Franciscan and because this project proposes an expansion of an existing facility, the staffing needs noted in Table 14 are relatively small. In an effort to assure that we always have the staff needed to support our existing and proposed new programs, CHI Franciscan offers a competitive wage and benefit package as well as numerous other recruitment and retention strategies.*

- *CHI Franciscan offers, and will continue to offer, a generous benefit package for both full and part time employees that includes: Medical, Dental, Paid Time Off/Extended Illness/Injury Time, Employee Assistance Plans, and a Tuition Reimbursement Program, among other benefits.*

- *CHI Franciscan posts all of its openings on our website via our online applicant tracking system. In addition to our own website, FHS has agreements with several job boards including Indeed.com, Health-e-Careers, and Washington HealthCare News to name a few.*

- *CHI Franciscan currently has contracts with more than 40 technical colleges, community colleges, and four year universities throughout the United States that enable us to offer either training and/or job opportunities. In addition, CHI Franciscan Education Services staff serves on healthcare program advisory boards and as clinical or affiliate faculty at a number of local institutions. FHS constantly monitors the "wage" market, making adjustments as necessary to ensure that our hospitals' wage structures remains competitive.*

- *In partnership with Pierce County Health Careers Council, CHI Franciscan provides a career counselor who is available to all staff to encourage development and growth within*

*the healthcare industry. This is further supported through a tuition reimbursement program and referrals to state and federal funds for continuing education. In addition, the Franciscan Foundation has annual scholarships available for current employees to advance their education.*

- *CHI Franciscan's various facilities serve as clinical training sites for healthcare specialties such as nursing, diagnostic imaging, physical/occupational therapy, and pharmacy, (to name a few).*
- *CHI Franciscan also offers various other recruitment strategies (i.e., nursing new grad events, nursing school class visits, job fairs, career days, direct e- mail campaigns, etc.) as other ways to bring new healthcare workers to the FHS organization.*
- *CHI Franciscan works closely with agency personnel, not only to negotiate rates but to also ensure that agency staff is able to provide the same high quality skill level that CHI Franciscan requires of our own employees.*
- *CHI Franciscan recruiters regularly attend local job fairs that reach targeted applicants within the greater Puget Sound area. These efforts have been extremely effective due, in large part, to the outstanding reputation CHI Franciscan has garnered as being an employer of choice due to our "Best Place to Work" initiatives.*

*As a result of the above efforts, the average vacancy rate of CHI Franciscan is at only 7.3% today. SAH's is even lower, at 2.2%. With the above, SAH has demonstrated that it has the necessary infrastructure in place to recruit the additional staff needed for this project."*

Public Comments
None

Rebuttal Comments
None

Department Evaluation
SAH is currently operational with 80 acute care beds. In year 2018, the additional 32 acute care beds are expected to become operational, for a facility total of 112 acute care beds. Under this timeline, full calendar year one is 2018 and full year three is 2020. Staffing for SAH is based on the projected occupancy of 62.7% in year one; 64.9% in year two; and 67.1% in year three. As noted in Table 15, CHI Franciscan intends to increase FTEs proportionately with the increased occupancy of SAH. For years 2018 through 2020, an additional 30 FTEs would be needed at SAH. Key staff for the hospital is already in place.

CHI Franciscan intends to use the strategies for recruitment and retention of staff it has successfully used in the past to staff this project. The strategies identified by CHI Franciscan are consistent with those of other applicants reviewed and approved by the department.

Information provided in the application demonstrates that CHI Franciscan is a well-established provider of healthcare services in King, Kitsap, and Pierce counties. Specific to SAH, it has been part of CHI Franciscan since its opening in March 2009. Based on the above information, the department concludes that CHI Franciscan has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project. **This sub-criterion is met.**

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

WAC 246-310 does not contain specific WAC 246-310-230(2) criteria as identified in WAC 246-310-200(2)(a)(i). There are known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that a facility must meet when it is to be Medicare certified and Medicaid eligible. Therefore, using its experience and expertise the department assessed the applicant's ability to establish and maintain appropriate relationships.

CHI Franciscan

CHI Franciscan provided the following statements related to this sub-criterion. [source: Application, pp44]

> *"SAH has determined that existing hospital support departments will be more than adequate to meet the additional demands resulting from the 32 bed addition. In fact, when SAH was originally designed, it was envisioned that it would be a 112 bed facility. Therefore, the ancillary and support departments are more than adequate to support the additional 32 beds."*

CHI Franciscan provided a list of services currently provided on-site at SAH, services that are provided by CHI Franciscan or an affiliate, and services that are provided under contract by an entity other than CHI Franciscan or an affiliate. [source: August 12, 2016, screening responses, pp4-5]

| ***Services provided on site*** | ***Services provided by FHS or Affiliate*** | ***Services provided under contract with an entity other than FHS or Affiliate*** |
|---|---|---|
| *SAH Imaging Services* | *Franciscan Medical Group (clinics)* | *Lithotripsy* |
| *SAH Physical Therapy* | *Accounting* | *Blood bank* |
| *Interventional Radiology* | *Risk Management* | *Pathology* |
| *Laboratory Services* | *Revenue Cycle* | *Anesthesia* |
| *Mammography* | *Dialysis* | *Wound care* |
| *Palliative Care* | *Legal Services* | *Sleep center* |
| *Pharmacy* | *Medical Affairs* | *Occupational Therapy* |
| *Spiritual Care* | *Patient Access* | *Speech therapy* |
| *Support Groups* | | *Oncology* |
| | | *Neurology* |
| | | *Radiology* |
| | | *Interpretation Services* |
| | | *Emergency Physicians (Team Health)* |

Public Comments

None

Rebuttal Comments

None

Department Evaluation

CHI Franciscan has been providing acute care services at SAH in Gig Harbor since March 2009 and all ancillary and support services are already in place. This project proposes the addition of 32

medical-surgical beds on the fifth floor. CHI Franciscan does not expect the existing ancillary and support services to change with the added beds.

Based on the information reviewed in the application, the department concludes that there is reasonable assurance that CHI Franciscan will continue to maintain the necessary relationships with ancillary and support services with additional 32 beds at SAH. The department concludes that approval of 32 acute care beds at SAH would not negatively affect existing healthcare 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.*
WAC 246-310 does not contain specific WAC 246-310-230(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that a facility must meet when it is to be Medicare certified and Medicaid eligible. Therefore, using its experience and expertise the department assessed the applicant's history in meeting these standards at other facilities owned or operated by the applicant.

CHI Franciscan
CHI Franciscan provided the following statements related to this sub-criterion. [source: Application, p46]

> *"Neither CHI Franciscan nor SAH have any history with respect to the actions noted in Certificate of Need regulations WAC 248-19-390(5) (a) (now WAC 246-310-230). SAH operates all of its programs in conformance with applicable federal laws, rules and regulations."*

Public Comments
None

Rebuttal Comments
None

Department Evaluation
As part of this review, the department must conclude that the proposed services provided by an applicant would be provided in a manner that ensures safe and adequate care to the public.[20] To accomplish this task, the department reviewed the quality of care compliance history for all healthcare facilities owned, operated, or managed by CHI Franciscan or its subsidiaries.

CHI Franciscan Health System is part of Catholic Health Initiatives (CHI), which is one of the largest not-for-profit healthcare systems in the United States. CHI operates several healthcare facilities and services nationwide through a number of subsidiaries. Its Washington facilities are operated under the CHI Franciscan Health subsidiary. [sources: Application, p1 and Exhibit 1]

Washington Facilities
The eight hospitals owned or operated by CHI Franciscan include Harrison Medical Center in Bremerton and Silverdale, Highline Medical Center in Burien, Regional Hospital located in Burien,

[20] WAC 246-310-230(5).

St Anthony Hospital located in Gig Harbor, St Clare Hospital located in Lakewood, St Elizabeth Hospital located in Enumclaw, St Francis Community Hospital located in Federal Way, and St Joseph Medical Center located in Tacoma.

Seven of the eight hospitals are accredited by the Joint Commission.[21] Highline Medical Center and St Joseph Medical Center have additional advanced certification as Primary Stroke Centers. [source: Joint Commission website, CN historical files]

In addition to the eight hospitals, department also reviewed the compliance history for the six dialysis centers, two ambulatory surgery centers,[22] hospice care center, and hospice agency owned and operated by CHI Franciscan. With the exception of one dialysis center, all CHI Franciscan facilities are operational.[23] Using its own internal database, the survey data showed that more than 25 surveys have been conducted and completed by Washington State surveyors since year 2011. All surveys resulted in no significant non-compliance issues. [source: ILRS survey data and Department of Health Investigations and Inspections Office]

Other States

In addition to a review of all Washington State facilities owned and operated by CHI Franciscan, the department also examined a sample of CHI facilities nationwide. According to information in the application and its website, CHI operates healthcare facilities in 19 states. The department reviewed information from the licensing authorities for each of the facilities listed below, and concluded that these facilities are substantially compliant with state licensure and Medicare conditions of participation. The department did not identify facility closures or decertification.

**Table 16**
**CHI Rehabilitation Hospitals**

| Hospital Name | Location | Joint Commission Accredited? |
|---|---|---|
| St Vincent Rehabilitation Hospital | Sherwood, AR | yes |
| St Anthony Hospital | Lakewood, CO | yes |
| Jewish Hospital | Louisville, KY | yes |
| CHI Mercy Hospital | Devils Lake, ND | yes |
| Good Samaritan Hospital | Dayton, OH | yes |
| CHI Mercy Medical Center | Roseburg, OR | yes |
| CHI Memorial | Chattanooga, TN | yes |
| CHI St Luke's Heath Memorial | Lufkin, TX | yes |

[sources: February 1, 2016 screening response Attachment 11, Joint Commission website]

Based on the above information, the department concludes that CHI Franciscan demonstrated reasonable assurance that SAH would continue to operate in compliance with state and federal requirements if this project is approved. **This sub criterion is met.**

[21] Harrison Medical Center is accredited through year 2016, Highline Medical Center through 2016, Regional Hospital through 2018, St Anthony Hospital through 2018, St Clare Hospital through 2017, St Francis Community Hospital through 2017, and St Joseph Medical Center through 2017. St Elizabeth Hospital does not hold Joint Commission accreditation.

[22] Gig Harbor Ambulatory Surgery Center is operated under St. Joseph Medical Center's hospital license and Franciscan Endoscopy Center is operated under the St. Francis Hospital license.

[23] Franciscan Bonney Lake Dialysis Center is not yet operational.

*(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.*

WAC 246-310 does not contain specific WAC 246-310-230(4) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how to measure unwarranted fragmentation of services or what types of relationships with a services area's existing health care system should be for a project of this type and size. Therefore, using its experience and expertise the department assessed the materials in the application.

CHI Franciscan

CHI Franciscan provided the following statements related to this review criteria. [source: Application, p45]

> *"The additional acute care beds will greatly assist SAH in promoting continuity of care. As discussed in the Need Section [of the application], SAH's increasing inpatient utilization is impacting its ability to promote timely access to inpatient services. The additional beds will enhance SAH's ability to serve the community. Additionally, it will allow SAH to be more responsive to all of the patients presenting in the ED and in need of an inpatient bed."*

Public Comments

The department received 14 letters of support for this project. Many of the letters provided general support for SAH's bed addition. Some of the letters focused on the importance of SAH operating an adequate number of bed for the community. Below are excerpts of statements related to this sub-criterion.

- *The addition of a new hospital has been a huge gain for our community in terms of access to healthcare. Residents are no longer leaving the Gig Harbor area for inpatient services, emergency services, outpatient services (surgery, physical therapy, occupational therapy, to name a few), and diagnostic services (MRI, CT, ultrasound and mammography).* [source: Jill Guernsey, Mayor of Gig Harbor public comment, p1]

- *A number of years ago, before St. Anthony was built, I was employed as a medical social worker at St. Joseph Hospital in Tacoma. Many times I observed the inconvenience and hardships for patients and families who needed health care, but who lived on the Olympia Peninsula. Without a doubt, St. Anthony Hospital serves a great need to all in our community.* [source: Barbara Beson, Gig Harbor resident public comment, p1]

- *I take care of mostly elderly patients in the Gig Harbor and surrounding Kitsap communities. My patients are especially appreciative of having a hospital right in there backyard and additional beds would be very beneficial. Gig Harbor has also seen tremendous growth, this includes new retirement communities like "Heron's Key" which will bring a new older and higher risk population. Having more bed capacity in St. Anthony also decreases transfers to other tertiary hospitals and lets care stay local - closer to families and support of the patients. This closer access to support does benefit overall cost of ca re for patient and the community.* [source: Francis Meraco, MD, Franciscan Medical Group & Rainier Health Network public comment, p1]

- *As a Cardiac patient of SAH, I experienced first hand the stress on family members, who endured the worry and frustration following me to another facility in Tacoma, due to the limited capacity in Gig Harbor. I am aware of how important a continuum of care is to a patient's emotional and physical health and I believe the expansion at SAH will make a very positive difference in our community.* [source: Richard Larson public comment, p1

- *Gig Harbor is growing rapidly and it is essential that the additional beds become available. It is stressful for both family and hospital staff to be unable to place a person in a bed when needed. Being moved to another hospital should not be an option due to additional trauma to the patient. It would also reduce the use of ambulances to transport patients to other facilities. Family members have lived in Gig Harbor for over 23 years, and the opening of St. Anthony's Hospital was considered a major improvement to the quality of life. It has also been a driving force to people retiring to Gig Harbor. Keeping patient care local is essential.* [source: Christine Peterson, St. Anthony Patient Family Advisory Council public comment, p1]

- *The need will greatly increase when the Heron's Key retirement community opens in a few months. SAH is about 2 miles from Heron's Key, which is reported to be the largest building project in WA state at present. The 350 new residents will increase the health care need in this area. In addition, in the past year, there has been a literal explosion of residential home building in our immediate area. We strongly support the proposed expansion by building out the fifth floor. We are thankful that the State had the foresight to allow the unfinished shell to be part of the building. We ask that the* ***certificate of need*** *be expedited so that the needed expansion can be finished quickly.* [source: Thomas & Judith Wagner public comment, p1]

- *I am the state Senator for the 25th district and have been involved with the building of this hospital since its inception. This hospital is an important asset to our community and is immensely used by the citizens of our neighboring areas. It is now time for this expansion to keep providing patients with a local facility versus having to leave the community for care when our hospital is full. It reduces travel time by ambulance for the same reason and this expansion will create additional jobs in the Gig Harbor area. We need to reduce extended stays in the Emergency Department waiting for an inpatient bed and provide improved access to Intensive Care beds by creating additional capacity. Our hospital is at capacity and it is now time to implement Phase II.* [source: Legislative District #26 Senator Jan Angel public comment, p1]

- *We partner together with Saint Anthony Hospital to support the health and safety of our community. We believe the SAH addition would improve access to inpatient services and support the continuity of care by keeping our citizen/patients local. The expansion would likely reduce the time that our medic units are involved in moving patients to alternative facilities when SAH is full, keeping our units in service locally to better serve our citizens.* [source: Danette Weyn, Gig Harbor Fire & Medic One public comment, p1]

Rebuttal Comments
None

Department Evaluation
The letters sent by Gig Harbor Fire and Medic One, Franciscan Medical Group, and St. Anthony Patient Advisory Council provide valuable perspectives related to this sub-criterion. The excerpts above demonstrate the importance of SAH's availability to accept emergent patients during transport or referral by law enforcement.

The letters sent by Key Peninsula residents or community members also provide an important perspective. Short travel and local convenience for patients and their families are important considerations for them.

Information in the application demonstrates that as a long-time provider of acute care services, SAH has the basic infrastructure in place to expand its beds and services.

As the only acute care hospital in Gig Harbor and with its Level IV adult trauma designation, patients come to SAH with a variety of diagnoses and acuities. The additional acute care beds will allow SAH to continue to provide the necessary care to these patients with co-morbidities. SAH also holds accreditation with Joint Commission which also requires referral relationships to ensure a continuum of care necessary for patients.

Based on the information provided in the application, the department concludes there is reasonable assurance that this project will continue to promote continuity in the provision of health care services in the community with additional medical/surgical beds at SAH. **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 met**.

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

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that CHI Franciscan Health **met** 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.*

To determine if a proposed project is the best alternative, in terms of cost, efficiency, or effectiveness, the department takes a multi-step approach. First the department determines if the application has met the other criteria of WAC 246-310-210 thru 230. If the project has failed to meet one or more of these criteria then the project cannot be considered to be the best alternative in terms of cost, efficiency, or effectiveness as a result the application would fail this sub-criterion.

If the project has met the applicable criteria in WAC 246-310-210 through 230 criteria, the department then assesses the other options considered by the applicant. If the department determines the proposed project is better or equal to other options considered by the applicant and the department has not identified any other better options this criterion is determined to be met unless there are multiple applications.

If there are multiple applications, the department's assessment is to apply any service or facility superiority criteria contained throughout WAC 246-310 related to the specific project type. The adopted superiority criteria are objective measures used to compare competing projects and make the determination between two or more approvable projects which is the best alternative. If WAC 246-310 does not contain any service or facility type superiority criteria as directed by WAC 246-

310-200(2) (a)(i), then the department would look to WAC 246-310-240(2)(a)(ii) and (b) for criteria to make the assessment of the competing proposals. If there are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b), then using its experience and expertise, the department would assess the competing projects and determine which project should be approved.

CHI Franciscan

Step One

For this project, CHI Franciscan met the applicable review criteria under WAC 246-310-210, 220, and 230. Therefore, the department moves to step two below.

Step Two

Before submitting this application, CHI Franciscan considered two options. The options and CHI Franciscan's rationale for rejecting them is below. [source: Application, p48 and August 12, 2016, screening responses, p5]

- *Do Nothing*
  *"As noted in the application, not doing the application was never seriously considered. When SAH was designed, the design included 112 beds. In fact, as the CN Program is aware, the initial CN application requested approval for a new 112 bed hospital even though the CN was only approved for 80 beds; the full capital expenditure was approved and FHS was allowed to construct the space for all 112 beds. Given the census pressures, the ability to add 32 beds at a relatively low capital cost (significant construction is not required); the option of 'not doing the project' was eliminated as an alternative."*

- *Build Out Space on Fifth Floor for Observation / Outpatient Space*
  *"The only alternative to adding the beds that CHI Franciscan considered was developing the space on the 5th as observation/outpatient beds. The benefit of this alternative is that no prior CN review is required (because the beds are not added to the license), and therefore this project could be undertaken and completed more quickly. The significant downside to this alternative is that, in reality, observation is a billing classification, not a clinical designation. Increasingly, the determination as to whether a specific patient's status is observation or inpatient is often not made until post discharge. This means that the patient needs to be in a licensed inpatient bed so that in the event they are deemed inpatient for billing purposes, reimbursement for the care is not denied due to the status of the bed. The capital and staffing costs are not considerably less, because it is highly likely that the unit would operate 24/7, just like an inpatient unit. Further, in a relatively small hospital (112 beds) flexibility is needed for peak census times. Having all 112 beds licensed will assure we have the flexibility to meet patient demand."*

Step Three

This step is applicable only when there are two or more approvable projects. CHI Franciscan's application is the only application under review to add acute care beds in central Pierce County. Therefore, this step does not apply.

Public Comments

None

Rebuttal Comments
None

Department Evaluation
Information provided in the CHI Franciscan application and within public comments demonstrates that there is need for additional acute bed capacity in central Pierce County. The public comments related to lack of bed capacity supports that a "do nothing" option was appropriately ruled out by the applicant.

CHI Franciscan expects some of its inpatient services at SAH to experience growth in upcoming years. When constructed, CHI Franciscan designed SAH to accommodate a total of 112 acute care beds. Once it was determined that additional acute care bed capacity needed to be added to the planning area, CHI Franciscan concluded that it should add the additional 32 beds proposed in its initial application submitted in 2003. The department's methodology was based on most recent utilization data [2006-2015] and demonstrated that the addition of 32 beds is reasonable in the central Pierce planning area.

The department did not identify any alternative that was a superior alternative in terms of cost, efficiency, or effectiveness that is available or practicable.

Taking into account the public comments related to need for additional acute care beds at SAH and the options considered by CHI Franciscan, the department concurs that a 32-bed expansion at SAH is reasonable and the best available option for the planning area and surrounding communities. **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;*

CHI Franciscan
This project involves completion of shelled in space on the 5th floor of SAH. The initial approval in 2003 included the costs to shell this space. CHI Franciscan states that "*capital costs for both design and construction will be minimized because we are not constructing new space, simply completing an existing shell.*" [source: Application, p49]

Public Comments
None

Rebuttal Comments
None

Department Evaluation
As part of its analysis, HFCC provided the following statements regarding the construction costs, scope, and method:

"*The costs of the project are the cost for construction, planning and process. St. Anthony's projections are below."*

| | |
|---|---|
| Total Capital | $15,601,740 |
| Beds/Stations/Other (Unit) | 32 |
| Total Capital per Unit | $487,554 |

*"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. St. Anthony is building out existing shelled space and will construct facility to the latest energy and hospital standards. Staff is satisfied the applicant plans are appropriate."* [source: HFCC analysis, p5]

Based on the information provided in the application, the demonstrated need for additional acute care beds at SAH, and the analysis from HFCC, the department concludes **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.*

**CHI Franciscan**
CHI states that this project allows for the ability to add 32 beds at a relatively low capital cost because significant construction is not required. [source: August 12, 2016, screening responses, p5]

Public Comments
None

Rebuttal Comments
None

Department Evaluation
As part of its analysis, HFCC provided the following statements related to this sub-criterion.

*"Staff is satisfied that adding 32 acute care beds servicing a bed need area which has bed need and where the population is growing in number will not have an unreasonable impact of the costs and charges to the public of providing services by other persons. Staff is satisfied the project is appropriate and needed."*

This project involves construction by completing shelled-in space at SAH. With need for additional acute care beds at SAH and the assumptions related to the costs and charges discussed under the Financial Feasibility section of this evaluation, the department does not anticipate this project would have an unreasonable impact on the costs and charges to the public. Therefore, the department concludes **this sub-criterion is 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.*

CHI Franciscan Health
CHI Franciscan asserts that the addition of 32 acute care beds to SAH would improve the delivery of health services to central Pierce County and surrounding communities. This rationale is primarily based on the current out-migration of central Pierce County patients that is anticipated to continue without the additional beds at SAH.

Public Comments
None

Rebuttal Comments
None

Department Evaluation
This project has the potential to improve delivery of acute care services to the residents of central Pierce County and surrounding communities with the addition of 32 beds to SAH. The department is satisfied the project is appropriate and needed. **This sub-criterion is met.**

# APPENDIX A

| 2006-2015 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **10-YEAR TOTAL** |
| **HSA #1** | 1,190,838 | 1,236,804 | 1,283,791 | 1,278,317 | 1,272,789 | 1,298,227 | 1,282,023 | 1,300,706 | 1,339,663 | 1,406,654 | **12,889,812** |
| | | | | | | | | | | | **0** |
| **STATEWIDE TOTAL** | **1,938,280** | **1,999,882** | **2,069,175** | **2,065,777** | **2,055,241** | **2,068,011** | **2,054,931** | **2,067,274** | **2,116,496** | 2,210,893 | **20,645,960** |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| 2000-2010 CHARS | | | | | | | | | | | |
| MDC 15 - newborn and other neonates excluded | | | | | | | | | | | |
| MDC 19 - mental diseases and disorders excluded | | | | | | | | | | | |
| Rehabilitiation excluded | | | | | | | | | | | |

| 2006-2015 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 10-YEAR TOTAL |
| HSA #1 | 1,190,838 | 1,236,804 | 1,283,791 | 1,278,317 | 1,272,789 | 1,298,227 | 1,282,023 | 1,300,706 | 1,339,663 | 1,406,654 | **12,889,812** |
| STATEWIDE TOTAL | 1,938,280 | 1,999,882 | 2,069,175 | 2,065,777 | 2,055,241 | 2,068,011 | 2,054,931 | 2,067,274 | 2,116,496 | 2,210,893 | **20,645,960** |

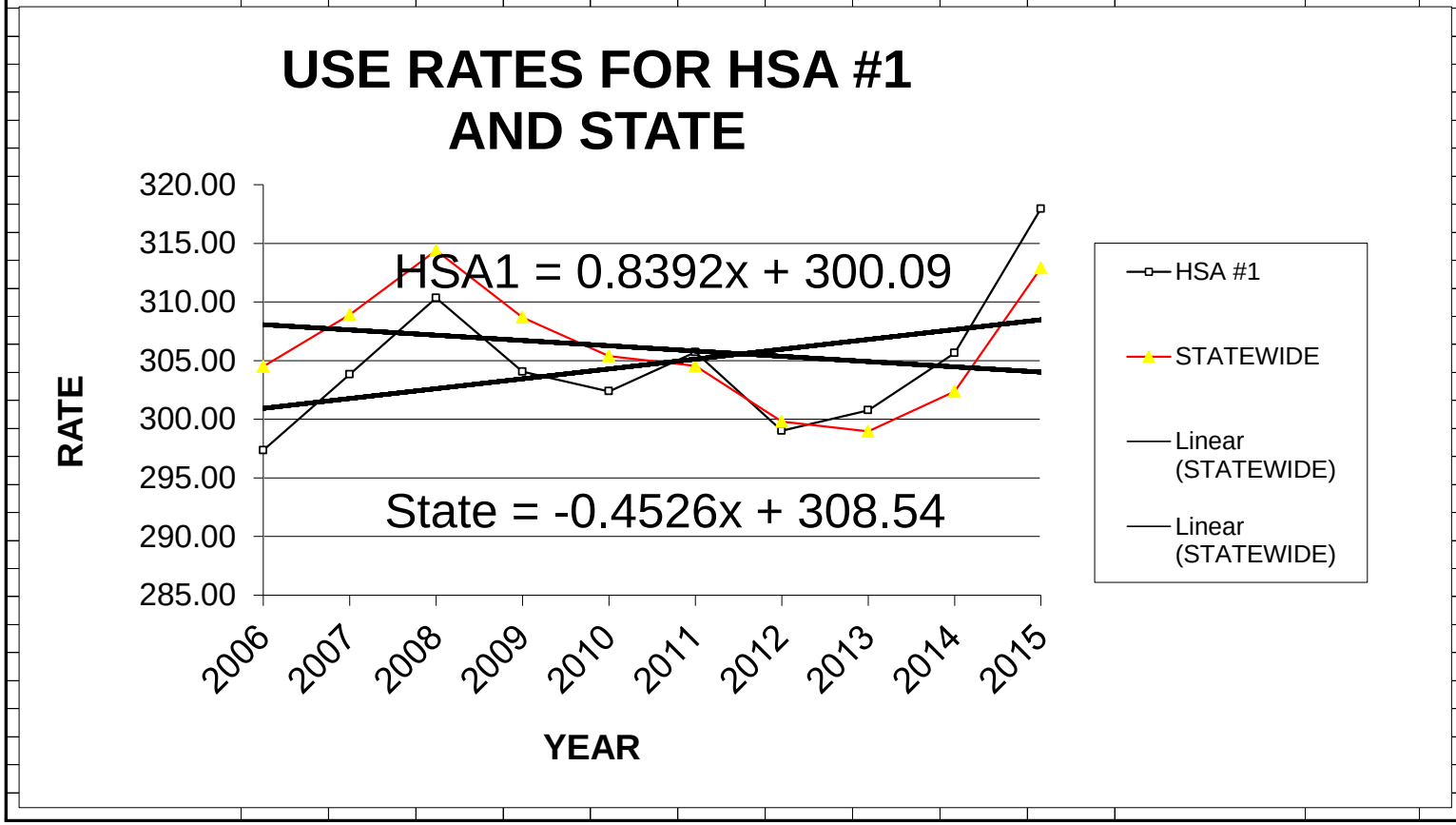
| 2005-2016 HSA TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 10-YEAR TOTAL |
| HSA #1 | 508 | 781 | 1,067 | 1,826 | 1,392 | 1,639 | 2,911 | 3,104 | 9,804 | 11,700 | **34,732** |
| STATEWIDE TOTAL | **618** | **930** | **1,152** | **2,129** | **1,571** | **1,916** | **3,189** | **3,413** | **11,129** | **13,630** | **39,677** |

**HSA #1 Hospitals include: BHC Fairfax in Kirkland, Cascade Behavioral Health in Tukwila, West Seattle Psych Hospital in Seattle, and Puget Sound Behavioral Health in Tacoma**

| 2005-2016 HSA TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 10-YEAR TOTAL |
| HSA #1 | 1,190,330 | 1,236,023 | 1,282,724 | 1,276,491 | 1,271,397 | 1,296,588 | 1,279,112 | 1,297,602 | 1,329,859 | 1,394,954 | **12,855,080** |
| STATEWIDE TOTAL | **1,937,662** | **1,998,952** | **2,068,023** | **2,063,648** | **2,053,670** | **2,066,095** | **2,051,742** | **2,063,861** | **2,105,367** | **2,197,263** | **20,606,283** |

| 2006-2015 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS MINUS PSYCH DAYS | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 10-YEAR TOTAL | |
| HSA #1 | 1,190,330 | 1,236,023 | 1,282,724 | 1,276,491 | 1,271,397 | 1,296,588 | 1,279,112 | 1,297,602 | 1,329,859 | 1,394,954 | **12,855,080** | |
| STATEWIDE TOTAL | **1,937,662** | **1,998,952** | **2,068,023** | **2,063,648** | **2,053,670** | **2,066,095** | **2,051,742** | **2,063,861** | **2,105,367** | **2,197,263** | **20,606,283** | |
| TOTAL POPULATIONS | | | | | | | | | | | | |
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 10-YEAR TOTAL | |
| HSA #1 | 4,003,059 | 4,068,118 | 4,133,178 | 4,198,237 | 4,204,534 | 4,241,101 | 4,277,669 | 4,314,236 | 4,350,804 | 4,387,371 | **42,178,307** | |
| STATEWIDE TOTAL | **6,363,584** | **6,470,767** | **6,577,951** | **6,685,134** | **6,724,540** | **6,784,072** | **6,843,604** | **6,903,136** | **6,962,668** | **7,022,200** | **67,337,656** | |
| USE RATE PER 1,000 | | | | | | | | | | | | |
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 10-YEAR TOTAL | |
| HSA #1 | 297.36 | 303.83 | 310.35 | 304.05 | 302.39 | 305.72 | 299.02 | 300.77 | 305.66 | 317.95 | **3,047** | |
| STATEWIDE | **304.49** | **308.92** | **314.39** | **308.69** | **305.40** | **304.55** | **299.80** | **298.97** | **302.38** | **312.90** | **3,061** | |

| RESIDENT USE RATE PER 1,000 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **10-YEAR TOTAL** | | **Trendline** |
| **HSA #1** | 297.36 | 303.83 | 310.35 | 304.05 | 302.39 | 305.72 | 299.02 | 300.77 | 305.66 | 317.95 | **3,047.09** | | 1.0401 |
| | | | | | | | | | | | | | |
| **STATEWIDE** | **304.49** | **308.92** | **314.39** | **308.69** | **305.40** | **304.55** | **299.80** | **298.97** | **302.38** | **312.90** | **3,060.50** | | **-0.0899** |



| **STEP #5** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **2015 HOSPITAL PATIENT DAYS** | | | | | | | | | | | |
| | # of Pat days | Less OOS | TOTAL LESS OOS | | | | | | | | |
| | | | | % | | | | | | | |
| 0-64 | 119,005 | 762 | **118,243** | 0.64% | | | | | | | |
| 65+ | 88,281 | 815 | **87,466** | 0.92% | | | | | | | |
| **TOTAL** | **207,286** | **1,577** | **205,709** | | | | | | | | |
| | | | | | | | | | | | |
| **WA - Good Sam** | | | | | | | | | | | |
| 0-64 | 1,109,365 | 62,849 | **1,046,516** | 5.67% | | | | | | | |
| 65+ | 894,242 | 41,072 | **853,170** | 4.59% | | | | | | | |
| **TOTAL** | **2,003,607** | **103,921** | **1,899,686** | | | | | | | | |
| | | | | | | | | | | | |
| | **TO C Pierce** | **TO WA** | | | | **TOTAL # OF DAYS FOR** | **ADD DAYS** | **TOTAL # OF DAYS FOR** | | | |
| | | | | | | **RESIDENTS BY HSA** | **PROVIDED IN** | **RESIDENTS BY HSA** | | | |
| **Patients FROM C Pierce** | | | | | | **(LESS PATS FROM OOS)** | **OREGON **** | | | | |
| 0-64 | 50,531 | 20,181 | | | | 70,712 | 100 | 70,812 | | | |
| 65+ | 45,222 | 10,605 | | | | 55,827 | 200 | 56,027 | | | |
| **TOTAL** | **95,753** | **30,786** | | | | **126,539** | **300** | **126,839** | | | |
| | | | | | | | | | | | |
| **Patients FROM WA** | | | | | | | | | | | |
| 0-64 | 67,712 | 1,026,335 | | | | 1,094,047 | 39,972 | 1,134,019 | | | |
| 65+ | 42,244 | 842,565 | | | | 884,809 | 19,747 | 904,556 | | | |
| **TOTAL** | **109,956** | **1,868,900** | | | | **1,978,856** | **59,719** | **2,038,575** | | | |
| | | | | | | | | | | | |
| | **205,709** | **1,899,686** | | | | ** Patient Days as reported by 2009 HCUP data for Oregon CHARS w/o MDC15 & 19 | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **MARKET SHARE** | | | | | | | | | | | |
| **PERCENTAGE OF PATIENT DAYS** | | | | | | | | | | | |
| | | | | | | | | | | | |
| | **TO C Pierce** | **TO WA** | | **TO OREGON** | | | | | | | |
| % OF C Pierce RESIDENTS | | | | | | | | | | | |
| 0-64 | 71.36% | 28.50% | | 0.14% | | | | | | | |
| 65+ | 80.71% | 18.93% | | 0.36% | | | | | | | |
| **TOTAL** | | | | | | | | | | | |
| | | | | | | | | | | | |
| % OF WA - C Pierce RESIDENTS | | | | | | | | | | | |
| 0-64 | 5.97% | 90.50% | | 3.52% | | | | | | | |
| 65+ | 4.67% | 93.15% | | 2.18% | | | | | | | |
| **TOTAL** | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| 2015 POPULATIONS BY PLANNING AREA | | | | | | | | | | | |
| | | | | | | | | | | | |
| | **C Pierce** | **TO WA** | | | | | | | | | |
| 0-64 | 263,800 | 5,811,335 | | | | | | | | | |
| 65+ | 44,110 | 964,107 | | | | | | | | | |
| **TOTAL** | **307,910** | **6,775,442** | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| **STEP #6** | | | | | | | | | | | |
| USE RATE BY PLANNING AREA | | | | | | | | | | | |
| | | | | | | | | | | | |
| | **C Pierce** | **TO WA** | | | | | | | | | |
| USE RATES | | | | | | | | | | | |
| 0-64 | 268.43 | 195.14 | | | | | | | | | |
| 65+ | 1,270.17 | 938.23 | | | | | | | | | |
| | | | | | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| USE RATE BY PLANNING AREA FROM STEP 6 | | | | | | | |
| | | | | | | | |
| | **C Pierce** | | | | | | |
| YEAR 2015 USE RATES | | | | | | | |
| 0-64 | 268.43 | | | | | | |
| 65+ | 1,270.17 | | | | | | |
| | | | | | | | |
| | | | | | | | |
| PROJECTED POPULATION | YEAR 2022 | | | | | | |
| | **C Pierce** | | | | | | |
| 0-64 | 276,078 | | | | | | |
| 65+ | 53,897 | | | | | | |
| **TOTALS** | **329,975** | | | | | | |
| | | | | | | | |
| | | | | | | | |
| PROJECTED 2022 USE RATE | | | | | | | |
| | **C Pierce** | | | | | | |
| USE RATES* | | | | | | | |
| 0-64 using HSA Trend | 275.71 | | | | | | |
| 0-64 using Statewide Trend | **267.80** | | | | | | |
| 65+ using HSA Trend | 1,277.45 | | | | | | |
| 65+ using Statewide Trend | **1,269.54** | | | | | | |
| | | | | | | | |
| * Projected by applying either HSA trend or Statewide trend, whichever trend would result in the smaller adjustment | | | | | | | |
| **Bold Print** indicates use rate closest to current value | | | | | | | |

| | |
|---|---|
| USE RATE BY HSA FROM STEP 7A | |
| | |
| PROJECTED USE RATE - 2022 | **C Pierce** |
| USE RATES | |
| 0-64 | 267.80 |
| 65+ | 1,269.54 |
| | |
| | |
| | |
| | |
| PROJECTED POPULATION - 2022 | |
| | **C Pierce** |
| 0-64 | 276,078 |
| 65+ | 53,897 |
| **TOTALS** | **329,975** |
| | |
| | |
| | |
| PROJECTED # OF PATIENT DAYS | YEAR 2022 |
| | **C Pierce** |
| 0-64 | 73,934 |
| 65+ | 68,425 |
| **TOTALS** | **142,359** |

| PROJECTED # OF PATIENT DAYS | | | | | |
|---|---|---|---|---|---|
| YEAR 2022 | **C Pierce** | **WA - C Pierce** | | **TOTAL** | |
| 0-64 | 73,934 | 1,202,550 | | 1,276,484 | |
| 65+ | 68,425 | 1,270,921 | | 1,339,346 | |
| **TOTALS** | **142,359** | **2,473,471** | | **2,615,830** | |
| **MARKET SHARE % OF PATIENT DAYS FROM STEP 5** | | | | | |
| % OF C Pierce RESIDENTS | **C Pierce** | **WA - C Pierce** | | **TO OREGON** | |
| 0-64 | 71.36% | 28.50% | | 0.14% | |
| 65+ | 80.71% | 18.93% | | 0.36% | |
| | | | | | |
| % OF WA - C Pierce RESIDENTS | **C Pierce** | **WA - C Pierce** | | **TO OREGON** | |
| 0-64 | 5.97% | 90.50% | | 3.52% | |
| 65+ | 4.67% | 93.15% | | 2.18% | |
| | | | | | |
| # OF C Pierce RESIDENTS | **C Pierce** | **WA - C Pierce** | | **TO OREGON** | **Total** |
| 0-64 | 52,759 | 21,071 | | 104 | 73,934 |
| 65+ | 55,229 | 12,952 | | 244 | 68,425 |
| | | | | | 142,359 |
| # OF WA - C Pierce RESIDENTS | **C Pierce** | **WA - C Pierce** | | **TO OREGON** | **Total** |
| 0-64 | 71,804 | 1,088,358 | | 42,388 | 1,202,550 |
| 65+ | 59,354 | 1,183,823 | | 27,745 | 1,270,921 |
| | | | | | 2,473,471 |

| | | | | | |
|---|---|---|---|---|---|
| # OF RESIDENT PAT DAYS PROJECTED IN C Pierce | | | | | |
| 0-64 | 124,563 | | | | |
| 65+ | 114,583 | | | | |
| | | | | | |
| # OF RESIDENT PAT DAYS PROJECTED IN WA - C Pierce | | | | | |
| 0-64 | 1,109,429 | | | | |
| 65+ | 1,196,774 | | | | |
| | | | | | |
| # OF WA RESIDENT PAT DAYS PROJECTED IN OREGON | | | | | |
| 0-64 | 42,492 | | | | |
| 65+ | 27,989 | | | | |
| | | | | | |
| | | | | | |
| **OUT OF STATE % OF PATIENT DAYS FROM STEP 5** | | | | | |
| **C Pierce** | % | | | | |
| 0-64 | 0.64% | | | | |
| 65+ | 0.93% | | | | |
| | | | | | |
| **WA - C Pierce** | | | | | |
| 0-64 | 6.01% | | | | |
| 65+ | 4.81% | | | | |
| | | | | | |
| PROJECTED # OF PATIENT DAYS 2022 | | | | | |
| PLUS OUT OF STATE RESIDENTS | | | | | |
| | | | | | |
| **C Pierce** | | | | | |
| 0-64 | 125,366 | 1.695640314 | | | |
| 65+ | 115,650 | 1.690181912 | | | |
| **TOTAL** | **241,016** | | | | |

Central Pierce Acute Care Bed Need
Appendix 10a

| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **C Pierce Planning Area** | | | | | | | | | | | |
| **Population 0-64(1)** | 263,800 | 265,554 | 267,308 | 269,062 | 270,816 | 272,570 | 274,324 | 276,078 | 277,832 | 279,586 | 281,340 |
| **0-64 Use Rate** | 268.43 | 268.34 | 268.25 | 268.16 | 268.07 | 267.98 | 267.89 | 267.80 | 267.71 | 267.62 | 267.53 |
| **Population 65+(1)** | 44,110 | 45,508 | 46,906 | 48,305 | 49,703 | 51,101 | 52,499 | 53,897 | 55,296 | 56,694 | 58,092 |
| **65+ Use Rate** | 1,270.17 | 1270.08 | 1269.99 | 1269.90 | 1269.81 | 1269.72 | 1269.63 | 1269.54 | 1269.45 | 1269.36 | 1269.27 |
| | | | | | | | | | | | |
| **Total Population** | 307,910 | 311,062 | 314,214 | 317,367 | 320,519 | 323,671 | 326,823 | 329,975 | 333,128 | 336,280 | 339,432 |
| **Total C Pierce Res Days** | 126,839 | 129,058 | 131,276 | 133,494 | 135,711 | 137,927 | 140,143 | 142,359 | 144,574 | 146,788 | 149,002 |
| **Total Days in C Pierce Hospitals (2)** | 214,768 | 218,520 | 222,272 | 226,023 | 229,772 | 233,521 | 237,269 | 241,016 | 244,762 | 248,507 | 252,251 |
| | | | | | | | | | | | |
| **Available Beds** | | | | | | | | | | | |
| FHS St. Anthony (3) | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 |
| FHS St. Joseph Medical Center (4) | 276 | 276 | 276 | 276 | 276 | 276 | 276 | 276 | 276 | 276 | 276 |
| MultiCare Tacoma General/Allenmore (5) | 337 | 337 | 337 | 337 | 337 | 337 | 337 | 337 | 337 | 337 | 337 |
| MultiCare Mary Bridge Children's Hospital (6) | 82 | 82 | 82 | 82 | 82 | 82 | 82 | 82 | 82 | 82 | 82 |
| **Total** | **775** | **775** | **775** | **775** | **775** | **775** | **775** | **775** | **775** | **775** | **775** |
| | | | | | | | | | | | |
| **Wtd Occ Std(7)** | 70.08% | 70.08% | 70.08% | 70.08% | 70.08% | 70.08% | 70.08% | 70.08% | 70.08% | 70.08% | 70.08% |
| **Gross Bed Need** | **840** | **854** | **869** | **884** | **898** | **913** | **928** | **942** | **957** | **971** | **986** |
| | | | | | | | | | | | |
| **Net Bed Need/(Surplus)** | **65** | **79** | **94** | **109** | **123** | **138** | **153** | **167** | **182** | **196** | **211** |
| | | | | | | | | **7 yr** | | | **10 yr** |
| | | | | | | | | | | | |
| **(1) Source: Claritas** | | | | | | | | | | | |
| **(2) Adjusted to reflect referral patterns into and out of C Pierce Planning Area to other planning areas and Oregon** | | | | | | | | | | | |
| **(3) Source: CN #1332 issued on 06/15/06** | | | | | | | | | | | |
| **(4) Source: CN #1425 issued on 08/02/10** | | | | | | | | | | | |
| **(5) Source: CN #1543 issued on 04/21/15** | | | | | | | | | | | |
| **(6) Source: CN #1482 issued on 08/07/12** | | | | | | | | | | | |
| **(7) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,** | | | | | | | | | | | |

| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **C Pierce Planning Area** | | | | | | | | | | | |
| **Population 0-64(1)** | 263,800 | 265,554 | 267,308 | 269,062 | 270,816 | 272,570 | 274,324 | 276,078 | 277,832 | 279,586 | 281,340 |
| **0-64 Use Rate** | 268.43 | 268.34 | 268.25 | 268.16 | 268.07 | 267.98 | 267.89 | 267.80 | 267.71 | 267.62 | 267.53 |
| **Population 65+(1)** | 44,110 | 45,508 | 46,906 | 48,305 | 49,703 | 51,101 | 52,499 | 53,897 | 55,296 | 56,694 | 58,092 |
| **65+ Use Rate** | 1,270.17 | 1270.08 | 1269.99 | 1269.90 | 1269.81 | 1269.72 | 1269.63 | 1269.54 | 1269.45 | 1269.36 | 1269.27 |
| | | | | | | | | | | | |
| **Total Population** | 307,910 | 311,062 | 314,214 | 317,367 | 320,519 | 323,671 | 326,823 | 329,975 | 333,128 | 336,280 | 339,432 |
| **Total C Pierce Res Days** | 126,839 | 129,058 | 131,276 | 133,494 | 135,711 | 137,927 | 140,143 | 142,359 | 144,574 | 146,788 | 149,002 |
| **Total Days in C Pierce Hospitals (2)** | 214,768 | 218,520 | 222,272 | 226,023 | 229,772 | 233,521 | 237,269 | 241,016 | 244,762 | 248,507 | 252,251 |
| | | | | | | | | | | | |
| **Available Beds** | | | | | | | | | | | |
| FHS St. Anthony (3) | 80 | 80 | 80 | 112 | 112 | 112 | 112 | 112 | 112 | 112 | 112 |
| FHS St. Joseph Medical Center (4) | 276 | 276 | 276 | 276 | 276 | 276 | 276 | 276 | 276 | 276 | 276 |
| MultiCare Tacoma General/Allenmore (5) | 337 | 337 | 337 | 337 | 337 | 337 | 337 | 337 | 337 | 337 | 337 |
| MultiCare Mary Bridge Children's Hospital (6) | 82 | 82 | 82 | 82 | 82 | 82 | 82 | 82 | 82 | 82 | 82 |
| **Total** | **775** | **775** | **775** | **807** | **807** | **807** | **807** | **807** | **807** | **807** | **807** |
| | | | | | | | | | | | |
| **Wtd Occ Std(7)** | 70.08% | 70.08% | 70.08% | 70.38% | 70.38% | 70.38% | 70.38% | 70.38% | 70.38% | 70.38% | 70.38% |
| **Gross Bed Need** | **840** | **854** | **869** | **880** | **894** | **909** | **924** | **938** | **953** | **967** | **982** |
| | | | | | | | | | | | |
| **Net Bed Need/(Surplus)** | **65** | **79** | **94** | **73** | **87** | **102** | **117** | **131** | **146** | **160** | **175** |
| | | | | | | | | **7 yr** | | | **10 yr** |
| | | | | | | | | | | | |
| **(1) Source: Claritas** | | | | | | | | | | | |
| **(2) Adjusted to reflect referral patterns into and out of C Pierce Planning Area to other planning areas and Oregon** | | | | | | | | | | | |
| **(3) Source: CN #1332 issued on 06/15/06** | | | | | | | | | | | |
| **(4) Source: CN #1425 issued on 08/02/10** | | | | | | | | | | | |
| **(5) Source: CN #1543 issued on 04/21/15** | | | | | | | | | | | |
| **(6) Source: CN #1482 issued on 08/07/12** | | | | | | | | | | | |
| **(7) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,** | | | | | | | | | | | |