STATE OF WASHINGTON
DEPARTMENT OF HEALTH

December 5, 2011

CERTIFIED MAIL # 7009 2250 0001 8668 6033

Kristopher Kitz, Director
Strategic Planning and Business Development
MultiCare Health System
Post Office Box 5299
Mailstop: 315-L4-SBD
Tacoma, Washington 98415

Re: CN11-42

Dear Mr. Kitz:

We have completed review of the Certificate of Need application submitted on behalf of MultiCare Health System proposing to add eleven acute care beds to Good Samaritan Hospital in Puyallup. For the reasons stated in this evaluation, the application submitted by MultiCare Health System is consistent with applicable criteria of the Certificate of Need Program, provided MultiCare Health System agrees to the following in its entirety.

Project Description:

This project approves the addition of 11 acute care beds to MultiCare-Good Samaritan Hospital in Puyallup. At project completion, the allocation of Good Samaritan Hospital's 286 beds is as follows:

Bed Type	# of Licensed Beds
General Medical/Surgical	250
PPS Exempt Rehabilitation Beds	25
Level II Intermediate Care Nursery Beds	11
Total Number of Licensed Beds	**286**

Conditions:

1. MultiCare Health System agrees with the project description stated above.
2. MultiCare-Good Samaritan 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. MultiCare-Good Samaritan 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% for gross revenue and 4.41% for adjusted revenue. MultiCare-Good Samaritan Hospital will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

Approved Costs:

There is no capital expenditure associated with this project.

You have two options, either accept or reject the above in its entirety. If you accept the above in its entirety, your application will be approved and a Certificate of Need sent to you. If you reject any provision of the above, you must identify that provision, and your application will be denied because approval would not be consistent with applicable Certificate of Need review criteria. Please notify the Department of Health within 20 days of the date of this letter whether you accept the above in its entirety.

Your written response should be sent to the Certificate of Need Program, at one of the following addresses.

Mailing Address:	Other Than By Mail:
Department of Health	Department of Health
Certificate of Need Program	Certificate of Need Program
Mail Stop 47852	310 Israel Road SE
Olympia, WA 98504-7852	Tumwater, WA 98501

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

Sincerely,

Steven M. Saxe, FACHE
Director, Health Professions and Facilities

Enclosure

EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY MULTICARE HEALTH SYSTEM PROPOSING TO ADD ELEVEN ACUTE CARE BEDS TO GOOD SAMARITAN HOSPITAL IN PUYALLUP

APPLICANT DESCRIPTION

MultiCare Health System is a not-for-profit health system serving the residents of southwestern Washington State. MultiCare Health System (MHS) includes four hospitals, nearly 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 owned and/or operated by MHS. [source: CN historical files, MultiCare Health System website]

- Tacoma General / Allenmore, Tacoma[1]
- Mary Bridge Children's Hospital, Tacoma[2]
- Good Samaritan Hospital, Puyallup

PROJECT DESCRIPTION

This project under review focuses on MHS's Good Samaritan Hospital (M-GSH) located at 407 - 14th Avenue in Puyallup within Pierce County. M-GSH is currently a provider of Medicare and Medicaid acute care services to the residents of east Pierce County and surrounding areas. M-GSH is licensed for 275 acute care beds, holds a three-year accreditation from the Joint Commission[3], and is designated as a level III trauma hospital and a level I adult trauma rehabilitation hospital. Additionally, M-GSH is one of four level I pediatric trauma rehabilitation hospitals in Washington State. M-GSH also operates a 25 bed PPS exempt rehabilitation unit[4] and an 11-bed level II intermediate special care nursery within its 275 licensed beds. [source: Application, pp7-8 and DOH Office of Emergency Medical and Trauma Prevention]

---

[1] 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."

[2] Mary Bridge Children's Hospital is located within Tacoma General Hospital; each facility is licensed separately.

[3] An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 19,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. [source: Joint Commission website]

[4] Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups [DRGs] for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. [source: CMS website]

In addition to the hospital, M-GSH owns and operates a variety of other health care facilities in Pierce County. The health care facilities are listed below. [source: Application, p4]

Good Samaritan Rehabilitation	Puyallup
Good Samaritan Home Health / Hospice Services	Puyallup
Good Samaritan Maternal Case Management	Puyallup
Good Samaritan Surgery Center	Puyallup
Home Infusion Equipment / Home Infusion Drugs	Puyallup
Behavioral Health	Puyallup
Adult Day Health	Tacoma

This project proposes to add 11 acute care beds to the hospital for a facility total of 286 acute care beds. Below is a breakdown of M-GSH's current 275 licensed beds and proposed 286 licensed beds. [source: Application, p15]

Bed Type	Current # of Licensed Beds	Proposed # of Licensed Beds
General Medical/Surgical	239	250
PPS Exempt Rehabilitation Beds	25	25
Level II Intermediate Care Nursery Beds	11	11
Total Number of Licensed Beds	**275**	**286**

On April 10, 2003, M-GSH received approval to establish an 11-bed level II intermediate care nursery (ICN) at the hospital.[5] At that time, the hospital assumed that the 11 ICN beds did not have to be licensed as part of the hospital's acute care beds and was already operating 250 general medical surgical acute care beds. This assumption is incorrect. As a result, M-GSH submitted this application to add 11 acute care beds to the hospital's license. Since all 11 beds have been operational as general medical surgical beds, no additional construction or new equipment is required for this project. As a result, no capital expenditure is associated with this project. [source: Application, p7 and p44]

If this project is approved, M-GSH would work with the department's hospital licensing office to obtain licensure for the 11 beds as soon as possible. Under this timeline, year 2012 would be the hospital's first full calendar year of operation with 286 licensed beds and year 2014 would be year three. [source: Application, p17]

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need (CN) review because it is the change in bed capacity of a health care facility as defined in Revised Code of Washington (RCW) 70.38.105(4)(e) and WAC 246-310-020(1)(c).

[5] CN #1261 was issued to Good Samaritan Hospital on April 10, 2003. At that time, the hospital was not affiliated with MultiCare Health System.

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 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, the 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] Additionally, WAC 246-310 does not contain service or facility specific criteria for hospital projects. Therefore the department uses the acute care bed forecasting method from the 1987 State Health Plan as part of its need assessment.

[6] Each criterion contains certain sub-criteria. The following sub-criteria are not discussed in this evaluation because they are not relevant to this project: WAC 246-310-210(3) through (6); WAC 246-310-220(2) and (3); and WAC 246-310-240(2) and (3).

APPLICATION CHRONOLOGY

Below is a chronologic summary of this project.

Action	M-GSH
Letter of Intent Submitted	December 13, 2010
Application Submitted	June 8, 2011
Department's pre-review activities including screening and responses	June 9, 2011, through September 1, 2011
Beginning of Review • public comments accepted throughout review; • no public hearing requested or conducted	September 2, 2011
End of Public Comment	October 7, 2011
Rebuttal Comments Received[7]	October 25, 2011
Department's Anticipated Decision Date	December 9, 2011
Department's Actual Decision Date	December 5, 2011

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."

Throughout the review of this project, no entities sought and received affected person status under WAC 246-310-010(2).

SOURCE INFORMATION REVIEWED

- MultiCare-Good Samaritan Hospital Certificate of Need Application submitted June 8, 2011
- MultiCare-Good Samaritan Hospital supplemental information dated August 9, 2011
- Public comments submitted by community members and healthcare providers
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Hospital and Patient Data Systems
- Historical charity care data obtained from the Department of Health's Hospital and Patient Data Systems (2007, 2008, and 2009 summaries)
- Financial feasibility and cost containment evaluation prepared by the Department of Health's Hospital and Patient Data Systems received November 1, 2011
- Licensing and/or survey data provided by the Department of Health's Investigations and Inspections Office
- Joint Commission website [www.qualitycheck.org]
- Center for Medicare and Medicaid services website [www.cms.gov]

[7] 12 letters of support were provided as public comment and no letters of opposition. MHS chose to not provide rebuttal statements to the public comments.

CONCLUSION

For the reasons stated in this evaluation, the application submitted by MultiCare Health System proposing to add eleven acute care beds to Good Samaritan Hospital in Puyallup is consistent with the applicable review criteria, provided MultiCare Health System agrees to the following in its entirety.

Project Description:

This project approves the addition of 11 acute care beds to MultiCare-Good Samaritan Hospital in Puyallup. At project completion, the allocation of Good Samaritan Hospital's 286 beds is as follows:

Bed Type	# of Licensed Beds
General Medical/Surgical	250
PPS Exempt Rehabilitation Beds	25
Level II Intermediate Care Nursery Beds	11
Total Number of Licensed Beds	**286**

Conditions:

1. MultiCare Health System agrees with the project description stated above.
2. MultiCare-Good Samaritan 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. MultiCare-Good Samaritan 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% for gross revenue and 4.41% for adjusted revenue. MultiCare-Good Samaritan Hospital will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

Approved Costs:

There is no capital expenditure associated with this project.

A. Need (WAC 246-310-210) Need and Acute Care Bed Forecasting Method

Based on the source information reviewed and the applicant's agreement to the conditions identified in the "Conclusion" section of this evaluation, the department determines that MultiCare-Good Samaritan Hospital has met the need criteria in WAC 246-310-210(1) and (2) and the project is consistent with the applicable acute care bed methodology portions of the 1987 State Health Plan.

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

WAC 246-310 does not contain an acute care bed need forecasting method. Therefore the department uses the method from the 1987 State Health Plan as part of its need assessment. This forecasting method is designed to evaluate need for additional capacity in general, rather than identify need for a specific project. The department prepared bed need forecasts to determine baseline need for acute care capacity. This set of projections is completed prior to determining whether the applicant should be approved to meet any projected need.

Summary of Good Samaritan Hospital's Numeric Methodology

MHS used the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP) to assist in its determination of numeric need. The department's methodology uses population and healthcare use statistics on several levels: statewide, Health Service Area (HSA)[8], and planning area. Pierce County is included in HSA #1 and the county is broken into three planning areas: central, east, and west. MHS appropriately focused its need calculations on the east Pierce planning area. M-GSH is the only hospital in the planning area.

As previously stated in the project description portion of this evaluation, M-GSH is currently licensed for 275 beds, and of those, 25 are dedicated to rehabilitation services and 11 are dedicated to a level II ICN. M-GSH proposes to add 11 acute care, general medical surgical beds, for a facility total of 286. Since there is no construction or additional equipment to implement this project, if approved, year 2012 would be the hospital's first full calendar year of operation with 286 licensed beds, with 2014 as year three. [source: Application, p17]

For its numeric demonstration of need for additional beds, M-GSH produced a numeric methodology using the following factors:

- OFM medium series population data for the zip codes within the east Pierce planning area.
- 2001 through 2010 total number of resident patient days, excluding psychiatric, neonates, and rehabilitation days.
- GSH is the only hospital in the planning area; 239 general medical surgical beds were subtracted from the gross need in the planning area.

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

Table 1 below is a summary of the applicant's bed need projections for the east Pierce planning area for years 2012 through 2018.

Table 1
Summary of M-GSH's East Pierce County Numeric Methodology

	2012	2013	2014	2015	2016	2017	2018
Gross Number of Beds Needed	207.38	215.56	225.17	234.26	243.81	253.86	264.43
Minus Current Supply	239.00	239.00	239.00	239.00	239.00	239.00	239.00
Net Bed Need or (Surplus)	(31.62)	(23.44)	(13.83)	(4.74)	4.81	14.86	25.43

As shown in Table 1 above, MHS projects a surplus of acute care beds until year 2016, when a slight need of 4.8 beds materializes and then increases to 25.4 beds by the end of year 2018. [source: Application, p64 and August 9, 2011, supplemental information, Exhibit 1]

The Department's Determination of Numeric Need

The department uses the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP) to assist in its determination of need for acute care capacity. This forecasting method is designed to evaluate need for additional capacity in general, rather than identify need for a specific project. Though the SHP was "sunset" in 1989, the department has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds.

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

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

The completed methodology is presented as a series of appendices to this evaluation. The methodology presented here incorporates all adjustments that were made following preparation of the methodology. Where necessary, both adjusted and un-adjusted computations are provided. The methodology uses population and healthcare use statistics

on several levels: statewide, HSA, and planning area. The planning area for this evaluation is east Pierce County.[9]

When preparing acute care bed need projections, the department relies upon population forecasts published by the Washington State Office of Financial Management (OFM). OFM publishes a set of forecasts known as the "intermediate-series" county population projections, based on the 2000 census, updated November 2007.[10]

A seven-year horizon for forecasting acute care bed projections will be used in this evaluation which is consistent with the recommendations within the state health plan that states, "*For most purposes, bed projections should not be made for more than seven years into the future.*" Further, a seven year forecast is consistent with most projects for hospital bed additions reviewed by the CN Program. Year 2010 hospital data became available in July 2011 prior to the department making its decision. Unless directed by WAC 246-310 to use a specific data set, the department's policy has been to use the most current data available. This typically favors the applicant. For this project, the department used the 2010 hospital data to compile the bed forecasts. The seven year planning horizon is year 2017.

The next portion of the evaluation will describe the calculations the department made at each step and the assumptions and adjustments made in that process. It will also include a review of any deviations related to the assumptions or adjustments made by MHS in its application of the methodology. The titles for each step are excerpted from the 1987 SHP.

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least ten years proceeding the base year.
For this step, attached as Step 1, the department obtained planning area resident utilization data for 2001 through 2010 from the Department of Health Office of Hospital and Patient Data Systems' CHARS (Comprehensive Hospital Abstract Reporting System) database. Total resident patient days were identified for HSA 1 and the State of Washington as a whole, excluding psychiatric patient days (Major Diagnostic Category, MDC-19) and neonatal bassinette patient days (Diagnostic Related Group, MDC-15), and rehabilitation days (DRGs 945 and 946) according to the county in which care was provided.

MHS followed this step as described above, and also included calculations for the east Pierce planning area.

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

MHS followed this step as described above with no deviations, and also included calculations for the east Pierce planning area.

---

[9] East Pierce Planning area includes the cities of Ashford, Buckley, Carbonado, Eatonville, Elbe, Graham, Milton, Orting, Puyallup, South Prairie, Sumner, Bonny Lake, Wilkeson, Longmire, McKenna, and Roy.
[10] The November 2007 series is the most current data set available during the production of the state acute care methodology following the release of the 2008 CHARS data.

Step 3: For each year, compute the statewide and HSA average use rates.
The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in HSA 1 by the HSA population and multiplied by 1,000. Population figures for this analysis were derived from the State of Washington Office of Financial Management (OFM) "medium-series" county population forecasts.

MHS followed this step as described above with no deviations, and also included calculations for the east Pierce planning area.

Step 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.
The department computed trend lines for the State and HSA 1 based upon the trends in use rates from these ten years and has included them as Step 4. The resulting trend lines for the State and HSA 1 exhibit a slight upward slope. This conclusion is supported by increasing utilization reported by hospitals throughout the state in recent years, and is indicative of a growing population. More significant than overall population growth is the fact that the state's population is growing older as the large number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations.

MHS followed this step as described above with no deviations, and also included trend lines for the east Pierce planning area. MHS's trend lines also exhibited a slight upward slope.

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live. (The psychiatric patient day data are used separately in the short-stay psychiatric hospital bed need forecasts.)
The previous four steps of the methodology utilizes data particular to the residents of the HSA 1 and the state as a whole. In order to forecast the availability of services for the residents of a given planning area, patient days must also be identified for the facilities available within the planning area. Step 5 identifies referral patterns in and out of the east Pierce planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also used discharge data for Washington residents that receive health care in Oregon. This data was obtained from the Oregon Department of Human Services (the department is not aware of similar data for the State of Idaho).

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

MHS followed this step as described above with no deviations.

Step 6:Compute each hospital planning area's use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+).
Step 6 illustrates the age-specific use rates for the year 2010 for the east Pierce planning area and for the rest of the state.

MHS followed this step as described above with no deviations.

Step 7A:Forecast each hospital planning area's use rates for the target year by "trend-adjusting" each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the appropriate health planning region's ten-year use rate trend, whichever trend would result in the smaller adjustment.
As discussed in Step 4, the department used the ten-year use rate trends for 2001-2010 to reflect the use patterns of Washington residents. The 2010 use rates determined in Step 6 were multiplied by the slopes of both the Health Service Area's ten-year use rate trend line and by the slope of the statewide ten-year use rate trend line for comparison purposes. The statewide trend has a slightly lower projected rate (an annual increase of 0.8399 than the HSA trend rate of 0.8415). As directed in Step 7A, the department applied the statewide trend to project future use rates.

The methodology is designed to project bed need in a specified "target year." It is the practice of the department to evaluate need for a given project through seven years from the last full year of available CHARS data, or 2010 for purposes of this analysis. Therefore, the target year for this analysis will be 2017.

MHS followed this step as described above. MHS determined that the HSA had the lower projected rate (HSA 1.3875) than the statewide rate (1.4739). As a result, MHS applied the HSA rate.

Step 8:Forecast non-psychiatric patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.
Using the forecasted use rate for the target year 2017 and population projections, projected patient days for east Pierce planning area residents are illustrated in Step 8. As noted in Step 7, above, forecasts have been prepared for a series of years and are presented in summary in Step 10 as "Total E Pierce Res Days."

MHS followed this step as described above with no deviations.

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

Using the patient origin data developed for Step 5, Step 9 illustrates how the projected patient days for the east Pierce planning area and the remainder of the state were allocated from the planning area of residence to the area where the care is projected to be delivered in the target year 2017. The results of these calculations are presented in Step 10 as "Total Days in E Pierce Hospitals."

MHS followed this step as described above with no deviations.

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

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

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

SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information is typically gathered through a capacity survey of the state hospitals in the planning area. Since M-GSH is the only hospital in the planning area, a capacity survey was not conducted. Below is a summary of the number of acute care beds at M-GSH.

MultiCare-Good Samaritan Hospital

Located at 407 - 14th Avenue in Puyallup, M-GSH is currently licensed for 275 acute care beds. Of the 275, 25 are dedicated to rehabilitation services and 11 are dedicated to level II ICN services. As a result, 239 general medical surgical beds will be counted for this methodology.

MHS also acknowledged that M-GSH is the only hospital located in the east Pierce planning area and counted 239 acute care beds for years 2011 through 2023.

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

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

MHS also did not provide psychiatric forecasts within its methodology.

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

Within the department's application of the methodology, adjustments have been made where applicable and described above.

The results of the department's methodology are available in Exhibit A as Appendices 10A and 10B attached to this evaluation. Step 10A calculates the east Pierce planning area bed need without approval of this project. A summary of those results are shown in Table 2 below.

Table 2
Step 10A Summary

	2011	2012	2013	2014	2015	2016	2017	2018
Planning Area # of beds	239	239	239	239	239	239	239	239
Gross Need	204	211	219	226	234	242	249	257
Need/(Surplus) without Project (Step 10a)	(35)	(28)	(20)	(13)	(5)	3	10	18

Numbers shown in parentheses indicate a surplus of beds. All numbers are rounded.

As shown in Table 2, year 2016 produces a planning area net need of 3 beds, which increases to 10 beds in the target year 2017. In year 2018, just one year past the target year, 18 beds are projected to be needed. Step 10A indicates that without the addition of new beds to the planning area, the need would continue to grow in each subsequent year. [source: Exhibit A, Step 10A]

Step 10B calculates the impact of M-GSH's 11 bed addition beginning in year 2012. A summary of those results are shown in Table 3 on the following page.

Table 3
Step 10B Summary

	2011	2012	2013	2014	2015	2016	2017	2018
Planning Area # of beds	239	250	250	250	250	250	250	250
Gross Need	204	211	219	226	234	242	249	257
Need/(Surplus) with Project (Step 10b)	(35)	(39)	(31)	(24)	(16)	(8)	(1)	7

Numbers shown in parentheses indicate a surplus of beds. All numbers are rounded.

Step 10B illustrates the effect on the planning area if M-GSH adds 11 acute care beds to the planning area in year 2012. The net surplus tops out in year 2012 with 39 beds, and then begins to decrease, resulting in a net surplus of one bed in the target year 2017. Year 2018, just one year after the target year, 7 beds are projected to be needed. [source: Exhibit A, Step 10b]

When Tables 2 and 3 are reviewed together, Table 2 indicates a need for acute care beds in the planning area beginning in year 2016, and Table 3 indicates that 11 additional beds is reasonable.

MHS also computed Step 10A, but did not compute Step 10B. The results of MHS's Step 10A is shown in Table 1 of this evaluation and is summarized again below.

Summary of M-GSH's East Pierce County Numeric Methodology

	2012	2013	2014	2015	2016	2017	2018
Current Supply	239.00	239.00	239.00	239.00	239.00	239.00	239.00
Gross Number of Beds Needed	207.38	215.56	225.17	234.26	243.81	253.86	264.43
Net Bed Need or (Surplus)	(31.62)	(23.44)	(13.83)	(4.74)	4.81	14.86	25.43

Numbers shown in parentheses indicate a surplus of beds.

As shown above, MHS projected net need beginning in year 2016. Year 2017 shows a need for at least 14 acute care beds.

During the review of this application, the department received 12 letters of support for the project and no letters of opposition. Of the 12 letters of support, 6 were submitted by non-MHS entities, including elected representatives from the Washington State Senate and House of Representatives. All 12 letters pointed out the continued growth in population for the east Pierce planning area and expressed concern about M-GSH's ability to continue to meet the growth without additional medical surgical bed capacity. [source: Public comment provided during the review]

As demonstrated by the department's methodology, summarized above in Table 2, the east Pierce planning area currently shows a need for additional acute care bed capacity in the forecast years. Based on the above information and standards, the department concludes that adding bed capacity to M-GSH would meet the projected need shown in Table 2. **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.*

M-GSH 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, M-GSH 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, MHS provided a copy of the Admission Policy currently used at M-GSH. The policy outlines the process/criteria that the hospital uses to admit patients for treatment or care at the hospital. The policy includes the necessary non-discrimination language to ensure that all residents of the service area would have access to services at the hospital. [source: Application, Exhibit 8]

To determine whether the elderly would have access or continue to have access to the proposed services, the department uses Medicare certification as the measure to make that determination. M-GSH currently provides services to Medicare eligible patients. Documents provided in the application demonstrate that M-GSH intends to maintain this status at the hospital. For this project, a review of the policies and data provided in the application identifies the facility's financial pro forma includes Medicare revenues. [source: Application, Exhibit 11B]

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. M-GSH also provides services to Medicaid eligible patients. Documents provided in the application demonstrate that M-GHS intends to maintain this practice. For this project, a review of the policies and data provided in the application identifies the facility's financial pro forma includes Medicaid revenues. [source: Application, Exhibit 11B]

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.

M-GHS states that its charity care policy, like the admission policy, would not change with the 11 additional beds. To demonstrate its intent to continue to provide charity care to residents, M-GHS submitted its Department of Health approved charity care policy that outlines the process a patient uses to access this service. Further, M-GHS included a 'charity care' line item as a deduction from revenue within the pro forma financial documents. [source: Application, Exhibit 6]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Good Samaritan Hospital is one of 18 hospitals located in Puget Sound Region. According to 2007 - 2009[11] charity care data obtained from HPDS, M-GSH has historically provided charity care at averages less than the regional averages. M-GHS's most recent three-year (2007 - 2009) average percentage of charity care for gross and adjusted revenues are compared to the Puget Sound Regional averages and shown in Table 4 below.

Table 4
Good Samaritan Hospital Charity Care Comparison (2007-2009 Average)

	3-Year Average Puget Sound Region	3-Year Average M-GSH
Percentage of Gross Revenue	2.02%	1.47%
Percentage of Adjusted Revenue	4.41%	3.39%,

The pro forma revenue and expense statements submitted for M-GSH indicate that the hospital will provide charity care at approximately 2.12% of gross revenue and 4.16% of adjusted revenue. RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. Since the hospital's three-year historical average is less than the region, to ensure that the charity care averages will remain consistent with the regional averages, the department concludes that a condition related to the percentage of charity care to be provided at M-GSH is necessary if this project is approved.

With agreement to the condition regarding the charity care percentages, the department concludes that all residents, including low income, racial and ethnic minorities, handicapped, and other under-served groups would continue to have access to the services provided by M-GSH. **This sub-criterion is met.**

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

Based on the source information reviewed and the applicant's agreement to the conditions identified in the "Conclusion" section of this evaluation, the department determines that MultiCare-Good Samaritan Hospital has met the financial feasibility criteria in WAC 246-310-220(1).

(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.

[11] Year 2010 charity care data is not available as of the writing of this evaluation.

If this project is approved, M-GSH would work with the department's hospital licensing office to obtain licensure for the 11 beds as soon as possible. Under this timeline, year 2012 would be the hospital's first full calendar year of operation with 286 licensed beds and year 2014 would be year three. [source: Application, p17]

To demonstrate compliance with this sub-criterion, M-GSH provided its Statement of Operations for the hospital with all 286 licensed beds operational for projected years 2012 through 2014. [source: Application, Exhibit 11B] A summary of the Statement of Operations is shown in Table 5 below.

Table 5
M-GSH Projected Statement of Operations Summary
Years 2012 through 2014

	Projected Year 1 (2012)	**Projected Year 2 (2013)**	**Projected Year 3 (2014)**
# of Admissions	19,026	19,771	20,631
# of Patient Days	66,300	68,687	71,458
# of Set Up/Licensed Beds	286	286	286
Projected Occupancy	63.5%	65.8%	68.5%
Total Net Revenue	$ 328,156,000	$337,726,000	$ 347,643,000
Total Expenses	$ 279,408,000	$ 284,223,000	$ 289,213,000
Profit or (Loss)	**$ 48,748,000**	**$ 53,503,000**	**$ 58,530,000**
Minus MHS Allocated Costs	$ 24,628,000	$ 24,951,000	$ 25,389,000
Net Profit or (Loss)	**$ 24,220,000**	**$ 28,552,000**	**$ 33,041,000**

Table 5 reflects a gradual increase in admissions and patient days and includes all acute care services, including rehabilitation; the table does not include any emergency room visits. The occupancy percentages are expected to increase by approximately 5% in the next three years.

The 'Total Net Revenue' line item in Table 5 is the result of gross patient revenue minus any deductions for contractual allowances and charity care. It also includes non-patient care revenue from property. The 'total expenses' line item includes staff salaries/wages and all expenses to operate the hospital. The expense line item also includes any bad debt. The table above shows the net profits of the hospital before and after subtraction of allocated costs for MHS. As shown in Table 5, the hospital would operate at a profit in all three years with the additional 11 beds.

M-GHS based its projections shown in Table 5 above on the key assumptions summarized below. [source: Application, p49]

- The number of set up, licensed beds would be 286: 250 general medical surgical, 25 rehabilitation, and 11 level II ICN.
- No change in the scope of services is assumed.
- No change in payer mix is assumed.
- Volumes are projected to increase at the rate of 3.7% annually based on the most recent increase from years 2009 to 2010.

- Charity care is set at 2.12% of gross revenues; bad debt is expected to remain constant at 3.2% or gross revenue.
- Year 2015 reimbursement will fall 1% and remain constant thereafter, consistent with Washington State Hospital Association reform expectations for MultiCare.
- Payer mix is not expected to change.
- No wage inflation assumed; wages per hour and annual salaries are held constant at 2010 figures. FTEs were calculated at the cost center level.
- Operating expenses have been assumed to increase by 1% - 3% per year.
- Allocated costs from MHS are held constant at 2.5% of gross patient revenue.

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 the service and long term ability to sustain the service.

For Certificate of Need applications, HPDS compares the projected ratios with the most recent year's financial ratio guidelines for hospital operations. For this project, HPDS used 2009 data for comparison. The ratio comparisons are shown below. [source: November 1, 2011, HPDS analysis, p3]

Table 6
Current and Projected HPDS Debt Ratios for MultiCare-Good Samaritan Hospital

Category	Trend[12]	State 2009	Current 2010	Projected 2012	Projected 2013	Projected 2014
Long Term Debt to Equity	B	0.551	0.855	0.669	0.593	0.529
Current Assets/Current Liabilities	A	2.221	9.821	1.609	1.553	1.526
Assets Funded by Liabilities	B	0.433	0.507	0.424	0.401	0.380
Operating Exp/Operating Rev	B	0.942	0.812	0.926	0.915	0.905
Debt Service Coverage	A	5.928	6.005	4.419	4.160	4.866

Definitions:	Formula
Long Term Debt to Equity	Long Term Debt/Equity
Current Assets/Current Liabilities	Current Assets/Current Liabilities
Assets Funded by Liabilities	Current Liabilities + Long term Debt/Assets
Operating Exp/Operating Rev	Operating Expenses/Operating Revenue
Debt Service Coverage	Net Profit+Depr and Interest Exp/Current Mat. LTD and Interest Exp

Comparing M-GSH's most current (2010) ratios with the statewide ratios revealed that M-GSH is within the normal range in all except two ratios—current assets to current liabilities and debt service coverage. After evaluating the hospital's projected ratios, staff from HPDS provided the following analysis. [source: HPDS analysis, p2]

[12] A is better if above the ratio, and B is better if below the ratio.

The CON year 2014 fiscal year end ratios for MultiCare Good Samaritan are within acceptable range of the 2009 State average for the most part. The current assets/ current liabilities, while out of range are still reasonable since the parent corporation has great leeway in how and where it holds current assets and the parent MultiCare has adequate financial resources to deal with any issues at Good Samaritan. Debt service coverage while out of range also is dependent on how the parent corporation assigns debt among its facilities. Again in this case the parent MultiCare has adequate resources to deal with any financial issues at Good Samaritan. The hospital is breaking even in the third year of operations.

HPDS also reviewed M-GHS's 2010 historical balance sheet. The balance sheet is summarized in Table 7 below. [source: HPDS analysis, p2]

Table 7
MultiCare-Good Samaritan Hospital Balance Sheet for Year 2010

Assets		Liabilities	
Current Assets	$ 741,398,668	Current Liabilities	$ 75,489,417
Fixed Assets	$ 137,546,716	Long Term Debt	$ 376,414,196
Board Designated Assets	($ 6,761,783)	Other Liabilities	$ 0
Other Assets	$ 19,748,312	**Equity**	**$ 440,028,300**
Total Assets	**$ 891,931,913**	**Total Liabilities and Equity**	**$ 891,931,913**

After evaluating the hospital's current balance, staff from HPDS stated that the hospital's financial position is strong. [source: HPDS analysis, p2]

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.**

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

Based on the source information reviewed and the applicant's agreement to the condition identified in the "Conclusion" section of this evaluation, the department determines that MultiCare Health System has met the structure and process (quality) of care criteria in WAC 246-310-230.

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

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

M-GSH expects future staff increases for the hospital; however, the addition of these 11 beds to GSH does not require additional FTEs. [source: Application, p50] As a result, the department concludes that this **sub-criterion does not apply to this project**.

(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.

M-GSH currently provides health care services to the residents of east Pierce County and the surrounding areas. The hospital has been in operation for many years in Puyallup, and has extensive ancillary and support relationships. There is no indication that current relationships would be negatively affected with the addition of 11 acute care beds. [source: Application, pp52]

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

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

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.

M-GSH will continue to provide Medicare and Medicaid services to the residents of east 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 M-GSH in full compliance with all applicable standards following the most recent on-site survey in April 2011.[13]

Complementing reviews performed by the Joint Commission are the surveys conducted by the Department of Health's Investigations and Inspections Office. (IIO). For the most recent three years, IIO completed two quality of care / fire life safety surveys at the hospital.[14] There was no adverse licensing action as a result of these surveys. [source: facility survey data provided by DOH Investigations and Inspections Office]

[13] http://www.qualitycheck.org

[14] Surveys completed December 2008 and June 2010.

While MHS does not own or operate healthcare facilities outside of Washington State, it owns and operates three other acute care hospitals within Pierce County. The three hospitals are Tacoma General Hospital, Allenmore Hospital, and Mary Bridge Children's Hospital, all located in Tacoma. HO records indicate that the department has completed at least two compliance surveys for Tacoma General and Allenmore Hospitals and one for Mary Bridge Children's Hospital.[15] Additionally all three hospitals hold current accreditations from the Joint Commission. Each compliance survey revealed deficiencies typical for the facility and MHS submitted an acceptable plan of corrections and implemented the required actions.

Given the compliance history of MHS and specifically M-GSH, the department concludes that there is reasonable assurance that the hospital would continue to operate in compliance with state and federal regulations if this project is approved. **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). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how to measure unwarranted fragmentation of services or what types of relationships with a services area's existing health care system should be for a project of this type and size. Therefore, using its experience and expertise the department assessed the materials in the application.

In response to this sub-criterion, MHS stated the following. [source: Application, p54]

> *"MultiCare has a history of providing high quality health care services in a safe and appropriate manner. In addition to being licensed by the Washington State Department of Health and accredited by the Joint Commission, MultiCare hospitals are certified by Medicare and also participate in a variety of other accreditation, licensure, and certification reviews by external agencies. These accreditations and certifications demonstrate MultiCare's efforts to meet the expectations and requirements of patients and to exceed external standards."*

The department also considered MHS's history of providing care to residents in Washington State. The department concludes that the applicant has been providing acute care services to the residents of Washington State for several years and has been appropriately participating in relationships with community facilities to provide a variety of medical services. Nothing in the materials reviewed by staff suggests that approval of this project would change these relationships. [source: CN historical files]

Additionally, the department considers the results of the numeric methodology and review criteria outlined in WAC 246-310-210. Application of the numeric methodology shows a need for acute care beds in the east Pierce planning area. Within the application, MHS demonstrated it met the standards to receive approval to add additional acute care beds to M-GSH.

[15] Tacoma General and Allemore Hospital's surveys completed May 2009 and January 2011; Mary Bridge Children's Hospital survey completed March 2011.

The department concludes that approval of this project would not have the potential of fragmentation of acute care services within the planning area. **This sub-criterion is met.**

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.
This sub-criterion is addressed in sub-section (3) above and is considered met.

D. Cost Containment (WAC 246-310-240)
Based on the source information reviewed and the applicant's agreement to the condition identified in the "Conclusion" section of this evaluation, the department determines that the applicant has met the cost containment criteria in WAC 246-310-240 (1).

(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.

Step One
For this project, M-GSH has met the review criteria under WAC 246-310-210, 220, and 230. Therefore, the department moves to step two below.

Step Two

Before submitting this application, MHS considered and rejected the following three options. [source: Application, pp54-58]

- Do nothing
  This option resulted in M-GSH continuing to operate out of compliance. As a result, this option was appropriately rejected by MHS.

- Request less than 11 acute care beds
  Using the seven-year projection horizon, MHS's application of the acute care bed numeric methodology demonstrated need for an additional 25 beds in year 2018. MHS concluded that adding less than 11 acute care beds would increase resident outmigration from the east Pierce planning area for future years. As a result, this option was rejected.

- Request more than 11 acute care beds.
  While MHS considered this option, it was ultimately rejected. Since MHS's numeric methodology resulted in need for additional beds beginning in year 2016, MHS determined that any beds more than 11 could be considered excess bed capacity. MHS then determined that excess acute care bed capacity at M-GSH could result in a short-term negative financial performance issues since the excess capacity would incur depreciation costs.

As stated in the project description portion of this evaluation, MHS assumed that its 11 level II ICN beds did not require licensure. Since that assumption was incorrect, MHS was required to submit a Certificate of Need application to bring the facility's general medical surgical acute care beds into compliance. While other options were considered by MHS, submission of this application was the only option that would bring M-GSH into compliance with its licensed acute care beds.

Once MHS determined that a bed addition application was necessary, the next step was to determine the appropriate number of beds to request. Review of MHS's options two and three above concluded that 11 beds is the most prudent request. As a result, moving forward with this application was ultimately the best option.

Step Three

This step is used to determine between two or more approvable projects which is the best alternative. This step does not apply to this project.

Based on the information above, the department concludes this project continues to be the best available alternative for the residents of east Pierce County and surrounding communities. **This sub-criterion is met.**

APPENDIX A

2001-2010 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	10-YEAR TOTAL
HSA #1	1,162,777	1,173,852	1,185,068	1,194,260	1,223,414	1,235,319	1,282,804	1,328,827	1,321,575	1,313,342	12,421,238
											0
STATEWIDE TOTAL	1,875,612	1,878,385	1,891,439	1,906,739	1,969,331	2,007,868	2,068,766	2,135,745	2,130,225	2,118,577	19,982,687
2000-2010 CHARS no MDC1519 or Rehab.xlsx											

2001-2010 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	10-YEAR TOTAL
HSA #1	1,162,777	1,173,852	1,185,068	1,194,260	1,223,414	1,235,319	1,282,804	1,328,827	1,321,575	1,313,342	**12,421,238**
STATEWIDE TOTAL	1,875,612	1,878,385	1,891,439	1,906,739	1,969,331	2,007,868	2,068,766	2,135,745	2,130,225	2,118,577	**19,982,687**

2001-2010 HSA TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	10-YEAR TOTAL
HSA #1	502	492	741	717	662	616	805	1067	1713	1404	**8,719**
STATEWIDE TOTAL	**608**	**530**	**970**	**898**	**799**	**716**	**954**	**1,152**	**2,006**	**1,527**	**10,160**

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

2001-2010 HSA TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	10-YEAR TOTAL
HSA #1	1,162,275	1,173,360	1,184,327	1,193,543	1,222,752	1,234,703	1,281,999	1,327,760	1,319,862	1,311,938	**12,412,519**
STATEWIDE TOTAL	**1,875,004**	**1,877,855**	**1,890,469**	**1,905,841**	**1,968,532**	**2,007,152**	**2,067,812**	**2,134,593**	**2,128,219**	**2,117,050**	**19,972,527**

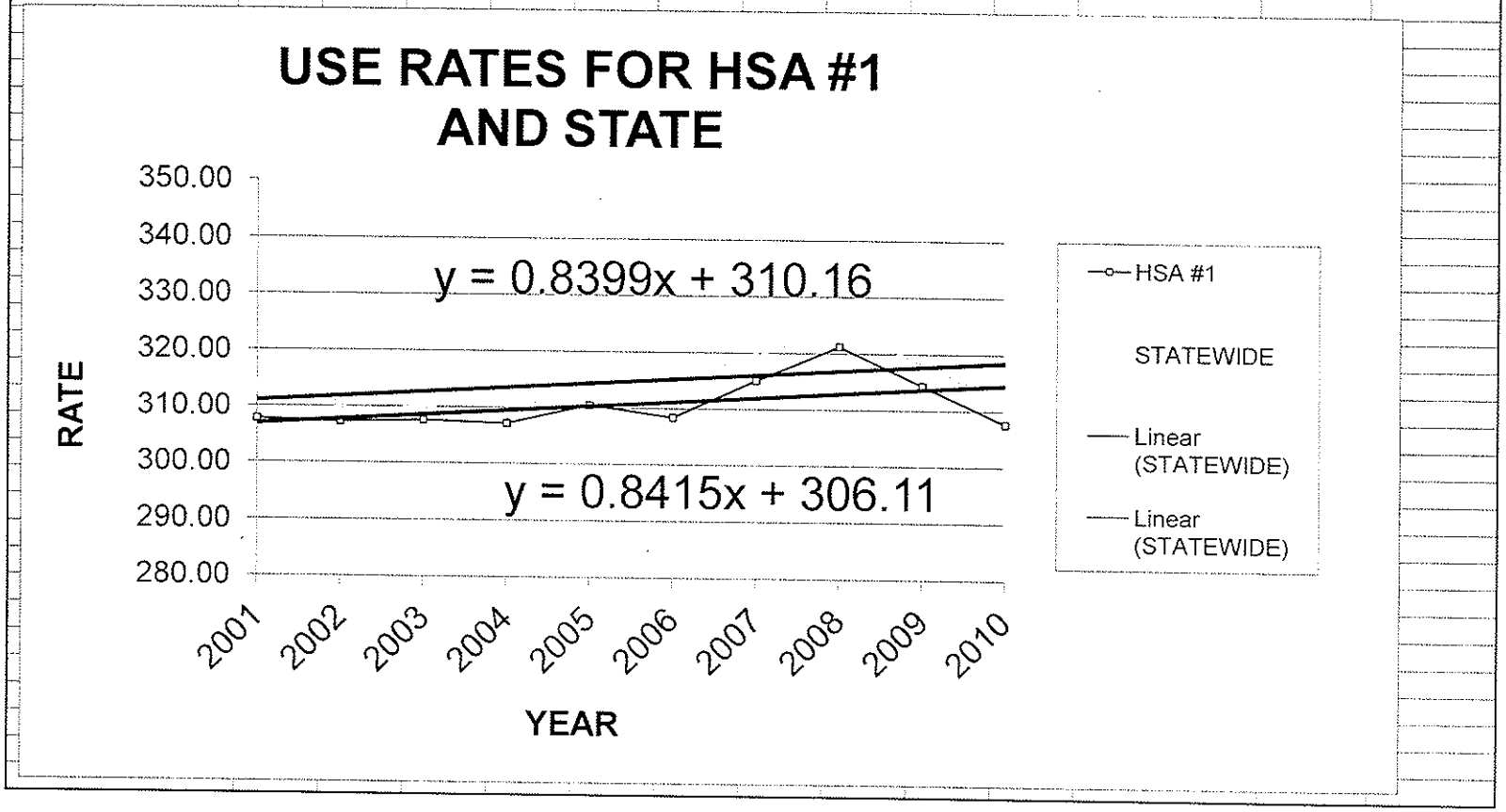
MultiCare-Good Samaritan Hospital CN App #11-42
East Pierce Acute Care Bed Need
Appendix 3

2001-2010 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS MINUS PSYCH DAYS											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	10-YEAR TOTAL
HSA #1	1,162,275	1,173,360	1,184,327	1,193,543	1,222,752	1,234,703	1,281,999	1,327,760	1,319,862	1,311,938	12,412,519
STATEWIDE TOTAL	1,875,004	1,877,855	1,890,469	1,905,841	1,968,532	2,007,152	2,067,812	2,134,593	2,128,219	2,117,050	19,972,527

TOTAL POPULATIONS											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	10-YEAR TOTAL
HSA #1	3,776,110	3,818,510	3,849,500	3,885,500	3,938,000	4,003,059	4,068,118	4,133,178	4,198,237	4,263,296	39,933,508
STATEWIDE TOTAL	5,974,910	6,041,710	6,098,300	6,167,800	6,256,400	6,363,584	6,470,767	6,577,951	6,685,134	6,792,318	63,428,874

USE RATE PER 1,000											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	10-YEAR TOTAL
HSA #1	307.80	307.28	307.66	307.18	310.50	308.44	315.13	321.24	314.38	307.73	3,107
STATEWIDE	313.81	310.82	310.00	309.00	314.64	315.41	319.56	324.51	318.35	311.68	3,148

RESIDENT USE RATE PER 1,000												
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	10-YEAR TOTAL	Trendline
HSA #1	307.80	307.28	307.66	307.18	310.50	308.44	315.13	321.24	314.38	307.73	3,107.35	0.8415
STATEWIDE	313.81	310.82	310.00	309.00	314.64	315.41	319.56	324.51	318.35	311.68	3,147.78	0.8399



STEP #5

2010 CHARS

	# of Pat days	Less OOS	TOTAL LESS OOS	
Good Sam				%
0-64	27,541	214	27,327	0.78%
65+	22,811	257	22,554	1.13%
TOTAL	50,352	471	49,881	
WA - Good Sam				
0-64	1,220,905	58,345	1,162,560	4.78%
65+	867,228	34,106	833,122	3.93%
TOTAL	2,088,133	92,451	1,995,682	

	TO E Pierce	TO WA	TOTAL # OF DAYS FOR RESIDENTS BY HSA (LESS PATS FROM OOS)	ADD DAYS PROVIDED IN OREGON **	TOTAL # OF DAYS FOR RESIDENTS BY HSA
Patients FROM E Pierce					
0-64	20,306	30,909	51,215	149	51,364
65+	18,645	16,594	35,239	47	35,286
TOTAL	38,951	47,503	86,454	196	86,650
Patients FROM WA					
0-64	7,021	1,131,651	1,138,672	39,923	1,178,595
65+	3,909	816,528	820,437	19,900	840,337
TOTAL	10,930	1,948,179	1,959,109	59,823	2,018,932
	49,881	1,995,682			

** Patient Days as reported by 2009 HCUP data for Oregon CHARS w/o MDC15 & 19

MARKET SHARE

PERCENTAGE OF PATIENT DAYS

	TO E Pierce	TO WA	TO OREGON
% OF E Pierce RESIDENTS			
0-64	39.53%	60.18%	0.29%
65+	52.84%	47.03%	0.13%
TOTAL			
% OF WA - E Pierce RESIDENTS			
0-64	0.60%	96.02%	3.39%
65+	0.47%	97.17%	2.37%
TOTAL			

2010 POPULATIONS BY PLANNING AREA

	E Pierce	TO WA
0-64	256,690	5,717,191
65+	29,262	789,175
TOTAL	285,952	6,506,366

STEP #6

USE RATE BY PLANNING AREA

	E Pierce	TO WA
USE RATES		
0-64	200.10	206.15
65+	1,205.86	1,064.83

USE RATE BY PLANNING AREA FROM STEP 6							
	E Pierce						
YEAR 2010 USE RATES							
0-64	200.10						
65+	1,205.86						
PROJECTED POPULATION	YEAR 2017						
	E Pierce						
0-64	280,706						
65+	42,110						
TOTALS	**322,815**						
PROJECTED 2017 USE RATE							
	E Pierce						
USE RATES*							
0-64 using HSA Trend	205.99						
0-64 using Statewide Trend	**205.98**						
65+ using HSA Trend	1,211.75						
65+ using Statewide Trend	**1,211.74**						
* Projected by applying either HSA trend or Statewide trend, whichever trend would result in the smaller adjustment							
Bold Print indicates use rate closest to current value							

USE RATE BY HSA FROM STEP 7A	
PROJECTED USE RATE - 2017	**E Pierce**
USE RATES	
0-64	205.98
65+	1,211.74
PROJECTED POPULATION - 2017	
	E Pierce
0-64	280,706
65+	42,110
TOTALS	**322,815**
PROJECTED # OF PATIENT DAYS	YEAR 2017
	E Pierce
0-64	57,820
65+	51,026
TOTALS	**108,846**

PROJECTED # OF PATIENT DAYS				
YEAR 2017	E Pierce	WA - E Pierce	TOTAL	
0-64	57,820	1,301,537	1,359,357	
65+	51,026	1,179,696	1,230,722	
TOTALS	**108,846**	**2,481,233**	**2,590,079**	
MARKET SHARE % OF PATIENT DAYS FROM STEP 5				
% OF E Pierce RESIDENTS	E Pierce	WA - E Pierce	TO OREGON	
0-64	39.53%	60.18%	0.29%	
65+	52.84%	47.03%	0.13%	
% OF WA - E Pierce RESIDENTS	E Pierce	WA - E Pierce	TO OREGON	
0-64	0.60%	96.02%	3.39%	
65+	0.47%	97.17%	2.37%	
# OF E Pierce RESIDENTS	E Pierce	WA - E Pierce	TO OREGON	Total
0-64	22,858	34,794	168	57,820
65+	26,962	23,996	68	51,026
				108,846
# OF WA - E Pierce RESIDENTS	E Pierce	WA - E Pierce	TO OREGON	Total
0-64	7,753	1,249,696	44,087	1,301,537
65+	5,488	1,146,272	27,936	1,179,696
				2,481,233
# OF RESIDENT PAT DAYS PROJECTED IN E Pierce				
0-64	30,612			
65+	32,450			
# OF RESIDENT PAT DAYS PROJECTED IN WA - E Pierce				
0-64	1,284,490			
65+	1,170,268			
# OF WA RESIDENT PAT DAYS PROJECTED IN OREGON				
0-64	44,255			
65+	28,004			
OUT OF STATE % OF PATIENT DAYS FROM STEP 5				
E Pierce	%			
0-64	0.78%			
65+	1.14%			
WA - E Pierce				
0-64	5.02%			
65+	4.09%			
PROJECTED # OF PATIENT DAYS 2017				
PLUS OUT OF STATE RESIDENTS				
E Pierce				
0-64	30,851	0.533576569		
65+	32,819	0.643187521		
TOTAL	63,671			

MultiCare-Good Samaritan Hospital CN App #11-42
East Pierce Acute Care Bed Need
Appendix 10a

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
E Pierce Planning Area											
Population 0-64(1)	256,690	260,121	263,552	266,982	270,413	273,844	277,275	280,706	284,136	287,567	290,998
0-64 Use Rate	200.10	200.94	201.78	202.62	203.46	204.30	205.14	205.98	206.82	207.66	208.50
Population 65+(1)	29,262	31,097	32,933	34,768	36,604	38,439	40,274	42,110	43,945	45,781	47,616
65+ Use Rate	1,205.86	1206.70	1207.54	1208.38	1209.22	1210.06	1210.90	1211.74	1212.58	1213.42	1214.26
Total Population	285,952	291,218	296,484	301,751	307,017	312,283	317,549	322,815	328,082	333,348	338,614
Total E Pierce Res Days	86,650	89,794	92,948	96,110	99,280	102,460	105,649	108,846	112,052	115,268	118,492
Total Days in E Pierce Hospitals (2)	50,102	52,025	53,954	55,887	57,825	59,769	61,717	63,671	65,629	67,593	69,562
Available Beds (3)											
Good Samaritan	239	239	239	239	239	239	239	239	239	239	239
Total	239	239	239	239	239	239	239	239	239	239	239
Wtd Occ Std(4)	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%
Gross Bed Need	196	204	211	219	226	234	242	249	257	265	272
Net Bed Need/(Surplus)	(43)	(35)	(28)	(20)	(13)	(5)	3	10.2	18	26	33
								7 yr			10 yr
(1) Source: Claritas											
(2) Adjusted to reflect referral patterns into and out of E Pierce Planning Area to other planning areas and Oregon											
(3) Source: Application											
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,											

MultiCare-Good Samaritan Hospital CN App #11-42
East Pierce Acute Care Bed Need
Appendix 10b w Project

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
E Pierce Planning Area											
Population 0-64(1)	256,690	260,121	263,552	266,982	270,413	273,844	277,275	280,706	284,136	287,567	290,998
0-64 Use Rate	200.10	200.94	201.78	202.62	203.46	204.30	205.14	205.98	206.82	207.66	208.50
Population 65+(1)	29,262	31,097	32,933	34,768	36,604	38,439	40,274	42,110	43,945	45,781	47,616
65+ Use Rate	1,205.86	1206.70	1207.54	1208.38	1209.22	1210.06	1210.90	1211.74	1212.58	1213.42	1214.26
Total Population	285,952	291,218	296,484	301,751	307,017	312,283	317,549	322,815	328,082	333,348	338,614
Total E Pierce Res Days	86,650	89,794	92,948	96,110	99,280	102,460	105,649	108,846	112,052	115,268	118,492
Total Days in E Pierce Hospitals (2)	50,102	52,025	53,954	55,887	57,825	59,769	61,717	63,671	65,629	67,593	69,562
Available Beds (3)											
Good Samaritan	239	239	250	250	250	250	250	250	250	250	250
Total	239	239	250	250	250	250	250	250	250	250	250
Wtd Occ Std(4)	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%
Gross Bed Need	196	204	211	219	226	234	242	249	257	265	272
Net Bed Need/(Surplus)	(43)	(35)	(39)	(31)	(24)	(16)	(8)	(1)	7	15	22
								7 yr			10 yr

(1) Source: Claritas
(2) Adjusted to reflect referral patterns into and out of E Pierce Planning Area to other planning areas and Oregon
(3) Source: Application
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,