EXECUTIVE SUMMARY-CORRECTED

EVALUATION DATED MARCH 28, 2012 FOR THE FOLLOWING TWO CERTIFICATE OF NEED APPLICATIONS PROPOSING TO EXPAND NEONATAL INTENSIVE CARE NURSERY LEVEL III/OBSTETRIC SERVICES WITHIN PIERCE COUNTY

- **MULTICARE HEALTH SYSTEM - TACOMA GENERAL/ALLENMORE HOSPITAL; AND**
- **FRANCISCAN HEALTH SYSTEM - ST. JOSEPH MEDICAL CENTER**

BRIEF PROJECT DESCRIPTIONS

MultiCare Health System

MultiCare Health System (MHS) is currently providing ICN level II and NICU level IIIB services at Tacoma General Hospital (TGH) located in the city of Tacoma within Pierce County. TGH obtained prior Certificate of Need approval to establish an 8-bed NICU level IIIB. Subsequent to the approval, TGH expanded its NICU level IIIB by 22 beds, resulting in 30 NICU level IIIB beds in operation at TGH. This project proposes to rectify the 22 bed discrepancy and add an additional 20 NICU level IIIB beds, for a total of 50 NICU level IIIB beds in operation at TGH. The current NICU is located in the Rainier Pavilion and would not be relocated as part of this project. This bed expansion includes space for the 20 additional level IIIB beds to be located in space adjacent to the current NICU in the Rainier Pavilion. The neonatal project is part of a larger expansion of the Rainer Pavilion which includes space for other programs and services that do not require prior Certificate-of Need approval.

Franciscan Health System

Franciscan Health System (FHS) operates a level I obstetric service and ICN level II services at St. Joseph Medical Center (SJMC) located in the city of Tacoma within Pierce County. This application proposes to establish a 5-bed NICU level IIIA unit. The existing ICN level II services operates on two separate floors-one with 8 beds and one with 10 beds. The proposed 5-bed level IIIA NICU will be located on the 12th floor of the hospital adjacent to the existing 8 bed ICN level II Unit.

APPLICABILITY OF CERTIFICATE OF NEED LAW

Both projects are subject to Certificate of Need review as the change in bed capacity of a health care facility the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

CONCLUSIONS

MultiCare Health System

For the reasons stated in this evaluation, the application submitted by MultiCare Health System on behalf of Tacoma General Hospital proposing to add bed capacity to its 8-bed NICU level III service is consistent with applicable criteria of the Certificate of Need Program and a Certificate

of Need should be issued, provided MultiCare Health System agrees to the following in its entirety.

Project Description:

This project focuses on Tacoma General Hospital (TGH) located 315 Martin Luther King Way in the city of Tacoma, within Pierce County. TGH obtained prior Certificate of Need approval to establish an 8-bed NICU level IIIB. Subsequent to the approval, TGH expanded its NICU level IIIB by 22 beds, resulting in 30 NICU level IIIB beds in operation at TGH. This project proposes to rectify the 22 bed discrepancy and add an additional 10 NICU level IIIB beds, for a total of 40 NICU level IIIB beds in operation at TGH. The current NICU is located in the Rainier Pavilion and would not be relocated as part of this project. This bed expansion includes space for the 10 additional level IIIB beds to be located in space adjacent to current NICU in the Rainier Pavilion. The neonatal project is part of a larger expansion of the Rainer Pavilion which includes space for other programs and services that do not require prior Certificate-of Need approval.

Since MultiCare Health System operates both Tacoma General Hospital and Allenmore Hospital under the same license, the table below contains a breakdown of the 567 licensed beds at both hospitals at completion of this project.

Tacoma General/Allenmore
Proposed Acute Care Bed Breakdown

Type of Service	Licensed Beds TGH	Licensed Beds Allenmore
General Medical Surgical	367	130
Intermediate Care Nursery Level II	30	0
Neonatal Intensive Care Unit Level IIIB	40	0
Total	**437**	**130**

Conditions

1. Approved project as described above.
2. Tacoma General Hospital is approved for a total of 40 licensed NICU level IIIB beds. A separate Certificate of Need is required for NICU level IIIC.
3. Tacoma General Hospital will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Tacoma General 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 2.02 % of gross revenue and 4.41% of adjusted revenue. Tacoma General Hospital will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

Approved Costs

The approved capital expenditure for this project is $7,809,189.

Franciscan Health System

For the reasons stated in this evaluation, the application submitted by Franciscan Health System proposing to establish a 5-bed level IIIA NICU within space at St. Joseph Medical Center is consistent with applicable criteria of the Certificate of Need Program and a Certificate of Need should be issued, provided Franciscan Health System agrees to the following in its entirety.

Project Description

SJMC currently provides level I and ICN level II services. This application proposes to establish a 5-bed NICU level IIIA unit. The existing ICN level II services operates on two separate floors- one with 8 beds and one with 10 beds. The proposed 5-bed NICU will be located on the 12th floor of the hospital adjacent to the existing 8 bed ICN level II Unit.

The table below contains the breakdown of beds at project completion.

St. Joseph Medical Center
Proposed Acute Care Bed Breakdown [1]

Type of Service	Licensed Beds
General Acute Care	~~276~~294
Intermediate Care Nursery Level II	18
Neonatal Intensive Care unit Level IIIA	5
Psychiatric	23
Dedicated Rehab PPS Exempt	26
Total	**~~348~~366**

Conditions

1. Approved project as described above.
2. St. Joseph Medical Center is approved to provide NICU level IIIA services. Expansion to NICU level IIIB services requires prior Certificate of Need approval.
3. St. Joseph Medical Center will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. St. Joseph Medical Center 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 2.02 % of gross revenue and 4.41% of adjusted revenue. St. Joseph Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

Approved Costs

The approved capital expenditure for this project is $1,638,436.

[1] This breakdown of beds includes CN#1425 issued on August 2, 2010 and CN#1453 issued September 2, 2011.

EVALUATION DATED MARCH 28, 2012 FOR THE FOLLOWING TWO CERTIFICATE OF NEED APPLICATIONS PROPOSING TO EXPAND NEONATAL INTENSIVE CARE NURSERY LEVEL III/OBSTETRIC SERVICES WITHIN PIERCE COUNTY

- **MULTICARE HEALTH SYSTEM - TACOMA GENERAL/ALLENMORE HOSPITAL; AND**
- **FRANCISCAN HEALTH SYSTEM - ST. JOSEPH MEDICAL CENTER**

APPLICANT DESCRIPTIONS

MultiCare Health System

MultiCare Health System (MHS) is a not-for-profit health system serving the residents of Washington State. MHS includes four hospitals, 20 physician clinics, six urgent care facilities, and a variety of health care services, including home health, hospice, and specialty clinics in Pierce and King counties. Below is a list of the three separately-licensed hospitals currently owned or operated by MHS. The other health care facilities are not listed below. [CN historical files, MultiCare Health System website]

Hospitals
Tacoma General/Allenmore, Tacoma [2]
Mary Bridge Children's Hospital, Tacoma[3]
Good Samaritan Hospital, Puyallup

In addition to the hospitals listed above, on January 7, 2011, MHS received Certificate of Need approval to establish a new hospital in Covington, within King County. The hospital, to be known as Covington Medical Center, is not yet operational.

For ease of discussion in this evaluation, Tacoma General Hospital (TGH) will be used throughout this application to refer to this project submitted by MultiCare Health Systems.

Franciscan Health System

Franciscan Health System (FHS) is part of Catholic Health Initiatives, one of the largest not-for-profit health care systems in the United States. Catholic Health Initiatives does not have direct ownership or management of any FHS facilities. Through one of its subsidiaries, Catholic Health Initiatives operates 118 health care facilities in 22 states.

For Washington State, FHS is the subsidiary that owns or operates twelve health care facilities—five hospitals, three dialysis centers, a skilled nursing facility, an ambulatory surgery center, a Medicare certified hospice agency, and a hospice care center. Below is a list of the five separately-licensed hospitals currently owned or operated by FHS. The other health care facilities are not listed below. [source: CN historical files and Application, Appendix 1]

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[2] Tacoma General Hospital and Allenmore Hospital are located at two separate sites; they are operated under the same hospital license of "Tacoma General/Allenmore Hospital."
[3] Mary Bridge Children's Hospital is located within Tacoma General Hospital; each facility is licensed separately.

Hospitals
St. Elizabeth Hospital, Enumclaw
St. Anthony Hospital, Gig Harbor
St. Joseph Medical Center, Tacoma
St. Clare Hospital, Lakewood
St. Francis Hospital, Federal Way

For ease of discussion in this evaluation, St. Joseph Medical Center (SJMC) will be used throughout this application to refer to this project submitted by Franciscan Health Systems.

PROJECT DESCRIPTIONS

TGH

This project focuses on Tacoma General Hospital (TGH) located 315 Martin Luther King Way in the city of Tacoma, within Pierce County. TGH obtained prior Certificate of Need approval to establish an 8-bed NICU level IIIB. Subsequent to the approval, TGH expanded its NICU level III by 22 beds, resulting in 30 NICU level IIIB beds in operation at TGH. This project proposes to rectify the 22 bed discrepancy and add an additional 20 NICU level IIIB beds, for a total of 50 NICU level IIIB beds in operation at TGH. The current NICU is located in the Rainier Pavilion and would not be relocated as part of this project. This bed expansion includes space for the 20 additional level III beds to be located in space adjacent to current NICU in the Rainier Pavilion. The neonatal project is part of a larger expansion of the Rainer Pavilion which includes space for other programs and services that do not require prior Certificate-of Need approval.

The applicant identified a capital expenditure for the larger project of $28,419,426. Of this amount, $11,280,840 is attributed to the portion requiring Certificate of Need approval, which includes the addition of 20 new NICU level III beds. Of the total costs under review, 58% is related to construction and improvements; 18% is allocated to equipment; 10% to Information Systems; and the remaining 14% is distributed between taxes and fees.

If this project is approved, TGH anticipates that the NICU would be operating with 50 beds by March 2015. Under this timeline, year 2016 would be the facility's first full calendar year of operation with a 50 bed NICU. [source: Application, p23 & 24]

SJMC

This project focuses on focuses on St. Joseph Medical Center (SJMC) located at 1717 South J Street in the city of Tacoma, within Pierce County. SJMC is currently licensed for ~~343~~ 361 acute care beds and holds a three-year accreditation from the Joint Commission.[4] A breakdown of SJMC's ~~343~~ 361 licensed acute care beds is shown in the table below:

[4] The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 17,000 health care organizations and programs in the United States.

SJMC
Current Acute Care Bed Breakdown [5]

Type of Service	Currently Licensed
General Acute Care	~~276~~294
Intermediate care nursery Level II	18
Psychiatric	23
Dedicated Rehab PPS Exempt	26
Total	**~~343~~361**

SJMC currently provides level I and ICN level II services. This application proposes to establish a 5-bed NICU level IIIA unit. The existing ICN level II services operates on two separate floors- one with 8 beds and one with 10 beds. The proposed 5-bed NICU will be located on the 12th floor of the hospital adjacent to the existing 8 bed ICN level II Unit.

The capital expenditure associated with this project is $1,638,436. Of that amount, 51% is related to construction and improvements; 34% is allocated to equipment; 1% to Information Systems, and the remaining 14% is distributed between taxes and fees. [source: Application, p15]

If this project is approved; SJMC anticipates that the 5-bed NICU would become operational by January 2013. Under this timeline, year 2013 would be the facility's first full calendar year of operation with a 5-bed level IIIA NICU. [source: Application, p15]

APPLICABILITY OF CERTIFICATE OF NEED LAW

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

CRITERIA EVALUATION

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

[5] This breakdown of beds includes CN #1425 issued on August 2, 2010 and CN#1453 issued September 2, 2011.

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 the 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, each applicant must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment).[6] Where applicable, meeting the 2010 Perinatal Level of Care Guidelines established by the Washington State Perinatal Advisory Committee assists in demonstrating compliance with the criteria.

APPLICATION CHRONOLOGY

Action	MHS	FHS
Letter of Intent Submitted	October 4, 2010	August 19, 2010
Application Submitted	November 23, 2010	December 21, 2011
Department's Pre-Review Activities: 1st & 2nd screening activities and responses	November 24, 2010 to March 11, 2010	December 22, 2010 to March 11, 2010
Beginning of Review	March 12, 2011	
Public Hearing Conducted / End of Public Comment	June 21, 2011	
Rebuttal Documents Submitted to Department	July 6, 2011	
Department's Anticipated Decision Date	August 22, 2011	

[6] Each criterion contains certain sub-criteria. The following sub-criteria are not discussed in this evaluation because they are not relevant to the projects: WAC 246-310-210 (3), (4), (5), and (6); and WAC 240-310-240(3).

Department's Actual Decision Date	March 28, 2012

CONCURRENT REVIEW

The concurrent review process promotes the expressed public policy goal of RCW 70.38 that the development or expansion of health care services is accomplished in a planned, orderly fashion and without unnecessary duplication. For hospital services, concurrent review allows the department to review applications proposing the serve the same planning area as defined in WAC 246-310-290 and simultaneously to reach a decision that serves the best interests of the planning area's residents.

For these two projects, the concurrent review allows the department to review applications proposing the serve the same planning area—Pierce County—simultaneously to reach a decision that serves the best interests of the planning area's residents. In the case of these projects, the department will issue one single evaluation regarding whether both, one, or none of the projects should be issued a Certificate of Need.

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."

For each application, the other applicant sought and received affected person status under WAC 246-310-010. No other entity sought or received affected person status for either application.

SOURCE INFORMATION REVIEWED

- Multicare Health System's Certificate of Need application received November 23, 2010
- Multicare Health System's supplemental information dated February 28, 2011
- Multicare Health System's supplemental information dated May 4, 2011
- Franciscan Health System's Certificate of Need application received December 21, 2010
- Franciscan Health System's supplemental information dated February 24, 2011
- Franciscan Health System's supplemental information dated May 3, 2011
- Public comments submitted throughout the review of both projects
- Comments submitted at the June 21, 2011, public hearing
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Hospital and Patient Data Systems
- Financial feasibility and cost containment evaluations prepared by the Department of Health's Hospital and Patient Data Systems dated August 12, 2011
- Joint Commission website [www.jointcommission.org]
- Certificate of Need Historical files
- Statewide Perinatal Advisory Committee, Washington State Perinatal Level of Care (LOC) Guidelines, September 2010

- July 6, 2011, Rebuttal documents submitted by MulitCare Health System
- July 7, 2011, Rebuttal documents submitted by Franciscan Health System
- Licensing and/or survey data provided by the Department of Health's Investigations and Inspections Office

CONCLUSIONS

MultiCare Health System

For the reasons stated in this evaluation, the application submitted by MultiCare Health System on behalf of Tacoma General Hospital proposing to add bed capacity to its 8-bed NICU level III service is consistent with applicable criteria of the Certificate of Need Program and a Certificate of Need should be issued, provided MultiCare Health System agrees to the following in its entirety.

Project Description:

The current NICU is located in the Rainer Pavilion and will not be relocated as part of this project. The addition of 32 NICU level III beds, which includes 10 new beds, will be located in new space in the Rainer Pavilion. Since MultiCare Health System operates both Tacoma General Hospital and Allenmore Hospital under the same license, the table below contains a breakdown of the 567 licensed beds at both hospitals at completion of this project.

Tacoma General/Allenmore
Proposed Acute Care Bed Breakdown

Type of Service	Licensed Beds TGH	Licensed Beds Allenmore
General Medical Surgical	367	130
Intermediate care nursery Level II	30	0
Neonatal intensive care nursery Level IIIB	40	0
Total	**437**	**130**

Conditions

1. Approved project as described above.
2. With approval of this project, Tacoma General Hospital is approved for a total of 40 licensed NICU level III beds. A separate Certificate of Need is required for NICU level IIIC.
3. Tacoma General Hospital will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Tacoma General 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 2.02 % of gross revenue and 4.41% of adjusted revenue. Tacoma General Hospital will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

Approved Costs
The approved capital expenditure for this project is $7,809,189.

Franciscan Health System
For the reasons stated in this evaluation, the application submitted by Franciscan Health System proposing to establish a 5-bed level IIIA NICU within space at St. Joseph Medical Center is consistent with applicable criteria of the Certificate of Need Program and a Certificate of Need should be issued, provided Franciscan Health System agrees to the following in its entirety.

Project Description

St. Joseph Medical Center currently provides both level I and ICN level II services. The existing ICN level II services operates on two separate floors-one with 8 beds and one with 10 beds. The 5-bed NICU will be located on the 12th floor adjacent to an existing 8 bed ICN level II unit. The table below contains the breakdown of beds at project completion.

St. Joseph Medical Center[7]
Proposed Acute Care Bed Breakdown

Type of Service	Licensed Beds
General Acute Care	~~276~~294
Intermediate care nursery Level II	18
Neonatal intensive care nursery Level III	5
Psychiatric	23
Dedicated Rehab PPS Exempt	26
Total	**~~348~~366**

Conditions

1. Approved project as described above.
2. St. Joseph Medical Center is approved to provide NICU level IIIA services. Expansion to NICU level IIIB services requires prior Certificate of Need approval.
3. St. Joseph Medical Center will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. St. Joseph Medical Center 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 2.02 % of gross revenue and 4.41% of adjusted revenue. St. Joseph Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

Approved Costs
The approved capital expenditure for this project is $1,638,436.

[7] This breakdown of beds includes CN#1425 issued on August 2, 2010 and CN#1453 issued on September 2, 2011.

A. Need (WAC 246-310-210)

TGH

Based on the source information reviewed and the applicant's agreement to the conditions identified in the 'conclusion' section of this evaluation, the department concludes that the applicant has met the need criteria in WAC 246-310-210(1) and (2).

SJMC

Based on the source information reviewed and the applicant's agreement with the conditions identified in the "conclusion" section of this evaluation, the department concludes that the applicant has met the need criteria in WAC 246-310-210(1) and (2).

(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 246-310-020 states (in summary) that a level III obstetric service is offered in an area designed, organized, equipped, and staffed to provide services to the few women and infants requiring full intensive care services for the most serious type of maternal-fetal and neonatal illnesses and abnormalities. Such a service provides the coordination of care, communication, transfer, and transportation for level III patients in a given region. Level III services include the provision of leadership in preparatory and continuing education in prenatal and perinatal care and may be involved in clinical and basic research.

Comprehensive Hospital Abstract Reporting System (CHARS) data is used to assist in demonstrating need for an NICU level III service. CHARS data is reported by each Washington State hospital to the department's Hospital and Patient Data Systems office (HPDS). The CHARS data provides historical trends in discharges and lengths of stay for newborn patients for the major diagnostic category (MDC) #15 - NEWBORNS AND OTHER NEONATES WITH CONDITIONS ORIGINATING IN THE PERINATAL PERIOD. MDC #15 is made up of seven diagnosis related groups (DRGs). For years 2003 through 2006, those DRGS were identified as 385 through 391. Beginning in year 2007, the DRGs are identified as 789 through 795. The chart below provides the DRG and corresponding definition for MDC #15.[8]

DRG	Definition	Level of Care
385/789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	NICU level III
386/790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	NICU level III
387/791	PREMATURITY WITH MAJOR PROBLEMS	ICN Level II
388/792	PREMATURITY WITHOUT MAJOR PROBLEMS	ICN level II
389/793	FULL TERM NEONATE WITH MAJOR PROBLEMS	ICN level II
390/794	NEONATE WITH OTHER SIGNIFICANT PROBLEMS	ICN Level II
391/795	NORMAL NEWBORN	Level I

[8] Each DRG corresponding level of care is based on October 3, 2001, testimony provided by Louis Pollack, MD, a board certified neonatologist and member of Washington State Perinatal Advisory Committee and October 16, 2007 testimony by Dr. Linda Wallen, MD, also a board certified neonatologist.

For ease of reference, the remainder of this evaluation will refer to the DRGs above using the current 700 series number, rather than the former 300 series number.

NICU level III services are considered tertiary services as defined by WAC 246-310-010. For some tertiary services, such as open heart surgery, the department uses an established methodology to assist in its evaluation of need for the services. For other tertiary services, including NICU level III services, no such methodology exists. Given that the department has not developed an established methodology for these services, an evaluation of the need criterion for these projects begins with an evaluation of the methodology provided by each applicant.

TGH

The applicant provided two different need methodologies in the application. One method is based on the female population age 15-44 in nine counties.[9] [source: Application: p26-33] The second methodology is based on NICU level III patient days provided in the nine-county planning area. Since TGH is the only level III provider in the nine-county planning area, this methodology is essentially based on only TGH's NICU level III patient days. [source: May 4, 2011 Supplemental Information, p2-8]

The results of both methodologies were similar. The first methodology projected a need for 53 NICU level III bassinets in year 2016; the second methodology projected a need for 50 bassinets in year 2016. Given that TGH is a provider of NICU level III services, the department concludes that the second methodology is the most reasonable because it relies on actual historical patient days. As a result, the remainder of this evaluation will focus on the second methodology provided by the applicant.

TGH Planning Area Need Methodology (9 counties)

Step 1 – Identify 10-year historic planning area resident days, discharges, and use rates for the 9-county planning area.

- Patient day statistics from CHARS 2000-2009 (DRGs 789-790) were used to calculate planning area resident NICU level III patient days and discharges.
- Average length of stay (ALOS) was calculated by dividing patient days by discharges, for each of the years 2000 through 2009. ALOS was calculated separately for each year. The resulting ALOS was held constant when applied in step 3 below.
- The number of females within the age cohort of 15-44 (childbearing age) were compiled from OFM intercensual and postcensal estimates for the 9-county planning area for each year of the historic period.
- A level III use rate was calculated based on discharges per 1,000 women of childbearing age for each year 2000-2009.
- Using the same rate estimates for years 2000 – 2009, a use rate trend adjustment factor of 0.48 was calculated. The applicant noted that the use rate had generally increased from years 2000 through 2009.

[9] Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Pierce, and Thurston counties.

Tables1A and 1B below is a summary of Step 1 above.

Table 1A
Planning Area Resident Days, Discharges, and Use Rates
2000-2005

	2000	2001	2002	2003	2004	2005
Level III Patient Days	8,492	10,093	9,074	10,643	10,264	10,900
Discharges	483	591	587	613	521	569
ALOS	17.58	17.08	15.46	17.36	19.70	19.16
Females ages 15-44	303,155	304,600	304,933	304,674	305,717	307,613
Use Rate	28.0	33.1	29.8	34.9	33.6	35.4

Table 1B
Planning Area Resident Days, Discharges, and Use Rates
2006-2009 and Averages

	2006	2007	2008	2009	Average Increase
Level III Patient Days	11,823	10,451	10,165	11,068	2.9%
Discharges	583	537	568	574	1.9%
ALOS	20.28	19.46	17.90	19.28	0.6%
Females ages 15-44	312,063	315,697	318,615	318,601	
Use Rate	37.9	33.1	31.9	34.7	0.48

Step 2: Calculate planning area provider Level III patient origin, in-migration ratio, and planning area provider market share

- Using CHARS data, the 2009 level III patient days to planning area providers were estimated. These included patient days from planning area residents as well as from residents from outside the planning area.
- Using these patient origin figures, the level III in-migration ratio for the planning area providers was calculated by dividing out-of-area resident patient days to the planning area providers.
- Planning area resident level III patient days occurring in both Washington and Oregon hospitals were added together to get the total number of level III patient days for planning area residents.
- The 2009 planning area provider's market share of all planning area resident level III patients was calculated as 83.6% in 2009.

Tables 2A and 2B below is a summary of Step 2 above.

Table 2A
Planning Area Provider Level III
Patient Origin, In-Migration Ratio, and Market Share

	Total	Area Residents	Out of Area Residents	In-migration ratio
Level III Patient Days	10,000	9,249	850	0.0919

Table 2B

	Total	Washington	Oregon	TGH 2009 Market Share
Level III Resident Patient Days	11,068	11,068	0	83.6%

Step 3: Calculate future total patient days based on forecast use rates and forecast population of women of childbearing age. Apply the market share figures and in-migration ratio from step 2 to calculate future total level III patient days to planning area providers.

- The use rate trend adjustment factor calculated in Step 1 was applied to the 2009 use rate for each forecast period, 2010-2020.
- The number of women of childbearing age was forecast using OFM projections for each year of the forecast period.
- Planning area resident level III patient days were forecast by multiplying the projected use rate by the forecast number of women of childbearing age for each year of the forecast period.
- Using the market share forecasts, the total number of planning area resident level III patient days occurring at the planning area hospitals for each year of the forecast period was calculated.
- Using the in-migration ratio, the total number of level III patient days from non-planning area residents provided at the planning area hospitals was calculated for each year of the forecast period.
- Resident and non-resident level III patient days occurring at the planning area's level III providers for each year of the forecast period were summed for total planning area provider patient day forecasts.

Results of Step 3 are shown in Tables 3A and 3B for years 2010 through 2020.

Table 3A
Total Level III Patient Days to Planning Area Providers
2010 to 2015

	2010	2011	2012	2013	2014	2015
2009 Use Rate	35.2	35.7	36.2	36.7	37.1	37.6
Females ages 15-44	316,717	321,142	325,643	330,221	334,876	339,816
Total Resident Patient Days	11,155	11,465	11,783	12,107	12,439	12,786
Planning Area Patient Days	9,322	9,581	9,846	10,117	10,395	10,685
Out-of-Area Patient Days	857	881	905	930	955	982
Total Planning Area Patient Days	**10,178**	**10,462**	**10,751**	**11,047**	**11,350**	**11,667**

Table 3B
Total Level III Patient Days to Planning Area Providers
2016 to 2020

	2016	2017	2018	2019	2020
2009 Use Rate	38.1	38.6	39.1	39.6	40.0
Females ages 15-44	343,059	346,340	349,661	353,022	356,526
Total Resident Patient Days	13,073	13,365	13,661	13,962	14,272
Planning Area Patient Days	10924	11,168	11,416	11,668	11,927
Out-of-Area Patient Days	1,004	1,026	1,049	1,072	1,096
Total Patient Days	**11,928**	**12,195**	**12,465**	**12,740**	**13,023**

Step 4: Use total days projected in Step 3 to determine gross and net level III basinet need.

- The average daily census (ADC) was calculated for each year of the forecast period.
- The forecast ADC was adjusted to reflect the occupancy standard of 65% for the level III NICU. These forecasts represent gross need for NICU level III bassinets.
- The supply figure for level III bassinets for the only level III provider, Tacoma General, was set at 8, the number recognized by the department (see Table 1 of this evaluation).
- Net need was calculated by subtracting current planning area supply from gross bassinet need.

Results of Step 4 are shown in Tables 4A and 4B for years 2010 through 2020.

Table 4A
Total Planning Area Projected Patient Days and
Planning Area Gross and Net Level III Bassinet Need

	2010	2011	2012	2013	2014	2015
Total Patient Days	10,178	10,462	10,751	11,047	11,350	11,667
Forecast ADC	27.9	28.7	29.5	30.3	31.1	32.0
Gross Need at 65% Occupancy	42.9	44.1	45.3	46.6	47.8	49.2
Minus current level III supply	8	8	8	8	8	8
Net Bassinet Need	34.9	36.1	37.3	38.6	39.8	41.2

Table 4B
Total Planning Area Projected Patient Days and
Planning Area Gross and Net Level III Bassinet Need

	2016	2017	2018	2019	2020
Total Patient Days	11,928	12,195	12,465	12,470	13,023
Projected ADC	32.7	33.4	34.2	34.9	35.7
Gross Need at 65% Occupancy	50.3	51.4	52.5	53.7	54.9
Minus current level III supply	8	8	8	8	8
Net Bassinet Need	42.3	43.4	44.5	45.7	46.9

As shown in Table 4B above, in year 2016 the applicant projects an average daily census of 32.7 patients and a gross need of 50.3 level III beds using an average of 65% occupancy.

Department's Review/Conclusion

The department's need review begins with the underlying assumptions used by the applicant in their provider based need methodology. The applicant's methodology is based on three main factors:

- service area;
- population projections, and
- current capacity.

Below is a review of each factor.

Service Area

The applicant defines its primary service area to be Pierce, Thurston, Kitsap, Lewis, Mason, Grays Harbor, Jefferson, Pacific, and Clallam counties and provided its market share percentages for TGH in each of the nine counties. Table 5 below shows TGH's market share data for the 2009 patient days.

Table 5
TGH
Year 2009 Level III Market Share

County	Market Share
Pierce	83.3%
Mason	85.2%
Kitsap	75.9%
Thurston	74.6%
Grays Harbor	74.2%
Clallam	47.7%
Lewis	44.6%
Pacific	32.7%
Jefferson	4.1%

As shown in Table 5 above, TGH's largest market share is in the counties of Pierce, Mason, Kitsap, Thurston, and Grays Harbor counties. It is reasonable to include these five counties in its primary service area for Level III services. Additionally, TGH has greater than 10% market share of NICU level III patient days in 2009 in Clallam, Lewis, and Pacific counties. It is also reasonable to include these three counties. While Jefferson County's market share is less than 5%, the applicant stated it included this county based on the geographic location of the county. Jefferson County is surrounded by counties that are included in the planning area and to maintain geographic continuity, it should be included.

Based on the information provided in the application, the department concludes TGH's 9-county service area is reasonable for NICU level III services.

Population Projections

The applicant projected the female aged 15-44 population based upon the medium series projections produced by OFM for all nine counties. The department also relies upon the OFM medium series for population projections. This approach is reasonable.

Current Capacity

TGH is approved for 8 NICU level III beds and is operating a 30 bed NICU. This project proposes approval of the 22 level III beds already in operation at TGH, and the addition of 20 more beds. For this review, The applicant must demonstrate need for all 42 [22+20] level III NICU beds. As a result, using the current approved capacity of 8 level III NICU beds at TGH is reasonable.

Use Rate

TGH made one change to their need projection methodology that the department does not use in making its bed projections. In step 1e of the methodology they added a trend adjustment factor of 0.48 to the use rate. This results in greater projected patient days. The department calculated revised projections using an average use rate calculated from the 10 year historical average and projected forward with no increase in use rate. The department's calculation does include the increase due the population increases projected for the planning area. Table 6 contains the department's calculation of projected patient days without using the trend adjustment.

Table 6
2010-2015 Department Patient Day Projections

	2010	2011	2012	2013	2014	2015
Use Rate	33.3	33.3	33.3	33.3	33.3	33.3
Females 15-44	316,717	321,142	325,643	330,221	334,876	339,816
Total Planning Area Patient Days(Pt.)	10,547	10,694	10,844	10,996	11,151	11,316
Resident Pt .Days	8,817	8,940	9,066	9,193	9,322	9,459
out of area Pt Days	810	822	833	845	857	869
Total Pt. Days To TGH	**9,628**	**9,762**	**9,899**	**10,037**	**10,179**	**10,329**

Using the projected patient days calculated by the department, the department then projected gross and net need for beds in the TGH planning area.

Table 7
2010-2015 Department Occupancy Projections

	2010	2011	2012	2013	2014	2015
Total Pt Days to TGH	9,628	9,890	10,084	10,278	10,471	10,665
ADC	26.4	26.7	27.1	27.5	27.9	28.3
% Occupancy @ 30 beds (8 +22)	88%	89%	90%	92%	93%	94%
% Occupancy @ 40 beds (8+22+10)	66%	67%	68%	69%	70%	71%
% Occupancy @ 50 beds (8+22+20)	53%	53%	54%	55%	56%	57%

As shown in table 7 the percent occupancy of the approved beds and the 22 beds in use exceeds 80% occupancy in 2010 and is projected to reach 94% in 2015 without any additional beds.
The department calculations show that TGH will exceed the 65% occupancy in 2010 with 40 beds and will reach 71% occupancy by 2015. The department calculations also show that TGH will be below 65 % occupancy in 2010 and will be at 57% occupancy by 2015 with the 50 beds.
In summary based solely on the projections described above, the department concludes the need for the 22 beds currently in use at TGH and an addition 10 NICU level IIIB beds is justified. **This sub-criterion is met.**

SJMC
The applicant began by defining the service area for SJMC's NICU level III services. Since SJMC does not currently provide level III NICU services, the applicant reviewed historical neonatal discharge data and concluded that 82% were from Pierce County. In addition, calculating projections for their NICU level III unit based on internal data, the applicant also calculated population based patient day projections for Pierce County. The following assumptions, from the supplemental materials, were used in developing these calculations [source: February 24, 2011 Supplemental Materials, p1-3]

SJMC planning area need methodology (Pierce County)

- Using DRG appropriate discharge data for Pierce County for years 2005 - 2009 , FHS determined the NICU level III use rate per 1,000 population for females aged 15-44.
- Based on the same historical data, FHS determined the average length of stay (ALOS).

These calculations are shown in Tables 8A and 8B below.

Table 8A
Provider Level III NICU Patients
Actual 2005-2009

DRG Discharges	2005	2006	2007	2008	2009
789	156	174	151	140	149
790	108	118	103	119	134
Total	**264**	**292**	**256**	**259**	**283**

Table 8B
Use Rate, Patient Days, and ALOS
Actual 2005-2009

	2005	2006	2007	2008	2009
Population Female 15-44	162,319	165,096	167,604	169,541	169,772
Calculated Use Rate	1.6	1.8	1.5	1.5	1.7
Patient Days for DRG 789	1,126	1,499	1,405	1,204	1,113
Patient Days for DRG 790	4,637	5,226	4,427	4,523	5,053
Total Patient Days	**5,763**	**6,725**	**5,832**	**5,727**	**6,166**
Average Length of Stay (ALOS)	21.8	23.0	22.8	22.1	21.8

- Using the 2005 – 2009 historical data, FHS determined the market share of days for Pierce County providers for Pierce County residents.
- Using the same historical data, the applicant calculated an average ratio of in-migration days to resident days for Pierce County.
- An average in-migration ratio of 0.82 to project in-migration days for Pierce providers.

These calculations are shown in Table 9 below.

Table 9
Pierce County and In-migration
Provider Level III NICU Patient Days
Actual 2005-2009

	2005	2006	2007	2008	2009
Pierce Provider Total Days	8,098	9,701	9,162	8,734	9,842
Pierce Provider Days From Pierce	4,457	5,558	4,719	4,655	5,648
Market Share	77.3%	82.6%	80.9%	81.3%	91.6%
In-Migration Days	3,641	4,143	4,443	4,079	4,194
In-Migration Ratio	0.82	0.73	0.94	0.88	0.74
Average Daily Census (ADC)	22.2	26.6	25.1	23.9	27.0
Total Bed Need at 65% Occupancy	34.1	40.9	38.6	36.8	41.5
Current Supply	30	30	30	30	30
Net Need	4.1	10.9	8.6	6.8	11.5

Source : February 24,2011 Supplemental Materials, p4

The applicant calculated an average use rate of 1.8 and length of stay of 22.3 days based on the historical five year data. These averages were applied to years 2010 through 2015 to determine the number of patient days for Pierce County residents. A summary of these calculations are shown in Table 10 below.

Table 10
Pierce County Only
Provider Level III NICU Patient Days
Projected 2010-2015

	2010	2011	2012	2013	2014	2015
Population Female 15-44	172,481	173,709	174,947	176,793	177,447	178,623
Average Use Rate	1.8	1.8	1.8	1.8	1.8	1.8
Total Discharges	**280**	**282**	**284**	**286**	**288**	**290**
5 year ALOS	22.3	22.3	22.3	22.3	22.3	22.3
Patient Days at ALOS	6,247	6,291	6,336	6,381	6,426	6,469

Based on the following factors, FHS determined the number of NICU beds needed for Pierce County only as shown in Table 11 below.

- 65% occupancy of its level III NICU beds
- Current supply of level III NICU beds to be 30 and all located at TGH.

Table 11
Pierce County and In-migration
Provider Level III NICU Patient Days
Projected 2010-2015

DRG	2010	2011	2012	2013	2014	2015
Pierce Providers Market Share	5,169	5,206	5,243	5,281	5,318	5,353
In-migration at Average Ratio	4,262	4,293	4,323	4,354	4,385	4,414
Total Pierce Provider Patient Days	9,432	9,499	9,567	9,635	9,703	9,768
Average Daily Census (ADC)	25.8	26.0	26.2	26.4	26.6	26.8
Total Bed Need at 65% Occupancy	39.8	40.0	40.3	40.6	40.9	41.2
Minus Current Supply	30	30	30	30	30	30
Net Need	9.8	10.0	10.3	10.6	10.9	11.2

Source: February 24,2011 Supplemental Materials, p4

As shown in Table 11 above, after subtracting 30 existing NICU level IIIB beds at Tacoma General Hospital, the applicant calculated a net need of 9.8 NICU level III beds for Pierce County alone for in year 2010. The net need increases to 11.2 beds in year 2015.

Department's Review/Conclusion

The applicant used a county-based methodology because SJMC does not currently provide level III NICU services. The department's review begins with the underlying assumptions used by the applicant in their need methodology. The applicant's methodology is also based on three main factors:

- service area;
- population projections, and
- current capacity.

Below is a review of each factor.

Service Area

The applicant defines its primary service area to be Pierce County only. The applicant states that a one-county service area is conservative, but reliable. Even though SJMC does not currently provide level III NICU services, basing a tertiary service on only one county is conservative. Without historical discharge data and since there is a level III NICU provider in the county, the department considers this small service area to be reasonable for this project.

Population Projections

The applicant projected the female aged 15-44 population based upon the medium series projections produced by OFM for Pierce County. The department also relies upon the OFM medium series for population projections. This approach is reasonable.

Current Capacity

The applicant determined that the number of existing NICU level III beds is 30 and all are located at TGH. While the department recognizes that TGH has been operating 30 NICU beds, as previously stated they are CN approved to operate 8 beds. Additionally, the service area identified by the applicant is much smaller than the service area identified by TGH. This evaluation recommends approval of the 22 level III beds already in operation at TGH, and the addition of 10 more NICU level IIIB beds. TGH also serves eight other counties, thereby reducing the number of beds available for Pierce County alone. The need calculation provided by the applicant showed a need for 11.2 NICU level III beds by 2015 for the smaller service area identified by the applicant. The applicant estimated the potential to generate sufficient NICU level III patient days for 5 beds based on retaining appropriate neonatal admissions and appropriate maternal admission resulting in births requiring NICU level IIIA services. The applicant also estimated that there would be sufficient NICU level III patient days to meet the ADC recommendations identified in the perinatal guidelines. The applicant also based its projections on a 65% occupancy of the unit. In previous evaluations for level III NICU services, the department has concluded that 65% occupancy is reasonable to allow for flexibility and accommodate peak usage of the NICU. The department concludes that the applicant's methodology is reasonable. **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.*

TGH

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

To demonstrate compliance with this sub-criterion, The applicant provided a copy of TGH's current Inpatient Admission Policy. The policy outlines the process/criteria that TGH uses to admit patients for treatment or care at the hospital. The policy also states that any patient requiring care is accepted for treatment at TGH without regard to race, religion, sex, age, or ability to pay. This policy is consistent with Certificate of Need requirements. [source: Application, Exhibit 16]

To determine whether low income residents would have access to the proposed services, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. TGH currently provides services to Medicaid eligible patients. Documents provided in the application demonstrate that it intends to maintain this status. For this project, a review of the policies and data provided for TGH identifies the facility's financial resources as including Medicaid revenues. [source: Application, p11; Exhibit 21]

For this project, it is unlikely that residents with Medicare will need access to neonatal services. However, nothing in the application suggests that this project will impact the services currently provided to Medicare patients.

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

TGH also provided a copy of its current charity care policy (Financial Assistance Program Policy) that would continue to be used if this project is approved. This version of the program policy dated September 2008 has been reviewed and approved by the department's Hospital and Patient Data Systems[10]. [source: Application, Exhibit 14]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems (HPDS), divides Washington State into five regions: King County, Puget Sound

[10] www.doh.wa.gov/ehsphl/hospdata/charitycare/charitypolicies

(less King County), Southwest, Central, and Eastern. Located in Pierce County, TGH is one of 18 hospitals in the Puget Sound Region. According to 2007-2009 charity care data obtained from HPDS, TGH has historically provided less than the average charity care provided in the region. TGH's most recent three years (2007-2009) percentages of charity care for gross and adjusted revenues are 1.43% and 3.18%, respectively. The 2007-2009 average for the Puget Sound Region is 2.02% for gross revenue and 4.41% for adjusted revenue. [source: HPDS 2007-2009 charity care summaries]

Table 12 compares the 3 year average for Puget Sound and the projected 3 year average for TGH. [source: HPDS 2007-2009 charity care summaries

Table 12
TGH Charity Care Comparison

	3-Year Average for Puget Sound Region	3-Year Average for TGH
% of Gross Revenue	2.02%	1.43%
% of Adjusted Revenue	4.41%	3.18%

TGH's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 1.43% of gross revenue and 3.18% of adjusted revenue. RCW 70.38.115(2) (j) requires hospitals to meet or exceed the regional average level of charity care. TGH has historically provided less charity care than the Puget Sound regional average. Because TGH proposes to provide charity care at a rate lower than the regional average, a charity care condition for the hospital is necessary.

With the applicant's agreement to the charity care condition found in the conclusion section of this analysis, the department concludes **this sub-criterion is met.**

SJMC

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

To demonstrate compliance with this sub-criterion, The applicant provided a copy of SJMC's current Admission Policy. The policy outlines the process/criteria that SJMC uses to admit patients for treatment or care at the hospital. The applicant states that any patient requiring care is accepted for treatment at SJMC without regard to race, religion, sex, age, or ability to pay. This policy is consistent with Certificate of Need requirements. [source: Application, pg 59]

To determine whether low income residents would have access to the proposed services, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. SJMC currently provides services to Medicaid eligible patients. Documents provided in the application demonstrate that it intends to maintain this status. For this project, a review of the policies and data provided for SJMC identifies the facility's financial resources as including Medicaid revenues. [source: Application, p2; Appendix 2]

For this project, it is unlikely that residents with Medicare will need access to neonatal services. However, nothing in the application suggests that this project will impact the services currently provided to Medicare patients.

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

The applicant also provided a copy of SJMC's current Charity Care Policy that would continue to be used if this project is approved. This version of the policy dated January 8, 2010 has been reviewed and approved by the department's Hospital and Patient Data Systems[11]. [source: Application, Exhibit 7]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Located in Pierce County, SJMC is one of 18 hospitals in the Puget Sound Region. According to 2007-2009 charity care data obtained from HPDS, SJMC has historically provided less than the average charity care provided in the Puget Sound Region. SJMC's most recent three years (2007-2009) percentages of charity care for gross and adjusted revenues are 1.73% and 3.39%, respectively. The 2007-2009 average for the Puget Sound Region is 2.02% for gross revenue and 4.41% for adjusted revenue. [source: HPDS 2007-2009 charity care summaries]

Table 13 compares the 3 year average for Puget Sound and the projected 3 year average for SJMC. [HPDS 2007-2009 charity care summaries]

Table 13
SJMC Charity Care Comparison

	3-Year Average for Puget Sound Region	3-Year Average for SJMC
% of Gross Revenue	2.02%	1.73%
% of Adjusted Revenue	4.41%	3.39%

[11] www.doh.wa.gov/ehsphl/hospdata/charitycare/charitypolicies

SJMC's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 1.73% of gross revenue and 3.39% of adjusted revenue. RCW 70.38.115(2) (j) requires hospitals to meet or exceed the regional average level of charity care. SJMC has historically provided less charity care than the regional average. Because SJMC proposes to provide charity care at a rate lower than the regional average, a charity care condition for the hospital is necessary.

With the applicant's agreement to the charity care condition found in the conclusion section of this evaluation, the department concludes **this sub-criterion is met.**

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

TGH

Based on the source information reviewed and the applicant's agreement to the conditions identified in the 'conclusion' section of this evaluation, the department concludes that TGH has met the financial feasibility criteria in WAC 246-310-220.

SJMC

Based on the source information reviewed and the applicant's agreement to the conditions identified in the 'conclusion' section of this evaluation, the department concludes that SJMC has met the financial feasibility criteria in WAC 246-310-220.

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

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.

TGH

As requested by the department during the review of this project, the applicant provided its pro forma financial statements for the NICU level III unit operating with 40 beds, and the hospital, as a whole, with the proposed project. Since the department concluded in the need section that the addition of 10 beds to the existing 8 CN approved and 22 non CN approved beds for a 40 bed total is justified; the financial information in this section are for the 40 bed NICU level IIIB unit. These financial statements provided the figures necessary to isolate the projections for the NICU level III services. A summary of the financial projections for the NICU level III alone is shown in Table 14 below. [source: May 4, 2011 Supplemental Information, Exhibit 32]

Table 14
TGH NICU level IIIB Cost Center
Years 2016 through 2018 Projected Statement of Operations Summary

	Year 1 - 2016	**Year 2 - 2017**	**Year 3 - 2018**
Net Operating Revenue	$33,759,680	$34,914,440	$39,914,440
Total Operating Expenses	$23,969,372	$24,090,964	$22,383,530
Net Profit or (Loss)	**$9,790,308**	**$10,823,476**	**$17,530,910**

The 'net operating revenue' line item in Table 14 is the result of gross revenue minus any deductions for contractual allowances, bad debt, and charity care directly related to the NICU level III cost center. The 'total operating expenses' line item includes staff salaries/wages all direct expenses, and indirect expenses related to the NICU level III cost center. As shown in Table 14, the NICU level III program is projected to meet its direct expenses with sufficient excess to contribute to the hospital's indirect expenses.

To assist the department in its evaluation of this sub-criterion, the department's Hospital and Patient Data Systems (HPDS) provided a summary of the short and long-term financial feasibility of the project, which includes a financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios typically analyzed are: **1)** long-term debt to equity; **2)** current assets to current liabilities; **3)** assets financed by liabilities; **4)** total operating expense to total operating revenue; and **5)** debt service coverage. If a project's ratios are within the expected value range, the project can be expected to be financially feasible. Additionally, HPDS reviews a project's three-year projected statement of operations to evaluate the applicant's immediate ability to finance provide the service and long term ability to sustain the service.

The comparison revealed that the hospital is in the normal range for all five ratios. Staff from HPDS indicated TGH has had an above average financial foundation in the past. [source: HPDS analysis, p2]

The capital expenditure for this project is $7,809,189. The project is part of a larger project estimated to have a capital expenditure of $28,419,426. Since both TGH and Allenmore are operated under the same hospital license, all data submitted to HPDS reflects the joint operation. Table 15 below provides a summary of the balance sheets for both TGH and Allenmore.

Table 15
Combined Balance Sheet for TGH/Allenmore for FYE 2009

Assets		**Liabilities**	
Current Assets	$524,967,731	Current Liabilities	$6,198,901
Board Designated Assets	-0	Long Term Debt	-
Property/Plant/Equipment	$241,480,006	**Total Liabilities**	**$6,198,901**
Other	$4,144	**Equity**	**$760,252,980**
Total Assets	**$766,451,881**	**Total Liabilities and Equity**	**$ 766,451.881**

From year-end financial statements reported to DOH

The capital expenditure for this project is $7,809,189. This project will not adversely impact reserves, or total assets, total liability or the general health of the hospital in a significant way. 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.**

SJMC

To demonstrate compliance with this sub-criterion, the applicant provided its pro forma financial statements for the neonatal unit alone and the SJMC as a whole, with the proposed project. These reports provided the figures necessary to isolate the projections for the NICU level III services. A summary of the financial projections for the neonatal project alone is shown in Table 16. [source: Application p 69]

Table 16
SJMC NICU level III Cost Center
Years 2013 through 2015
Projected Statement of Operations Summary

	Year 1 - 2013	Year 2 - 2014	Year 3 - 2015
Total Net Revenue	$2,587,000	$2,852,000	$3,050,000
Total Operating Expenses	$918,000	$942,000	$959,000
Net Profit or (Loss)	**$1,669,000**	**$1,910,000**	**$2,091,000**

The 'net operating revenue' line item in Table 16 is the result of gross revenue minus any deductions for contractual allowances, bad debt, and charity care directly related to the NICU level III cost center. The 'total operating expenses' line item includes staff salaries/wages and all direct expenses related to the cost center. The total operating expenses line item does not include indirect expenses. The NICU level IIIA program is projected to meet its direct expenses with sufficient excess to contribute to the hospital's indirect expenses. As noted in Table 14, the applicant expects this project to meet the immediate operating costs in the first year.

To assist the department in its evaluation of this sub-criterion, the department's Hospital and Patient Data Systems (HPDS) provided a summary of the short and long-term financial feasibility of the project, which includes a financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios typically analyzed are: **1)** long-term debt to equity; **2)** current assets to current liabilities; **3)** assets financed by liabilities; **4)** total operating expense to total operating revenue; and **5)** debt service coverage. If a project's ratios are within the expected value range, the project can be expected to be financially feasible. Additionally, HPDS reviews a project's three-year projected statement of operations to evaluate the applicant's immediate ability to finance provide the service and long term ability to sustain the service.

HPDS compared the financial health of SJMC to the statewide 2009 financial ratio guidelines for hospital operations. [source: HPDS analysis, p2] Comparing the applicant's most current (2010) ratios with the statewide ratios (2009) revealed that the hospital is within the normal range for all five ratios. The hospital has had an above average financial foundation in the past.

The capital expenditure for this project is $1,638,436. The applicant is proposing to use capital reserves to fund this project. A summary of the balance sheets for the applicant is shown in Table 17 below.

Table 17
SJMC Balance Sheet for Current Year 2010

Assets		Liabilities	
Current Assets	$144,955,835	Current Liabilities	$69,015,429
Board Designated Assets	$48,467,957	Long Term Debt	$21,077,332
Property/Plant/Equipment	$156,189,473	**Total Liabilities**	**$90,092,761**
Other	$12,449,513	**Equity**	**$271,970,017**
Total Assets	**$362,062,778**	**Total Liabilities and Equity**	**$362,062,778**

This project will not adversely impact reserves, or total assets, total liability or the general health of the hospital in a significant way. 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.

TGH

The applicant identified a capital expenditure of $7,809,189 for the 40 (8+22+10) bed project. The costs are broken down in Table 18.

Table 18
Capital Cost Breakdown

Breakdown Of Costs	Total	% Of Total
Construction Costs	$4,930,332	63.1%
Moveable Equipment	$1,035,500	13.3%
Architect / Consulting Fees	$362,375	4.6%
Supervision & Inspection of Site	$266,478	3.4%
Washington State Sales Tax/Other	$664,460	8.6%
Information Systems	$550,044	7.0%
Total	**$7,809,189**	**100.0%**

The cost per bed for the NICU level IIIB 32 bed project is $244,060, and the cost per square foot is $675.42, based on the original 11,562 square feet.

To further assist the department in its evaluation of this sub-criterion, HPDS reviewed the financial data reported by the hospital. Staff from HPDS provided the following analysis. [source: HPDS analysis, p3]

> *"There are several ways to review hospital newborn cost information. Hospitals report data to DOH through the financial format and the hospital inpatient format. In the financial reporting system, hospitals can report all newborn revenue and expense for delivery and post partum care under account 6100 Alternative Birth Center or they can report it under 6170 Nursery for the baby only and 6070 Acute Care for the mom. Newborns that need intensive care are reported under 6010 Intensive Care, which also includes Adult and Pediatric patients. TGH currently uses 6100 Alternative Birth Center when it reports its year end data to DOH. This applications projected revenue and expense is in the middle for those hospitals that report only using 6100 Alternative Birth Center."*

HPDS also notes those newborn days in the intensive care unit are usually a small percent of the total. HPDS reviewed the hospital inpatient database (CHARS) for comparison data. Revenue Code 0172 is ICN level II care and 0173 is NICU level III care in the CHARS database. HPDS calculated the average charges per day for those discharges that included Revenue Code 0172 and those for 0173. The average charge per day in 2009 in CHARS was similar to the projections in the applicant's individual ICN level II pro-forma. [source: HPDS analysis, p3] Based on that review, HPDS determined that the project costs to the patient and community appears to be comparable to current providers.

Based on the information above, the department concludes that the costs of the project will probably not result in an unreasonable impact on the costs and charges for health services. **This sub-criterion is met.**

SJMC

The applicant identified a capital expenditure for this project of $1,638,436. Table 19 contains a breakdown of this capital expenditure.

Table 19
Capital Cost Breakdown

Breakdown Of Costs	Total	% Of Total
Construction Costs	$838,202	51.2%
Moveable Equipment	$522,725	31.9%
Fixed Equipment	$29,700	1.8%
Architect/Engineering Fees	$94,091	5.7%
Consulting Fees	$16,237	1.0%
Washington State Sales Tax	$122,993	7.5%
Information Systems	$14,488	0.9%
Total	**$1,638,436**	**100.0%**

The cost per bed for the five-bed project is $372,687 and the cost per square foot is $562.33. To demonstrate compliance with this sub-criterion the applicant provided a non-binding construction cost estimate from its contractor.

To further assist the department in its evaluation of this sub-criterion, HPDS reviewed the financial data reported by the hospital. Staff from HPDS provided the following analysis. [source: HPDS analysis, p3]

> *"There are several ways to review hospital newborn cost information. Hospitals report data to DOH through the financial format and the hospital inpatient format. In the financial reporting system, hospitals can report all newborn revenue and expense for delivery and post partum care under account 6100 Alternative Birth Center or they can report it under 6170 Nursery for the baby only and 6070 Acute Care for the mom. Newborns that need intensive care are reported under 6010 Intensive Care, which also includes Adult and Pediatric patients. SJMC currently uses 6100 Alternative Birth Center when it reports its year end data to DOH. This applications projected revenue and expense is in the middle for those hospitals that report only using 6100 Alternative Birth Center."*

HPDS also notes those newborn days in the intensive care unit are usually a small percent of the total. HPDS reviewed the hospital inpatient database (CHARS) for comparison data. Revenue Code 0172 is ICN level II care and 0173 is NICU level III care in the CHARS database. HPDS calculated the average charges per day for those discharges that included Revenue Code 0172 and those for 0173. The average charge per day in 2009 in CHARS was similar to the projections in the applicant's individual ICN level II pro-forma. [source: HPDS analysis, p3] Based on that review, HPDS determined that the project costs to the patient and community appears to be comparable to current providers.

Based on the information above, the department concludes that the costs of the project will probably not result in an unreasonable impact on the costs and charges for health services. **This sub-criterion is met.**

(3) <u>The project can be appropriately financed.</u>

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 246310-200(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.

<u>TGH</u>

TGH's capital expenditure is $7,809,189. The applicant is proposing to use capital reserves and has adequate cash reserves to fund this project. This project will not adversely impact reserves, total assets, total liability, or the general health of the hospital or the applicant in a significant way. [source: HPDS analysis, p4]

To demonstrate compliance with this sub-criterion, TGH submitted a letter from the CFO attesting to the financial commitment to this project. [source: May 4, 2011 Response to Screening Questions, Exhibit 28]

Based on the source information reviewed for the bed addition project at TGH and the review provided by HPDS, the department concludes that the financing the project through the applicant's reserves is a prudent approach, and would not negatively affect the applicant's total assets, total liability, or general financial health. **This sub-criterion is met.**

SJMC

SJMC 's capital expenditure is $1,638,436. The applicant is proposing to use capital reserves and has adequate cash reserves to fund this project. This project will not adversely impact reserves, total assets, total liability, or the general health of the hospital or the applicant in a significant way. [source: HPDS analysis, p4]

To demonstrate compliance with this sub-criterion, SJMC submitted a letter from the CFO attesting to the financial commitment to this project. [source: May 3, 2011 Response to Screening Questions, Attachment 9]

Based on the source information reviewed for this project at SJMC and the review provided by HPDS, the department concludes that the financing the project through the applicant's reserves is a prudent approach, and would not negatively affect the applicant's total assets, total liability, or general financial health. **This sub-criterion is met.**

C. Structure and Process (Quality) of Care (WAC 246-310-230) and the Year 2010 Washington State Perinatal Level of Care Guidelines.

TGH

Based on the source information reviewed and the applicant's agreement to the conditions identified in the 'conclusion' section of this evaluation, the department concludes the applicant has met the structure and process of care criteria in WAC 246-310-230 and the Washington State Perinatal Levels of Care Guidelines.

SJMC

Based on the source information reviewed and the applicant's agreement to the conditions identified in the 'conclusion' section of this evaluation, the department concludes the applicant has met the structure and process of care criteria in WAC 246-310-230 and the Washington State Perinatal Levels of Care Guidelines.

(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.

TGH

TGH currently offers both ICN level II and NICU level III services and the combined nursery is staffed by qualified staff specifically trained in neonatal intensive care. The staff includes registered nurses (RN), respiratory therapists, neonatologists, neonatal nurse

practitioners, nurse case managers, social workers, neonatal pharmacist, neonatal nutritionist, lactation consultant, and ancillary support staff. The staff providing direct patient care is "flexed" with increasing patient days. There is some flexing of FTEs providing ancillary support services. [source: Application, p49 & 52]

Review of the NICU cost center projections provided by TGH indicates a moderate increase in staff. Since TGH is currently operating a 30 bed NICU level III unit (22 unlicensed) and would need to add staff only for the additional 10 new NICU level IIIB beds. In the need portion of this evaluation, the department determined that approval of an additional 10 new NICU level III beds was supported. As a result, this sub-criterion is reviewed as the approval of 10 NICU level IIIB beds and the staff needed for the 10 new additional beds. A review of the ancillary and support units affected by this project also indicates moderate increases in staff for the addition of the 10 NICU level IIIB beds. [source: Application, Exhibit 20]

TGH states that it expects no difficulty in retaining FTEs for a variety of reasons. The applicant offers a competitive wage scale and benefits package. In addition they offer internal residency programs to provide specific skills needed for staffing the neonatal unit. [source: Application, p52 & 53]

In addition to the staff identified above, TGH identified their key medical staff for the neonatal unit. The medical director for the obstetrical department is Richard Schroeder, MD and the medical director for the neonatal services is Ray Sato, MD (neonatal/perinatal medicine specialist).

These key medical staff positions are further evaluated in conjunction with the department's evaluation of the project's conformance with the Washington State Perinatal Levels of Care guidelines shown below. These guidelines detail the requirements for the services supporting the neonatal units.

Washington State Perinatal Levels of Care Guidelines

As part of its evaluation of structure and process of care criteria found under WAC 246-310-230, the department uses the standards of care guidelines outlined in the Washington State Perinatal Levels of Care Criteria as guidance in evaluating this project. The guidelines, adopted by the Perinatal Advisory Committee on September 2010, offer recommendations on facility and staffing standards for ICN level II and NICU level III services. Within the guidelines, NICU level III services are separated into A, B, and C categories with A being the lease intensive and C being the most intensive.

The Perinatal Levels of Care Criteria recommend that an applicant be providing the previous level of services before applying for the next higher level. TGH is already providing level I, level II and level IIIB services. The applicant provided a comparison chart as verification and documentation that its NICU level IIIB services currently meet or exceed the advisory committee's recommended guidelines. [source: Application, Exhibit 10] The comparison chart is provided in Appendix A attached to this evaluation.

In addition to the comparison chart provided in Appendix A, TGH also provided the following documents to further demonstrate that it meets the existing standards of care with its NICU level IIIB services:

- MultiCare Health System, Tacoma General Hospital, Neonatal Intensive Care Nursery Functional Program
  This program briefly describes the patients that will use this facility and the staff, and facilities that will operate this facility.
- MultiCare Health System Utilization Review Plan
  This policy is designed to determine whether a patient meets the criteria for admission and continued stay criteria for the hospital and to assist in the patients needs at discharge. [Source: Application, Exhibit 25]
- MultiCare Health System, Discharge Planning Policy
  This policy describes the personnel involved in planning for the discharge of patients and the steps required to ensure appropriate and coordinated discharge of all patients.

Based on the information provided by MHS in its application and supplemental documentation, the department concludes that, if approved, TGH's NICU level IIIB project is consistent with the Washington State Perinatal Levels of Care guidelines. **This sub-criterion is met.**

SJMC

SJMC is currently offering ICN level IIB services and is proposing to establish a 5-bed NICU level IIIA unit. SJMC currently provides care to babies with level III diagnoses that are born at their hospital and require stabilization prior to being transported to a NICU level IIIB unit. SJMC is proposing to add 4.5 FTE RNs and 0.3 FTE CNAs to the existing staff in 2013 if this project is approved. SJMC reports not having difficulty in recruiting clinical staff due to being located in a large urban area. SJMC offers a competitive wage and benefit package as well as numerous other recruitment and retentions strategies. SJMC projects a total staff of 27.03 FTEs through calendar year 2015 for the combined level II/IIIA unit.

Public Comment

TGH provided several research articles regarding concerns with quality of care provided by very small NICU level III units. The department reviewed this information and considered the information in the review of the proposed 5 bed unit.

Based on the information provided in the application and the small number of additional staff required for implementation of this project, the department concludes that the applicant will be able to recruit and retain the staff necessary for the new facility. [source: Application pp35 & 36]. **This sub-criterion is met.**

In addition to the staff identified above, the applicant identified their key medical staff for the neonatal unit. The medical director for the obstetrical department is Peter Robilio, MD (board certified in maternal-fetal medicine) and the medical director for neonatal services is Glen Jordan MD (board certified in neonatology).

These key medical staff positions are further evaluated in conjunction with the department's evaluation of the project's conformance with the Washington State Perinatal Levels of Care guidelines shown below. These guidelines detail the requirements for the services supporting the NICU level III units.

Washington State Perinatal Levels of Care Guidelines

As part of its evaluation of structure and process of care criteria found under WAC 246-310-230, the department uses the standards of care guidelines outlined in the Washington State Perinatal Levels of Care Criteria as guidance in evaluating this project. The guidelines, adopted by the Perinatal Advisory Committee on September 2010, offer recommendations on facility and staffing standards for ICN level II and NICU level III services. Within the guidelines, NICU level III services are separated into A, B, and C categories with A being the lease intensive and C being the most intensive.

The Perinatal Levels of Care Criteria recommend that an applicant be providing the previous level of services before applying for the next higher level. SJMC is already providing level I, and ICN level IIB services, and provided a comparison chart as verification and documentation that its proposed NICU level IIIA service will meet or exceed the advisory committee's recommended guidelines. [source: Application, Exhibit 1] The comparison chart is provided in Appendix B attached to this evaluation.

In addition to the comparison chart provided in Appendix B, the applicant also provided the following documents to further demonstrate that it meets the existing standards of care with its NICU level IIIA services:

- Neonatal transport policy and transfer agreement
  This agreement describes the policies and procedures for transporting babies to Tacoma General Hospital using their neonatal transport team.
- Neonatologist letter of support
  The medical group that would be staffing the NICU level IIIA unit provided a letter of support for the project.

The department concludes the SJMC's NICU level IIIA project is consistent with the Washington State Perinatal Levels of Care guidelines. **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(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.

TGH

This sub-criterion was extensively evaluated within the sub-criterion above. **This sub-criterion is met.**

SJMC

This sub-criterion was extensively evaluated within the sub-criterion above. **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 no 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.[12] 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.

TGH

TGH will continue to provide Medicare and Medicaid services to the residents of Pierce County and surrounding communities. The hospital contracts with the Joint Commission to survey and accredit the quality of service provided. The Joint Commission lists TGH in full compliance with all applicable standards following the most recent on-site survey in March 2008.

Complementing reviews performed by the Joint Commission are the surveys conducted by the department's Investigation and Inspection's Office (IIO). For the most recent two years, IIO completed one licensing survey at the hospital. There were no adverse licensing actions as a result of the survey. Review of the credentialing records maintained by the department on other healthcare facilities operated by the applicant did not reveal any major deficiencies. [source: Facility survey data provided by DOH Investigations and Inspections Office]

The majority of TGH's staff is already in place for the existing NICU level III service. TGH provided names and professional license number for all credentialed staff. Quality of care for TGH's staff is verified through the data maintained for the various licensing Boards and Commissions of the Department of Health. A compliance history review of all medical staff associated with TGH's NICU level III nursery did not reveal any compliance issues. [source: Compliance history provided by Medical Quality Assurance Commission]

Based on TGH's compliance history and the compliance history of the licensed staff associated with the neonatal unit, the department concludes that there is reasonable assurance

[12] Also pertains to WAC 246-310-230(5).

that the hospital would continue to operate in conformance with state and federal regulations. **This sub-criterion is met.**

SJMC

SJMC will continue to provide Medicare and Medicaid services to the residents of Pierce County and surrounding communities. The hospital contracts with the Joint Commission to survey and accredit the quality of service provided. The Joint Commission lists SJMC in full compliance with all applicable standards following the most recent on-site survey in August 2008.

Complementing reviews performed by the Joint Commission are the surveys conducted by the department's Investigation and Inspection's Office (IIO). For the most recent two years, IIO completed one licensing survey at the hospital. There were no adverse licensing actions as a result of the survey. Review of the credentialing records maintained by the department on other healthcare facilities operated by the applicant did not reveal any major deficiencies [source: Facility survey data provided by DOH Investigations and Inspections Office]

The majority of SJMC's staff is already in place for the existing ICN level IIB service. the applicant provided names and professional license number for all credentialed staff. Quality of care for SJMC's staff is verified through the data maintained for the various licensing Boards and Commissions of the Department of Health. A compliance history review of all medical staff associated with SJMC's family birth center and special care nursery reveals no recorded sanctions. [source: Compliance history provided by Medical Quality Assurance Commission]

The department concludes that there is reasonable assurance that the hospital would continue to operate in conformance with state and federal regulations. **This sub-criterion is met.**

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

WAC 246-310 does not contain specific WAC 246-310-230(4) criteria as identified in WAC 246-310-200(2) (a)(i). 0There 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.

TGH

In response to this sub-criterion, TGH reports currently having census in the unit that exceeds the capacity on a frequent basis. TGH is also improving its outreach activities which are expected to increase census in the unit. Currently TGH is only provider operating a NICU level III nursery in its defined service area and is also the Perinatal Regional Coordinator for the Southwest Washington Region. TGH has Mary Bridge Children's Hospital on site which provides immediate access to additional sub-specialty physicians to provide diagnostic and treatment services for the seriously ill newborns. TGH also provides the neonatal transport

services for this area and has transfer arrangements with most of the hospitals in this perinatal region.

The department concludes that there is reasonable assurance that approval of this project would allow continued access to a quality NICU level III service. Further, TGH's relationships within the existing health care system would continue and are not likely to result in an unwarranted fragmentation of services. **This sub-criterion is met.**

SJMC

In response to this sub-criterion, SJMC notes that they have a sizable newborn service. Expanding into NICU level IIIA would enable them to consistently care for infants that would have to be transferred. SJMC would continue to transfer some infants to a higher level of service than could be provided at SJMC.

The department concludes that establishment of a 5 bed NICU level IIIA unit would allow access to services not currently offered by SJMC. Further, SJMC's relationships within the existing health care system would continue and are not likely to result in an unwarranted fragmentation of services. **This sub-criterion is met.**

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

TGH

This sub-criterion is also addressed in sub-section (3) above. **This sub-criterion is met**

SJMC

This sub-criterion is also addressed in sub-section (3) above. **This sub-criterion is met.**

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

TGH

Based on the source information reviewed and the applicant's agreement to the conditions identified in the 'conclusion' section of this evaluation, the department concludes that the applicant has met the cost containment criteria in WAC 246-310-240.

SJMC

Based on the source information reviewed and the applicant's agreement to the conditions identified in the 'conclusion' section of this evaluation, the department concludes that the applicant has met the cost containment criteria in WAC 246-310-240.

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

To determine if a proposed project is the best alternative, the department takes a multi-step approach. Step one determines if the application has met the other criteria of WAC 246-310-210 thru 230. If it has failed to meet one or more of these criteria then the project is determined not to be the best alternative, and would fail this sub-criterion.

If the project met WAC 246-310-210 through 230 criteria, the department would move to step two in the process and assess the other options the applicant or applicants considered prior to submitting the application under review. If the department determines the proposed project is better or equal to other options the applicant considered before submitting their application, the determination is either made that this criterion is met (regular or expedited reviews), or in the case of projects under concurrent review, move on to step three.

Step three of this assessment is to apply any service or facility specific criteria (tie-breaker) contained in WAC 246-310. The tiebreaker 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 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.

TGH

Step One

For this project, TGH has met the review criteria under WAC 246-310-210, 220, and 230. Additionally, TGH has met the service specific review criteria identified in the Washington State Perinatal Levels of Care Criteria adopted by the Perinatal Advisory Committee on September 2010. Therefore, the department moves to step two below.

Step Two

Before submitting this application, the applicant considered three alternatives. Below is a summary of the applicant's alternatives and the rationale for rejecting them. [source: Application p56 thru 60]

Alternative 1-Do nothing.

This alternative was considered unacceptable by the applicant from a patient access, continuity of care and regulatory perspective. It does not address the issue of improving access and flexibility by increasing the number of NICU level III beds. While this alternative does not have any requirements for additional capital or space, it leaves the operation of 47% of TGHs NICU level III beds unlicensed. The applicant rejected this alternative.

Alternative 2-Request Fewer Level IIIB Bassinets

TGH states that based on its need calculations, they could be approaching a high level of occupancy for its existing 30 bed unit by 2015. If the TGH achieves the growth of patient days projected in the need calculations, they could also experience a need for additional ICN level II beds. While ICN level II services could be provided by other providers in the nine-county planning area, TGH is the only provider of NICU level III services in the planning area. This alternative was rejected by MHS since it would not address the increasing market demand. Also this alternative does not take advantage of the opportunity to be a part of a larger project for funding and space for the additional neonatal services.

Alternative 3-Request a larger number of beds

TGH reports that this alternative would provide for improved access, but it is not supported by the need calculations. This alternative would be more costly and less efficient and could possibly be disapproved.

The department agrees the 'do nothing' alternative must be rejected because TGH is currently operating 22 beds that are required to be included in its license. The remedy for an applicant who is operating out of compliance is to submit a Certificate of Need application. As a result, 'do nothing' is not a viable alternative for this project.

The feasible alternative identified by the applicant is to add beds to TGH. The department's need analysis supports less than the 20 beds proposed by applicant. Based on the documentation provided in the application and the response to screening questions, the department determined that the applicant's Alternative #2 is the best available alternative for the community. **This sub-criterion is met.**

SJMC

Step One

For this project, the applicant has met the review criteria under WAC 246-310-210, 220, and 230. Additionally, the applicant has met the service specific review criteria for a level IIIA NICU services identified in the Washington State Perinatal Levels of Care Criteria adopted by the Perinatal Advisory Committee on September 2010. Therefore, the department moves to step two below.

Step Two

Before submitting this application, the applicant considered two alternatives. Below is a summary of the applicant's alternatives and the rationale for rejecting them. [source: Application p40]

Alternative 1-Maintain status as an ICN level II provider only and continue to transfer neonates and maternal cases to other centers

The applicant determined this alternative is not acceptable for the several reasons. Currently SJMC staff finds that they are caring for level III neonates when a mother delivers with no prior signs that the infant would be a level III patient. In these instances, SJMC is providing NICU level III services without prior approval to do so. SJMC currently has staff and systems available to care for these infants prior to transfer. The applicant states that continuing to transfer neonates and maternal cases causes disruption in care delivery to their patients. They also state that because TGH has submitted an application for expansion of their NICU level III unit, the applicant believes there must be a need for additional level III beds in the planning area.

Alternative 2-Pursue a 10 or 15 bed NICU level III unit

The applicant states it rejected this alternative because it does not currently have the physical space to house a larger unit. A larger unit would require major construction resulting in a higher cost to the project.

The department agrees the do nothing option should be rejected because SJMC is occasionally providing level IIIA services. In order to provide the services on an ongoing basis, Certificate of Need approval must be obtained. As a result, the 'do nothing' alternative is unavailable to the applicant if SJMC intends to continue providing level IIIA services.

Since the only feasible alternative is to submit an application, the applicant must then determine the number of level IIIA beds needed. SJMC is not a current provider of level III services in Pierce County, the numeric methodology provided in the application may be conservative. However, based on the numeric methodology and current space constraints, FHS opted to reject Alternative #2 above by requesting only five level IIIA beds. As previously stated, the department's need analysis supports less than the 20 beds proposed by TGH and supports the addition of the 5 beds at SJMC. Based on the documentation provided in the application, FHS demonstrated that its project is the best available alternative for the community. **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;

WAC 246-310 does not contain specific WAC 246-310-240(2)(a) criteria as identified in WAC 246-310-200(2)(a)(i). There are known minimum building and energy standards that healthcare facilities must meet to be licensed or certified to provide care. If built to only the minimum standards all construction projects could be determined to be reasonable. However, the department, through its experience knows that construction projects are usually built to exceed these minimum standards. Therefore, the department considered information in the applications that addressed the reasonableness of their construction projects that exceeded minimum standards.

TGH
This sub-criterion is primarily evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that **this sub-criterion is met.**

SJMC
This sub-criterion is primarily evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that **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.

TGH
This sub-criterion is primarily evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that **this sub-criterion is met.**

SJMC
This sub-criterion is primarily evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that **this sub-criterion is met.**

APPENDIX A

Appendix A
TG Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIB	TG	PASS/FAIL
General Function		**Pass**
Level IIIA functions plus: Diagnosis and management of all complicated pregnancies and neonates of all gestational ages Advanced respiratory support (such as high frequency ventilation and inhaled nitric oxide) Immediate consultation from pediatric surgical subspecialists for diagnosis of complications of prematurity and capabilities to perform surgery on-site or at a closely related institution, which would ideally be in geographic proximity and share coordinated care, such as physician staff	Level IIIA functions plus: Diagnosis and management of all complicated pregnancies and neonates of all gestational ages Advanced respiratory support (such as high frequency ventilation and inhaled nitric oxide) Immediate consultation from pediatric surgical subspecialists for diagnosis of complications of prematurity and capabilities to perform surgery on-site or at a closely related institution, which would ideally be in geographic proximity and share coordinated care, such as physician staff	TG meets all Level IIIB guidelines.
Neonatal Patients: Services and Capabilities		**Pass**
Level IIIA patients and services plus: Capabilities: Neonates of all gestational ages To performs surgery to treat acute surgical complications of prematurity on-site or at a closely related institution, which would ideally be in geographic proximity and share coordinated care, such as physician staff. For advanced respiratory support (such as high frequency ventilation and inhaled nitric oxide) For advanced imaging with interpretation on an urgent basis, including CT, MRI, and echocardiography Average Daily Census (ADC) of at least 10 level II/level III patients.	Level IIIA patients and services plus: Neonates of all gestational ages Capabilities: To performs surgery to treat acute surgical complications of prematurity on-site or at a closely related institution, which would ideally be in geographic proximity and share coordinated care, such as physician staff. For advanced respiratory support (such as high frequency ventilation and inhaled nitric oxide) For advanced imaging with interpretation on an urgent basis, including CT, MRI, and echocardiography Average Daily Census (ADC) of at least 10 level II/level III patients.	TG meets all Level IIIB guidelines.

Appendix A
TG Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIB	TG	PASS/FAIL
Obstetrical Patients: Services and Capabilities		**Pass**
Level III A patients and services plus: Pregnancies at all gestational ages Capabilities include: Diagnosis and treatment of all perinatal problems	Level III A patients and services plus: Pregnancies at all gestational ages Capabilities include: Diagnosis and treatment of all perinatal problems	TG meets all requirements for OB patient's services and capabilities.
Patient Transport		**Pass**
All hospitals demonstrate capabilities to stabilize and initiate transport of patients in the event of unanticipated maternal-fetal- newborn problems that require care outside the scope of the designated level of care. Access to return transport services may be a necessary capability for Level IIIA and Level III B intensive care nurseries. **A hospital that transports patients to a higher level of care facility should:** Demonstrate on-going relationships with referral hospital(s) for education, immediate consultation, urgent transport facilitation, and quality assurance. Establish a written policy and procedures for maternal and neonatal transport that includes an established triage system for identifying patients at risk who should be transferred to a facility that provides the appropriate level of care. Establish guidelines that ensure a provider's continuing responsibility for and care of the patient until transport team personnel or receiving hospital personnel assume full responsibility for the patient. A hospital that accepts maternal or neonatal transports in order to provide a higher level of care than is offered at the referral hospital should: Participate in perinatal and/or neonatal case reviews a the referral hospital Collaborate with state contracted perinatal center for coordinating outreach education Maintain a 24/hr/day system for reliable, communication between hospitals for immediate consultation, and approval of maternal and newborn transports Provide referring physicians with ongoing communications and recommendations for ongoing patient care at discharge	Meets level IIIB criteria for patient transport	TG operates the Neonatal transport service and provided documentation required to meet patient transport guideline.

Appendix A
TG Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIB	TG	PASS/FAIL
Medical Director		**Pass**
Obstetrics: board –certified in maternal-fetal medicine Nursery: Board-certified in Neonatology	Obstetrics: board –certified in maternal-fetal medicine Nursery: board-certified in neonatology	Medical Directors meet Level IIIB requirements
Medical Providers		**Pass**
Level II A coverage plus: Obstetrics: Immediate availability of an obstetrician with demonstrated competence in the management of complicated labor and delivery patients Newborn: Immediate availability of neonatologist, pediatrician, or neonatal nurse practitioner with demonstrated competence in the management of severely ill neonates including those requiring mechanical ventilation Level IIIA staff plus: Anesthesiologist skilled in pediatric anesthesia on-call Pediatric imaging including CT, MRI, and echocardiography services and consultation with interpretation available on an urgent basis	Level IIA coverage plus Obstetrics: Immediate availability of an obstetrician with demonstrated competence in the management of complicated labor and delivery patients Newborn: Immediate availability of neonatologist, pediatrician, or neonatal nurse practitioner with demonstrated competence in the management of severely ill neonates including those requiring mechanical ventilation Level IIIA staff plus: Anesthesiologist skilled in pediatric anesthesia on-call Pediatric imaging including CT, MRI, and echocardiography services and consultation with interpretation available on an urgent basis	Medical providers meet criteria. Meets level IIIB requirements
Nurse Patient Ratio		**Pass**
Staffing parameters should be clearly delineated in a policy that reflects (a) staff mix and ability levels (b) patient census, intensity, and acuity (c) Plans for delegation of selected clearly defined tasks to competent assistive personnel. It is an expectation that allocation of personnel provides for safe care of all patients in a setting where census and acuity are dynamic Intrapartum 1:2 patients in labor 1:2 induction or augmentation of labor 1:1 patients in second-stage labor 1:1 patients with medical or obstetric complications	Meets all required nurse patient ratios, as delineated	TG meets NICU level IIIB requirements

Appendix A
TG Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIB	TG	PASS/FAIL
1:1 coverage for intuiting epidural anesthesia 1:1 circulation for caesarean delivery Antepartum/postpartum 1:6 patients without complications 1:4 recently born neonates and those requiring close observation 1:3-4 normal mother-baby couplet care 1:3 antepartum/postpartum patients with complications but in stable condition Newborns 1:6-8 neonates requiring only routine care* 1:4 recently born neonates and those requiring close observation 1:3-4 neonates requiring continuing care 1:2-3 neonates requiring intermediate care 1:1-2 neonates requiring intensive care 1:1 neonates requiring multisystem care 1:1 or greater unstable neonates requiring complex critical care *Reflects traditional newborn nursery care. A nurse should be available at all times, but only one may be necessary, as most healthy neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the nurse's direct supervision. Adequate staff is needed to respond to acute and emergency situations.		
Nursing Management		**Pass**
Nurse manger of perinatal services Nurse manager of nursery services	Advanced degree is desirable	TG meets requirement
Same as Level I plus: Advanced degree desirable		
Pharmacy, Nutrition/Lactation and OT/PT		**Pass**
Same as level IIB Registered pharmacist with experience in neonatal/perinatal pharmacology available for, 24 hrs/day and 7 days/wk.	Registered pharmacist with experience in neonatal/perinatal pharmacology available 24 hrs/day 7 days/week	TG meets requirement.

Appendix A
TG Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIB	TG	PASS/FAIL
Nutrition/Lactation At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates	Same as Level IIA services plus: At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates	TG meets requirement.
OT/PT Services Provide for inpatient consultation and outpatient follow-up services	Provide for inpatient consultation and outpatient follow-up services	TG meets requirement.
Social Services/Case Management		**Pass**
Level II B services plus: At least one full-time licensed MSW (for every 30 beds) who has experience with socioeconomic and psychosocial problems of high-risk mothers and babies available 24 hrs/days 7 days/wk.	Level IIB services plus: At least one full-time licensed MSW (for every 30 beds) who has experience with socioeconomic and psychosocial problems of high-risk mothers and babies available 24 hrs/days 7 days/wk.	TG meets requirement.
Nurse educator/Clinical Nurse specialist		
A nurse educator or clinical nurse specialist with appropriate training in intensive neonatal or perinatal care to coordinate staff education and development	A nurse educator or clinical nurse specialist with appropriate training in intensive neonatal or perinatal care to coordinate staff education and development	TG meets requirement.
Respiratory Therapy		**Pass**
Level IIB plus: 1 Respiratory Care Practitioner: 6 or fewer ventilated neonates with additional staff for procedures	Level IIB plus: 1 Respiratory Care Practitioner: 6 or fewer ventilated neonates with additional staff for procedures	TG meets requirement.
X-Ray/Ultrasound		**Pass**
Level IIB Service Plus: Advanced level Ultrasound available to Labor & Delivery and Nursery on-site	Level IIB plus: Advanced level Ultrasound available to Labor & Delivery and Nursery on-site	meets requirement
Laboratory		**Pass**
Comprehensive services available 24 hrs/day and 7 days/wk	Comprehensive services available 24 hrs/day	TG meets requirement.
Blood Bank		**Pass**
Blood bank technician on-call and available within 30 minutes for performance of routine blood banking procedures Provision for emergent availability of blood and blood products	Meet Blood Bank Criteria	TG meets requirement.

APPENDIX B

Appendix B
SJMC Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIA	SJMC	PASS/FAIL
General Function		**Pass**
All Level IIB functions plus Diagnosis and management of selected complicated pregnancies and neonates >28weeks gestation and >1000 grams Care of severely ill neonates requiring conventional mechanical ventilation Minor surgical procedures such as central venous catheter or inguinal hernia repair r Establishment of a perinatal database for quality improvement and outcomes monitoring	Level IIA functions plus: Diagnosis and Management of selected complicated pregnancies and neonates >32 0/7weeks gestation and >1500 grams Care of moderately ill neonates including those who may require conventional mechanical ventilation for brief duration (<24 hrs) or nasal CPAP	SJMC meets all Level IIIA guidelines.
Neonatal Patients: Services and Capabilities		**Pass**
Level IIB patients and services plus: Neonates ≥28 weeks gestation and 1000 grams Severely ill neonates at risk for or requiring mechanical ventilation Capabilities for: Prolonged conventional mechanical ventilation Minor surgical procedures such as central venous catheter or ingual hernia repair Average Daily Census (ADC) of at least 10 level II/III patients.	 SJMC's proposed Level III program will care for infants of gestational age >28 weeks gestation and > 1000 Grams SJMC's proposed Level III program Will provide prolonged conventional Mechanical ventilation and minor Surgical services SJMC's combined ADC with full implementation of Level III is estimated to be 15.4 in 2013	SJMC meets all Level IIIA guidelines.
Obstetrical Patients: Services and Capabilities		**Pass**
Level IIB patients and services plus: Pregnancies > 28 weeks gestation and estimated birth weight >1000 grams Capabilities include Immediate cesarean delivery Maternal intensive care	Level II A patients and services plus : Pregnancies > 32 0/7 weeks gestation and estimated birth weight >1500 grams Capabilities include management consistent with ACOG guidelines of selected high-risk pregnancy condition s such as (ref 3) Preterm labor judged unlikely to deliver before 32 weeks gestation	SJMC meets all Level IIIA guidelines.
Patient Transport		**Pass**
All hospitals demonstrate capabilities to stabilize and initiate transport of patients in the event of	Meets level IIB criteria for patient transport	SJMC meets all Level

Appendix B
SJMC Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIA	SJMC	PASS/FAIL
unanticipated maternal-fetal- newborn problems that require care outside the scope of the designated level of care. Access to return transport services may be a necessary capability for Level IIIA and Level III B intensive care nurseries. **A hospital that transports patients to a higher level of care facility should:** Demonstrate on-going relationships with referral hospital(s) for education, immediate consultation, urgent transport facilitation, and quality assurance. Establish a written policy and procedures for maternal and neonatal transport that includes an established triage system for identifying patients at risk who should be transferred to a facility that provides the appropriate level of care. Establish guidelines that ensure a provider's continuing responsibility for and care of the patient until transport team personnel or receiving hospital personnel assume full responsibility for the patient. A hospital that accepts maternal or neonatal transports in order to provide a higher level of care than is offered at the referral hospital should: Participate in perinatal and/or neonatal case reviews a the referral hospital Collaborate with state contracted perinatal center for coordinating outreach education Maintain a 24/hr/day system for reliable, comprehensive communication between hospitals for immediate consultation, initiation, and approval of maternal and newborn transports Provide referring physicians with ongoing communications and recommendations for ongoing patient care at discharge		IIIA guidelines.
Medical Director		**Pass**
Obstetrics: board –certified in maternal-fetal medicine Nursery: Board-certified in Neonatology	SJMC medical director board – certified in Maternal/fetal medicine Medical director board-certified in neonatology.	SJMC meets all Level IIIA guidelines.
Medical Providers		**Pass**
Level II A coverage plus: Obstetrics: Immediate availability of an obstetrician with demonstrated competence in the	Level IIA coverage plus Continuous in-house presence of personnel experienced in airway	SJMC meets all Level IIIA guidelines.

Appendix B
SJMC Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIA	SJMC	PASS/FAIL
management of complicated labor and delivery patients Newborn: Immediate availability of neonatologist, pediatrician, or neonatal nurse practitioner with demonstrated competence in the management of severely ill neonates including those requiring mechanical ventilation Level II staff plus: Obstetrical-anesthesiologist or nurse practitioner immediately available Pediatric-echocardiography services with written protocols for pediatric cardiology consultation, including videotape interpretation Complete range of genetic diagnostic services and genetic counselor on staff, referral arrangement for geneticist and diagnostics per written protocol Arrangement for perinatal pathology services	management and diagnosis and treatment of pneumothorax when a patient is being treated with nasal CPAP or conventional mechanical ventilation Radiologist on-staff with daily availability who can interpret neonatal studies such as chest and abdominal radiographs, and cranial ultrasounds Ophthalmologist with pediatric experience available to do eye exams for neonates who are at high risk for retinopathy of prematurity (ROP) if accepting back transport of such infants; written protocol for referral or treatment Arrangement for neurodevelopment follow-up or referral per written protocol	
Nurse Patient Ratio		**Pass**
Staffing parameters should be clearly delineated in a policy that reflects (a) staff mix and ability levels (b) patient census, intensity, and acuity (c) Plans for delegation of selected clearly defined tasks to competent assistive personnel. It is an expectation that allocation of personnel provides for safe care of all patients in a setting where census and acuity are dynamic Intrapartum 1:2 patients in labor 1:2 induction or augmentation of labor 1:1 patients in second-stage labor 1:1 patients with medical or obstetric complications 1:1 coverage for intuiting epidural anesthesia 1:1 circulation for caesarean delivery Antepartum/postpartum 1:6 patients without complications 1:4 recently born neonates and those requiring close observation 1:3-4 normal mother-baby couplet care 1:3 antepartum/postpartum patients with complications but in stable condition	Meets all required nurse patient ratios, as delineated	SJMC meets all Level IIIA guidelines.

Appendix B
SJMC Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIA	SJMC	PASS/FAIL
Newborns 1:6-8 neonates requiring only routine care* 1:4 recently born neonates and those requiring close observation 1:3-4 neonates requiring continuing care 1:2-3 neonates requiring intermediate care 1:1-2 neonates requiring intensive care 1:1 neonates requiring multisystem care 1:1 or greater unstable neonates requiring complex critical care *Reflects traditional newborn nursery care. A nurse should be available at all times, but only one may be necessary, as most healthy neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the nurse's direct supervision. Adequate staff is needed to respond to acute and emergency situations.		
Nursing Management		**Pass**
Nurse manager of perinatal services Nurse manager of nursery services	Both nurse managers have advanced degrees	SJMC meets all Level IIIA guidelines.
Same as Level I plus: Advanced degree is desirable		
Pharmacy, Nutrition/Lactation and OT/PT		**Pass**
Same as level II B Registered pharmacist with experience in neonatal/perinatal pharmacology available for, 24 hrs/day and 7 days/wk.	Registered pharmacist with experience in neonatal/perinatal pharmacology available 24 hrs/day 7 days/week	SJMC meets all Level IIIA guidelines.
Nutrition/Lactation At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates	Same as Level IIA services plus: One healthcare professional knowledgeable in management of parental nutrition of low birth-weight and other high-risk neonates	
OT/PT Services Provide for inpatient consultation and outpatient follow-up services	SJMC provides for inpatient consultation and outpatient follow-up services	
Social Services/Case Management		**Pass**
Level II B services plus:	Level IIA services plus: At least one MSW with relevant	SJMC meets all Level IIIA guidelines.

Appendix B
SJMC Perinatal Levels of Care Criteria Comparison

GUIDELINE LEVEL IIIA	SJMC	PASS/FAIL
At least one full-time licensed MSW (for every 30 beds) who has experience with socioeconomic and psychosocial problems of high-risk mothers and babies available 24 hrs/days 7 days/wk.	experience whose responsibilities include perinatal patients; specific personnel for discharge planning and education, community follow-up, referral process, and home care arrangements	
Nurse educator/Clinical Nurse specialist		**Pass**
A nurse educator or clinical nurse specialist with appropriate training in intensive neonatal or perinatal care to coordinate staff education and development	The program will have a nurse educator	SJMC will meet the Level III A guideline
Respiratory Therapy		**Pass**
Level IIB plus: 1 Respiratory Care Practitioner: 6 or fewer ventilated neonates with additional staff for procedures	Same as Level II plus: Respiratory Care Practitioner with documented competence and experience in the management of neonates with cardiopulmonary disease; when CPAP in use, an RCP should be in-house and immediately available	SJMC meets all Level IIIA guidelines.
X-Ray/Ultrasound		**Pass**
Level IIB Service Plus: Advanced level Ultrasound available to Labor& Delivery and Nursery on-site	Level I services plus: Ultrasound equipment immediately accessible and available to the Labor and Delivery unit 24 hrs/day	SJMC meets all Level IIIA guidelines.
Laboratory		**Pass**
Comprehensive services available 24 hrs/day and 7 days/wk	Comprehensive services is available 24 hrs/day	SJMC meets all Level IIIA guidelines.
Blood Bank		**Pass**
Blood bank technician on-call and available within 30 minutes for performance of routine blood banking procedures Provision for emergent availability of blood and blood products	SJMC has blood bank services available to both urgent and non urgent needs	SJMC meets all Level IIIA guidelines.