STATE OF WASHINGTON
DEPARTMENT OF HEALTH

July 20, 2012

CERTIFIED MAIL # 7011 1570 0002 7802 6203

Theresa Boyle
Senior Vice President
MultiCare Health System
315 Martin Luther King Jr. Way
Tacoma, Washington 98415-0299

Dear Mrs. Boyle:

We have completed review of the Certificate of Need application submitted by MultiCare Health System proposing to add pediatric acute care beds to Mary Bridge Children's Hospital in Tacoma. For the reasons stated in this evaluation, the application to add 10 new beds is consistent with applicable criteria of the Certificate of Need Program, provided it agrees to the following in its entirety.

Project Description:
Mary Bridge Children's Hospital and Health Center is approved to add 10 general acute care pediatric beds to Mary Bridge's current licensed capacity of 72 beds. At project completion Mary Bridge Children's Hospital and Health Center will have a total of 82 beds

Conditions:

1. MultiCare Health System agrees to the above project description.
2. Mary Bridge will provide to the department, for review and approval, a revised Admission Policy to be used at the hospital. The revised policy must specifically address a patient's admission without regard to race, ethnicity, national origin, age, sex, pre-existing condition, physical or mental status and be consistent with the other components of the draft agreement provided in the application.

3. Mary Bridge 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. Mary Bridge will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Pierce County Region. Currently, this amount is 2.18% of total revenue and 4.71% of adjusted revenue. Mary Bridge will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

Approved capital expenditure: $16,726,895

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	111 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,

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

Enclosure

EVALUATION DATED JULY 20, 2012 OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY MULTICARE HEALTH SYSTEM PROPOSING TO ADD 20 GENERAL ACUTE CARE PEDIATRIC BEDS TO MARY BRIDGE CHILDREN'S HOSPITAL AND HEALTH CENTER IN TACOMA

APPLICANT DESCRIPTION

MultiCare Health System (MultiCare) is a not-for-profit health system serving the residents of Washington State. MultiCare Health System includes four hospitals[1], 20 physician clinics, six urgent care facilities, and a variety of health care services, including home health, hospice, and specialty clinics in Pierce County and the surrounding communities. Below is a list of the separately-licensed hospitals owned and/or operated by MultiCare. [source: CN historical files, MultiCare Health System website]

- Tacoma General / Allenmore, Tacoma[2]
- Mary Bridge Children's Hospital and Health Center, Tacoma[3]
- Good Samaritan Hospital, Puyallup

PROJECT DESCRIPTION

Mary Bridge Children's Hospital and Health Center (Mary Bridge) was established in 1955 as a pediatric hospital in southwest Washington and is located at 317 Martin Luther King Jr. Way in Tacoma, Washington. Mary Bridge provides comprehensive and multidisciplinary inpatient pediatric services to the residents of Thurston, Lewis, King, Pierce, Kitsap, Mason, Grays Harbor, Jefferson and Pacific counties. Mary Bridge currently holds the designation as a pediatric level II trauma center and has recently expanded the size of its 24-hour emergency department.

MultiCare proposes to add up to 20 general acute care pediatric beds to Mary Bridge's current licensed capacity of 72 beds. The new beds would be housed in the addition of a 6th floor, with a shelled-in 7th floor, to the existing Milgard Pavilion. At project completion Mary Bridge will have 92 general medical surgical beds dedicated to pediatric services. [source: Application, p18]

The capital expenditure associated with the total 20-bed project is $27.1 million. Of this amount, $21,227,167 is attributed to the portion requiring Certificate of Need approval. If this project is approved, MultiCare anticipates 10 of the beds would become operational by September, 2014. The remaining 10 would be placed into service prior to January 1, 2016. [source: Application, p18 & 46]

Of the total costs under review, 65% is related to construction and improvements; 16% is allocated to equipment; and the remainder distributed between taxes and fees. The totals are outlined below. [source: Application, p46]

Breakdown Of Capital Costs	Total	% of Total
Construction & Leasehold Improvements	$ 13,759,484	65%
Fixed & Moveable Equipment	$ 3,358,333	16%
Architect / Consulting Fees	$ 2,159,140	10%
Taxes & Review Fees	$ 1,950,210	9%
Total Estimated Capital Costs	**$ 21,227,167**	**100.00%**

[1] An approval for a new hospital in Covington is currently in development and not listed here

[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.

APPLICABILITY OF CERTIFICATE OF NEED LAW

These projects are subject to Certificate of Need review as the bed addition to 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 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, MultiCare 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).[4]

[4] 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), (4), (5), & (6).

APPLICATION CHRONOLOGY

Action	MultiCare
Letter of Intent Submitted	April 29, 2011
Application Submitted	October 19, 2011
Department's pre-review Activities including screening and responses	October 20, 2011 through December 27, 2011
Beginning of Review	December 28, 2011
Public Hearing	February 1, 2012
End of Public Comment	February 1, 2012
Rebuttal Comments Received	February 16, 2012
Department's Anticipated Decision Date	April 2, 2012
Department's Updated Decision Date	May 2, 2012
Department's Actual Decision Date	July 20, 2012

CONCURRENT REVIEW AND AFFECTED PERSONS

One additional entity sought and received affected person status under WAC 246-310-010.

- Franciscan Health System – A provider of health care service in the service area

SOURCE INFORMATION REVIEWED

- MultiCare Health System's Certificate of Need application submitted October 19, 2011
- MultiCare Health System's supplemental information dated December 22, 2011
- MultiCare Health System's rebuttal information dated February 16, 2012
- Department of Health's Office of Hospital and Patient Data Systems (HPDS) financial feasibility and cost containment analysis for MultiCare Health System dated February 17, 2012
- Comprehensive Hospital Abstract Reporting System (CHARS) data and Charity Care Policy approvals obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Public comment received during the course of the review and at hearing
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Population estimates and forecasts obtained from the Claritas, Inc.
- Data obtained from the HPDS website
- Certificate of Need Historical files
- Department of Health's Investigation and Inspection's Office (IIO) files

CONCLUSION

For the reasons stated in this evaluation, the application submitted on behalf of MultiCare Health System proposing to add 20 acute care beds to Mary Bridge Children's Hospital and Health Center is not consistent with applicable criteria of the Certificate of Need Program. However, the addition of 10 acute care beds is consistent with applicable review criteria, and a Certificate of Need is approved provided MultiCare Health System agrees to the following in its entirety.

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A. Need (WAC 246-310-210)

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 Health System's project to add 10-acute care beds has met the need criteria

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

The department uses the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan to assist in its determination of need for acute care capacity. This forecasting method is designed to evaluate need for additional capacity in general, rather than identify need for a specific project.

The department had multiple meetings with representatives of MultiCare to discuss the use of the traditional numeric acute care bed methodology for the forecast of beds within a hospital which focuses upon pediatric care. Though the department determined the 10-step process would continue to allow for a mathematical tool to forecast potential need, the applicant expressed concerns regarding the age groups, patient days, and use rates traditionally applied.

The applicant also expressed concerns about how to account for the differing use rates of the traditional 0-14 pediatric population and that of the patients that were 15 years and above that the hospital regularly served. The department's definition of pediatrics/children is under the age of 18. As stated above, there is no specific pediatric/children's bed need forecasting method adopted in rule. Therefore, consistent with past decisions, the department evaluates the methodology contained in the application along with any modifications proposed. The applicant is expected to maintain the traditional construct of the acute care bed methodology with changes in the data applied.

Summary of MultiCare's Numeric Methodology

MultiCare proposes to add 20 general acute care pediatric beds in a tower expansion of the Mary Bridge Campus. Given that this proposal involves construction, MultiCare intends to begin the project in the summer of 2012 and have all 20 beds in service[5] prior to January 1, 2016. Under the proposed timeline, 2018 would be Mary Bridge's third year of operation with 97 general acute care pediatric beds. [source: Application, p27]

The method submitted to support the expansion relied upon discharge data for the years between 2001 and 2010. The method also considered the two age cohorts of 0-14 and 15-20. [source: Application, Exhibit 8]

MultiCare states "*this application uses the same methodology and planning areas applied*" in the approval of an expansion at Seattle Children's Hospital in King County. A review of the supporting need methodology reveals that MultiCare's methodology was modified from that used in the Seattle Children's project. [source: Application, p15; Rebuttal, p4]

In this application, MultiCare included both the 0-14 and 15-20 age cohorts to compute separate growth trends in steps 1-4. This differs from the approach of the program used in the Children's decision, which set the growth trend on only the 0-14 age cohort, which produces the clear majority of a pediatric-focused facility's patient days[6]. MultiCare then applies the corresponding growth trends for the individual age cohorts in the subsequent steps of the need forecast. The use of the additional 15-20 age cohort in the initial steps of the methodology directly affects some of the later steps and will be addressed in more detail below. The results of the applicants modified approach are outlined in the table below. [source: Application, Exhibit 8]

[5] MultiCare intends to activate 10 beds mid-2014 as construction is completed.

[6] In 2010, Mary Bridge recorded 12,335 patient days for 0-14 and 1,614 for the 15-20 age cohorts.

Table 1
Summary of the MultiCare Need Methodology

	2011	2012	2013	2014	2015	2016	2017
Patient Days	14,658	15,334	16,013	16,965	17,387	18,041	18,697
Planning Area Beds	72	72	72	72	72	72	72
Adjusted Gross Need	67	70	73	76	79	82	85
Net Need	**-5**	**-2**	**1**	**4**	**7**	**10**	**13**

* All numbers are rounded.

MultiCare computed an initial surplus of beds, but an emerging need for additional capacity is calculated within the forecast period, reaching 13 in the target year of 2017. The request for 20 beds is based upon MultiCare's extended target year of 2020 which produces a need for 22 additional beds. [source: Application, Exhibit 8, step 10]

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 application, 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 resident 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.

When preparing acute care bed need projections, the department traditionally relies upon population forecasts published by the Office of Financial Management (OFM). Because OFM does not provide population estimates at the age breakouts necessary for the intermediate ages applied in this application, and to maintain data integrity, the department relied upon estimates and projections developed by Claritas, Inc. for the populations in both age cohorts.

A seven-year horizon for forecasting acute care bed projections will be used in the evaluation of the application, 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". The department of Health produced the 2010 hospital data used to compile the bed forecasts. As a result, the department will set the target year as 2017.

This portion of the evaluation will describe the calculations made at each step and the assumptions and adjustments made in that process. It will also include a review of any deviations related to the use of age cohorts described above. A summary of any deviations applied by MultiCare is also described in each step. The titles for each step are excerpted from the 1987 SHP and are use to convey the concept being measured in that step.

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least ten years preceding the base year.

For this step, attached as Step 1, the department considered 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 by Health Service Area, the State, and age cohort 0-14 years, excluding psychiatric patient days (Major Diagnostic Category, MDC-19) and tertiary neonatal bassinette patient days (Major Diagnostic Category, MDC-15).

MultiCare

MultiCare followed this step as described, but included breakouts for the ages of 0-14 and 15-20 for both the state as a whole and for the Mary Bridge facility by itself. When the totals the applicant applied for the 0-14 cohort are compared with the department's totals, the figures show only minute differences.

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.

MultiCare

MultiCare followed this step as described above.

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

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each group by that group's population and multiplied by 1,000. To maintain data continuity, the department's totals are solely based upon Claritas data which provide the age groups required for the methodology. The forecasts are anchored in the estimations for 2010 and 2015.

MultiCare

MultiCare followed this step as described above, but applied values computed from OFM county population forecasts for the 0-14 age group and then used available Claritas data for the 15-20 age cohort. By comparison with the department's figures, the applicant's 0-14 figures are less linear in their growth and result in higher totals from 2007 through 2010. The 15-20 totals maintain a more linear growth pattern with all totals exceeding those computed by the department. The disparity between the figures applied increases in each forecast year. [source: Exhibit A, Pop Data Sheet]

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

The department has computed a 0-14 trend line based upon the use rates from these ten years historical data and has included them as Step 4. The resulting trend lines project an upward slope in each instance, and establish a slight annual growth rate of 0.0276.

MultiCare

MultiCare followed this step in the manner described above but established two independent growth trends for the 0-14 and 15-20 age cohorts. Unlike the programs results, the 0-14 age cohort for Mary Bridge produced a slightly declining rate of -0.032, but produced a positive growth rate of 0.964 for the 15-20 ages. These rates are carried forward and applied separately in Step 7.

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.)

In order to forecast the availability of services for the residents of a given region, patient days must also be identified for the facilities available within the planning area. Step 5 identifies referral patterns in and out of the planning area and illustrates where residents of the planning area currently receive care. For this review, the department separated 2010 CHARS patient days and included a 0-14 and a 15-20 age cohort, but limited the analysis to just the Mary Bridge facility.

As has been noted earlier, the original purpose for this methodology was to create comprehensive, statewide resource need forecasts. Step 5 illustrates the age-specific patient days for the Mary Bridge facility and for the rest of the state; where applicable. Services provided to residents outside the state are omitted and the resulting market shares are computed.

MultiCare

MultiCare followed this step as described above with 2010 CHARS data for the two age cohorts.

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 calculates the age-specific use rates per 1,000 residents for the year 2010. Since no state use rate would be applied in this methods later steps, only use rates for Mary Bridge were established.

MultiCare

MultiCare followed this step as described for each age cohort. The applicant's and the department's results of this step are nearly equal and are shown below.

Table 2
2010 Use Rates by Age Cohort

	0-14	**15-20**
Department of Health	9.46	2.96
MultiCare/Mary Bridge	9.34	2.95

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 Mary Bridge 0-14 growth trend established in step 4. This is consistent with the Seattle Children's hospital methodology referenced by the applicant and is also consistent with past Mary Bridge applications.

The methodology is designed to project bed need in a specified "target year." It is the practice of the department to evaluate need for an expansion 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 the expansion projects will be 2017. The projected used rates for the 0-14 and 15-20 age groups for 2017 are computed to be 9.65 and 3.16, respectively.

MultiCare
MultiCare applied the use rate of each age cohort established in step 4 separately and projected the use rate in consecutive years up to and beyond the projection period. Due to the declining trend calculated by MultiCare in the 0-14 cohort, the use rates gradually decline, falling to 9.12 in the target year of 2017.

As mentioned, and in contrast with the department, MultiCare established a separate 15-20 growth trend and applied it separately to that age group. The results provide a substantial increase in the use rate of this older age cohort in each of the forecast years. When combining the 2010 use rate of 2.95 with an annual growth trend of 0.964, the projected use rate in the target year reaches 9.70. This rate exceeds the forecasted 0-14 use rate in the same year and represents more than a three-fold increase in this cohorts use rate in a seven year time span.

Table 3
Projected 2017 Use Rates by Age Cohort

	0-14	**15-20**
Department of Health	9.65	3.16
MultiCare/Mary Bridge	9.12	9.70

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 and 2017 population projections, potential patient days from area residents are illustrated in Step 8. Forecasts have been prepared for each of the forecast years and are presented in Step 10 under "Total Res Days."

MultiCare
MultiCare followed this step as described above but computed projections through the target year and beyond for each of the two age cohorts. For the 0-14 age cohort, the decreasing use rate cited above is offset by increasing population figures and produces minor increases in the forecasted patient days.

When the use rate and population figures for the 15-20 ages are applied, the patient days increase substantially. By comparison, the historical patient days for patients 15-20 reported in step 1 of the applicant's methodology average 1,518 days a year. The calculations outlined above produce a forecast 5,387 days for this age cohort in 2017. The increase equals a 334% increase in patient days from 2010 and is the primary driver in the applicants methodology forecast of needed capacity in later steps. [source: Application, Exhibit 8, Step 1]

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 percentages produced for Step 5, Step 9 illustrates how the projected patient days for the respective planning areas and the remainder of the state were allocated. These results are consistent

to the projected patient days established in Step 8. The results of these calculations represent the total days at the Mary Bridge facility and are applied in the calculation of the adjusted patient days in Step 10.

MultiCare

MultiCare followed this step as described and maintained a 2017 target year. The table below shows the results from each methodology in that forecast year.

Table 4
Projected Patient Days for 2017

	0-14	15-20
Department of Health	13,458	1,739
MultiCare/Mary Bridge	13,307	5,390[7]

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 planning area, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information is obtained through the Department of Health's Office of Hospital and Patient Data Systems records. Below are a summary of the applicant's facility and the department's determination of the capacity values used in the production of the bed need methodology.

Mary Bridge Hospital is located at 317 Martin Luther King Jr. Way in Tacoma, within Pierce County. Mary Bridge currently maintains a licensed capacity of 72 beds. Of these beds, none are reported as providing services excluded from the methodology. Mary Bridge will be recorded to have a total capacity of 72 general acute care pediatric beds. [source: Application, Exhibit 8; CN licensing records]

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

The weighted occupancy standard for a planning area is defined by the SHP as the sum, across all hospitals in the planning area, of each hospital's expected occupancy rate times that hospital's percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected

[7] Value differs slightly from 5,387 recorded in step 8 and may be due to rounding and does not result in a substantial change.

in the 1987 SHP are higher than can be maintained by hospitals under the current models for provision of care. As a result, the department adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds).

As a result of this change, the weighted occupancy has been determined to be 60% for the Mary Bridge need methodology. The weighted occupancy standard assumptions detailed above, is reflected in the line "Wtd Occ Std" in Step 10.

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.

MultiCare

MultiCare omitted this step.

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.

MultiCare

MultiCare omitted this step.

Department Methodology – Exhibit A

The results of the department's methodology are available in Appendix A attached to this evaluation. Step 10A calculates the department's numeric need forecast. A negative projected need indicates a surplus of beds. [Appendix A]

Table 5
Summary of Department's Mary Bridge Methodology
Step 10A – Without Proposed Project

	2011	2012	2013	2014	2015	2016	2017
Projected Total Patient Days	14,105	14,300	14,495	14,692	14,891	15,090	15,291
Planning Area # of beds	72	72	72	72	72	72	72
Adjusted Gross Need	**64**	**65**	**66**	**67**	**68**	**69**	**70**
Projected Need– Without Project (Step 10a)	-8	-7	-6	-5	-4	-3	-2

The forecasted need methodology does not support a 20 bed addition at Mary Bridge. Further, based upon 2010 CHARS, the hospital is operating at an average daily census of 38.2[8] in the 72-bed facility. This

[8] 13,949 total Mary Bridge 2010 patient days

equates to an occupancy rate of 53%[9]. A facility of this size has a minimum occupancy standard of 60%. The 2010 patient day total also represents a decrease in total patient days from 2009 CHARS reporting[10].

When the two methodologies are compared, the primary computations are comparable or beneficial to the applicant in the department's methodology. A summary of the primary calculations are represented below.

Table 6
Key Methodology Factor Results

	DOH 0-14	MB 0-14	DOH 15-20	MB 15-20
2010 Patient Days	12,335	12,254	1,614	1,613
Historical Growth Trend	0.0276	-0.032	n/a	0.964
2010 Use Rate	9.46	9.34	2.96	2.65
2017 Forecasted Use Rate	9.65	9.12	3.16	9.70
2017 Forecasted Patient Days	13,458	13,189	1,739	5,387

As shown, the figures are similar in many respects. The department establishes a positive growth trend in contrast with the applicant's negative figure. The primary difference in the forecasted results of the two methods considered here, though, is the discrepancy in the forecasted patient days for the 15-20 age cohort. Only when the method is changed to include the larger growth trend of the 15-20 cohort to project the future patient days does the need forecast begin to support the requested expansion. This change alone drives the applicant's method to produce a 13 bed need in the target year. To test the value of these additional days, the table below summarizes the results if the additional 15-20 patient days projected by the applicant are substituted into the department's need forecast.

Table 7
Department's Methodology Substituting
Applicants Projected Patient Days

	2011	2012	2013	2014	2015	2016	2017
Projected Total Patient Days	17,298	17,509	17,720	17,933	18,147	18,361	18,576
Planning Area # of beds	72	72	72	72	72	72	72
Adjusted Gross Need	**79**	**80**	**81**	**82**	**83**	**84**	**85**
Projected Need– Without Project (Step 10a)	**7**	**8**	**9**	**10**	**11**	**12**	**13**

As shown, when the applicant's projected patient days are added to the forecast totals, the department's 2017 need increases of 3,648 days. This accounts for 77% of the 13 beds produced in the target year which then matches the applicants forecast in the same year.

When looked at in its totality, the department's methodology matches or exceeds the applicant's methodology in most of the key computations and the population differences are not sufficient to significantly impact the results. Only after considering the higher growth trend of the 15-20 patient days does the forecasted need for additional capacity begin to emerge.

[9] The applicant calculates an occupancy rate of 56% [Application, p10]
[10] Exhibit 8 of the application reported 14,366 patient days in 2009, which equates to an ADC of 39.4 and an occupancy of 54.6%

By comparison, and though not presented in this application, the department decided to construct a methodology similar to that produced in the recent denial of a Mary Bridge expansion application. Exhibit B includes steps 1 through 10 of that need methodology with a single 0-17 cohort, but still considering the state as the planning area. The results produce a slightly better historical trend of 0.0535, a slightly lower facility use rate of 8.82, and apply the Claritas population data for the 0-17 age group. These changes to the department's method lead to an increase of 94 additional projected patient days, bringing the 2017 total to 15,291; insufficient to substantially impact the need forecast.

Public Comment

During the review, the department received numerous letters of support for this project. Comments were received from both providers and non-providers. The department did not receive any comments in opposition to the project outside of those urging consistency of the methodology used.

Among those received included support from a state senator and hospitals such as Seattle Children's, Providence St. Peter, and the Clallam County Public Hospital District. Each supported concerns that were presented by the applicant regarding the adequacy of the current bed supply and the need to maintain the access to specialized pediatric services available to the people of the region. [source: Public comment provided during the review]

According to the Applicant, there are particular issues related to the practices and operations of dealing with pediatric patients that make the low occupancy of the facility more problematic than would generally be expected. In part, they point out: [source: Application, p8]

- Mary Bridge is the only Level II pediatric Trauma center in Western Washington. This program, in unison with a Pediatric Transport Team work to provide transport of pediatric patients to the hospital to receive care from multidisciplinary teams of doctors. Lack of sufficient capacity may directly impact the ability for these critically injured children to gain admission.
- Growth in numerous outpatient clinics is seen to be problematic when they need to transfer new patients to the main facility for the necessary care.
- The facility's Inpatient Pediatric Service, which specializes in the care of hospitalized children, function as an extension of a primary care provider and work to be available on a 24-hour basis. Since many of these patients require a hospital stay, capacity of the hospital impact the number of residents that can benefit from this specialized team of specialist operating from within the Mary Bridge facility.

The applicant also supplements their response to concerns regarding their low occupancy rate by noting the numbers alone "significantly understate the capacity constraints [Mary Bridge] experiences during the winter months". Though most hospitals experience high and low census periods through the course of the year, Mary Bridge notes that during high occupancy periods that would require diverting to the next closest children's hospital, are at the same time when Settle Children's would also be experiencing seasonal high patient counts and are often unable to admit diverted patients.

The department generally does not consider planning for surge capacity since it would ultimately lead to an expansion of un-utilized capacity. However, in this instance, the department does believe some consideration of capacity issues is warranted in a pediatric hospital. Since there is no need methodology available specifically designed to meet the varied needs of a pediatric-focused facility, the program is receptive to these other factors presented. It appears to the department that these issues may, in part, explain the public comments regarding the concern over lack of access to pediatric services.

Although the department's numerical need methodology does not support the need for additional acute care capacity, these unique challenges and comments from community health providers, volunteer agencies, and

community members lead the department to conclude that there is need for some relief to the constraints presented by the applicant.

The application materials included information for a 10-bed expansion,. With no need methodology to support the entire number presented, the department can accept that the reduced addition of 10 beds into single occupancy rooms may help to reduce the limitations presented in comments received. This would also lessen the possibility of un-necessarily over-bedding the community. Therefore, the department has determined that a 10-bed expansion would be satisfied under this sub-criterion and that the further review of this application can be focused upon the 10-bed option. **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.

Mary Bridge 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. MultiCare hospitals also currently participate in the Medicare and Medicaid programs. To determine whether all residents of the service area would continue to have access to an applicant's proposed services, the department requires applicants to provide a copy of its current or proposed admission policy. The admission policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and any assurances regarding access to treatment.

To demonstrate compliance with this sub-criterion, Mary Bridge provided a copy of its Inpatient and Pediatric Admission Policies that are used at the hospital. The policies outline the process and parameters that Mary Bridge will use to admit patients for treatment or care. The applicant states that the policy applies to any patient requiring care at a MultiCare facility, but does not address admission without regard to items such as a patients race, ethnicity, national origin, age, sex, pre-existing condition, physical or mental status, insurance status, economic status or the ability to pay for medical services. [source: Application, Exhibits 11A & B]

If this project is approved, a condition would be added stating:

> Mary Bridge will provide to the department, for review and approval, a revised Admission Policy to be used at the hospital. The revised policy must specifically address a patient's admission without regard to race, ethnicity, national origin, age, sex, pre-existing condition, physical or mental status and be consistent with the other components of the proposed agreement provided in the application.

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.

Mary Bridge currently provides services primarily to Medicaid eligible patients, with no anticipated revenue from Medicare. Details provided in the application demonstrate that Mary Bridge intends to maintain this status. For this project, a review of the policies and data provided for Mary Bridge identifies the facility's financial pro forma includes Medicaid revenues. [source: Application, p56]

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. As a children's hospital, the department does not expect Mary Bridge to provide services to the typical Medicare recipient (over age 65). However, Medicare does pay for individuals with certain disabilities, and individuals of any age who may have been diagnosed with End-Stage Renal Disease (ESRD). Mary Bridge reports 0.2% of its revenue

comes from Medicare. [source: Application, p56] Nothing reviewed in this application would suggest that the addition of beds would change this access.

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.

MultiCare demonstrated its intent to continue to provide charity care to residents by submitting its current charity care and financial assistance policy that outlines the process a patient would use to access this service. Further, MultiCare included a 'provision for charity' line item as a deduction from revenue within the pro forma financial documents for MultiCare. [source: Supplemental Information, Exhibits 23]

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. The proposed MultiCare facility is located in Pierce County and is one of 18 hospitals located within the region. According to 2008-2010 charity care data obtained from HPDS, Mary Bridge has historically provided less than the average charity care provided in the region. Mary Bridge's most recent three years (2008-2010) percentages of charity care for gross and adjusted revenues are detailed in Table 6. [source: HPDS 2008-2010 charity care summaries; Supplemental Information, Exhibits 23]

Table 8
Mary Bridge Charity Care Comparison

	3-Year Average for Pierce County Region	3-Year Average for Mary Bridge
% of Gross Revenue	2.18 %	0.38 %
% of Adjusted Revenue	4.71 %	0.78 %

Although MultiCare and Mary Bridge state it provides a variety of community programs and investment these activities are not the measure of charity care used for Certificate of Need purposes or as reported to the department under RCW 70.170.060. MultiCare provided a summary of their organization's charity care rates, broken down by facility. The historical financial reports indicate that Mary Bridge has previously provided charity care well below the regional average. A review of the applicant's pro forma shows they are projecting to substantially improve upon this trend and begin to exceed the adjusted revenue regional average (4.71%, 3-year average). Though Mary Bridge proposes to exceed the regional average, a charity care condition for the hospital is necessary to approve the project. [source: Application, p38; Supplemental Information, Exhibits 23]

> Mary Bridge 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. Mary Bridge will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Pierce County Region. Currently, this amount is 2.18% of total revenue and 4.71% of adjusted revenue. Mary Bridge will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

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

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

Based on the source information reviewed and the applicant's agreement to the conditions identified in the "Conclusion" section of this evaluation, the department determines that MultiCare Health System's project to add 10-acute care beds has meet the Financial Feasibility criteria

(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.

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

HPDS provides a summary of the balance sheets from the application in Table 9. [source: HPDS MultiCare analysis, p2]

Table 9
MultiCare Balance Sheets
Mary Bridge Fiscal Year End 2010

Assets		Liabilities	
Current	179,451,916	Current	414,331
Board Designated	-	Long Term Debt	-
Property/Plant/Equip	84,957,366	Other	-
Other	-	Equity	263,994,951
Total	264,409,282	Total	264,409,282

Fiscal Year-end report

MultiCare Fiscal Year End 2010

Assets		Liabilities	
Current	444,905,000	Current	204,302,000
Board Designated	636,140,000	Long Term Debt	178,866,000
Property/Plant/Equip	1,103,879,000	Other	764,833,000
Other	48,048,000	Equity	1,084,951,000
Total	2,232,972,000	Total	2,232,952,000

Above figures from CN application

The reported capital expenditure for the 10-bed expansion portion of the project is projected to be $16,726,895. With the non-CoN reviewable costs added in, the total reaches $22,603,848. MultiCare will use available cash reserves from within the organization. The table below shows percentages of the certificate of need project expenditures compared to various assets of Mary Bridge and MultiCare 2010 fiscal year end. The total project costs would not significantly increase the percentages.

Table 10
Projected Project Expenditures

Mary Bridge Children's Hospital	
CN Portion of Project	
Capital Expenditure	$ 16,726,895
Percent of Total Assets	6.33 %
Percent of Equity	6.34 %
MultiCare Health System	
CN Portion of Project	
Capital Expenditure	$ 16,726,895
Percent of Total Assets	0.75 %
Percent of Board Designated Assets	2.63 %
Percent of Equity	1.54 %

As mentioned above, HPDS also compared the financial health of MultiCare to the statewide year 2010 financial ratio guidelines for hospital operations. Statewide 2010 ratios are included as a comparison and are calculated from all community hospitals in Washington State whose fiscal year ended in that year. The data is collected by the Washington State Department of Health Hospital and Patient Data section of the Center for Health Statistics. HPDS compared the financial ratios for current year 2010 and 2014 through 2019. Table 13 displays the comparison provided by HPDS for only the three years after project completion. [source: HPDS analysis, p3]

The A means it is better if the number is above the State number and B means it is better if the number is below the state number.

Table 11
MultiCare's Current and Projected Financial Ratios

Ratio Category	Trend	State10	Mary Bridge 2010	2014 Year 1	2015 Year 2	2016 Year 3
Long Term Debt to Equity	B	0.555	-	N/A	N/A	N/A
Current Assets/Current Liabilities	A	2.278	433.11	N/A	N/A	N/A
Assets Funded by Liabilities	B	0.434	0.002	N/A	N/A	N/A
Operating Expense/Operating Rev.	B	0.947	0.881	0.868	0.886	0.875
Debt Service Coverage	A	5.894	19.008	N/A	N/A	N/A

Definitions	
Long Term Debt to Equity	Long Term Debt/Equity
Current Assets/Current Liabilities	Current Assets/Current Liabilities
Assets Funded by Liabilities	Current Liabilities + Long term Debt/Assets
Operating Expense/Operating Revenue	Operating Expense/Operating Revenue
Debt Service Coverage	Net Profit + Depr and Int. Exp/Current Mat. LTD and Int. Exp

As HPDS concludes, "Review shows that while this project will have an impact to the hospital; this project will not adversely impact the financial health of the hospital. Certificate of Need year 2019 for Mary Bridge Children's Hospital is better than the State average". [source: HPDS MultiCare analysis, p3]

The department concludes that Mary Bridge is able to meet its short and long term costs of the 10-bed expansion. **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.

MultiCare proposes to add 10 acute care beds to the Mary Bridge facility. The 10 beds would be added in by 2014 and the costs, when the non-CoN reviewable costs are added in, are outlined below. [source: Application, p49]

Table 12
Estimated Capital Costs of Total MultiCare Project

Breakdown Of Capital Costs	Total	% of Total
Leasehold Improvements	$ 15,800,630	70%
Fixed & Moveable Equipment	$ 2,400,000	11%
Architect / Consulting Fees	$ 2,812,715	12%
Taxes & Review Fees	$ 1,590,503	7%
Total Estimated Capital Costs	**$ 22,603,848**	**100.00%**

A summary of the reasonableness of building construction costs in relation to the potential impact on revenue and charges. [source: Supplemental Information, Exhibit 23d]

Table 13
Analysis of Forecasted Rates for 10-bed Expansion at Mary Bridge

Mary Bridge	2014	2015	2016	2017	2018
Rate per Various Items	**CONyr1**	**CONyr2**	**CONyr3**	**CONyr4**	**CONyr5**
Admissions	4,884	5,053	5,229	5,410	5,598
Patient Days	17,985	18,609	19,254	19,922	20,614
Gross Revenue	574,528,000	594,462,000	615,087,000	636,428,000	658,509,000
Deductions From Revenue	355,419,000	373,695,000	386,661,000	400,076,000	413,957,000
Net Patient Billing	219,109,000	220,767,000	228,426,000	236,352,000	244,552,000
Other Operating Revenue	6,416,000	6,545,000	6,675,000	6,809,000	6,945,000
Net Operating Revenue	225,525,000	227,312,000	235,101,000	243,161,000	251,497,000
Operating Expense	195,854,000	201,493,000	205,741,000	210,136,000	214,685,000
Operating Profit	29,671,000	25,819,000	29,360,000	33,025,000	36,812,000
Net Profit	29,671,000	25,819,000	29,360,000	33,025,000	36,812,000
Operating Revenue per Admission	$ 44,863	$ 43,690	$ 43,684	$ 43,688	$ 43,686
Operating Expense per Admission	$ 40,101	$ 39,876	$ 39,346	$ 38,842	$ 38,350
Net Profit per Admission	$ 6,075	$ 5,110	$ 5,615	$ 6,104	$ 6,576
Operating Revenue per Patient Day	$ 12,183	$ 11,863	$ 11,864	$ 11,864	$ 11,863
Operating Expense per Patient Day	$ 10,890	$ 10,828	$ 10,686	$ 10,548	$ 10,415
Net Profit per Patient Day	$ 1,650	$ 1,387	$ 1,525	$ 1,658	$ 1,786

As shown, the net profit by patient day ranges could be from $1,650 to a high of $1,786. The department concludes that costs of the project to add 10 acute care beds alone is unlikely to have an unreasonable impact upon the costs and charges for health services. **This sub-criterion is met**.

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

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

As part of the review of the financing of this project, HPDS confirms that the funding will come from available cash reserves currently available within the MultiCare organization. [source: Supplemental Information, Exhibit 24; HPDS analysis, p4] Use of cash reserves is generally the least expensive form of financing for a project.

Based on the source information reviewed for the bed addition project at MultiCare and the review performed by HPDS, the department concludes that the proposed financing for a 10-bed expansion is a prudent approach, and would not negatively affect MultiCare'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)

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 Health System's project to add 10-acute care beds has met the Structure and Process of Care criteria

(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.

If this project is approved, MultiCare anticipates adding FTEs (full time equivalents) to the hospital in specific staffing areas of nursing, technicians, and other related support and positions beginning in 2011. Table 14 shows the breakdown of MultiCare's projected FTE needs for the proposed 10-bed acute care bed expansion. [source: Application, p279]

Table 14
Mary Bridge Projected FTE Increases

Classification	Current	2011	2012	2013	2014	2015	2016	Total
Management	70	0	0	0	0	0	0	0
Nursing	222	18	7	7	7	8	7	54
Tech/Professional	282	24	8	9	9	9	10	69
Support	260	11	4	4	4	4	5	32
Totals	**834**	**53**	**19**	**20**	**20**	**21**	**22**	**155**

As shown above, the bulk of the staff increases in the first year of operation then continue at a steady rate throughout the projection years. MultiCare expects to incremental hires to expand pertinent staff.

MultiCare states it expects no difficulty in recruiting staff for the additional beds through its practice of partnering with local universities and colleges, supporting employee career development, and utilizing a broad range of local, regional and national recruiting strategies. MultiCare states that due to their historical hiring volume, "MHS has demonstrated its capacity to recruit, orient and train the employees needed to staff this expansion". [source: Application, p60]

Based on the information provided in the application, the department concludes that MultiCare provided a comprehensive approach to recruit and retain staff necessary for the additional general acute care pediatric beds. As a result, the department concludes that qualified staff can be recruited and retained. **This sub-criterion is met**.

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

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. 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.

MultiCare currently provides health care services to the residents of Pierce County and throughout the region. The applicant states that the hospital currently has the ancillary and support service infrastructure required to perform in-patient and out-patient services. MultiCare adds, *"It is not expected that there will be significant incremental demand from the addition of 20 additional general acute care pediatric beds"*.

This is not expected to change with a 10-bed expansion. With the additional staff proposed, there is no indication that current programs would not be able to expand related services to accommodate the proposed expansion. [source: Application, p60]

Therefore, the department concludes that there is reasonable assurance that MultiCare will continue its relationships with ancillary and support services within and associated with the hospital and this 10-bed 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.

Mary Bridge 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 Mary Bridge in full compliance with all applicable standards following the most recent on-site survey in March 2011.[11]

The department's Investigation and Inspection's Office (IIO) completed two licensing surveys at Mary Bridge in the past four years.[12] There were no adverse licensing actions as a result of the licensing surveys. In addition, the IIO completed a recent investigation at Mary Bridge. No citations were issued or plans of corrections required. [Facility survey data provided by DOH Investigations and Inspections Office]

Based on MultiCare compliance history, the department concludes that there is reasonable assurance that the proposed 10 bed addition would 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). 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.

MultiCare states that the hospital has established formal relationships with many of their community and regional partners. Mary Bridge will continue to be able to provide pediatric hospitalists and satellite services to pediatric programs within the region. When combined with formal transfer agreements and discharge policies, Mary Bridge, "*promotes the continuity in the provision of health care as patients.*" [source: Application, p61 & Exhibits 19 & 20]

[11] http://www.qualitycheck.org
[12] Most recent completed April 2010.

The promotion of continuity of care and unwarranted fragmentation of services does not require nor is it intended to have a single facility provide each and every service a patient might require. If that was the intent, there would be no concern about unnecessary duplication of services. The application guidelines provide guidance regarding the intent of this criterion. These guidelines ask for identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health services and resources serving the applicant's primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreement, and transfer agreements.

As an existing provider the department agrees that MultiCare has existing relationships with area providers, therefore **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 for MultiCare and is **determined to be me**t.

D. Cost Containment (WAC 246-310-240)
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 Health System's project to add 10-acute care beds has met the Cost Containment criteria

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.
WAC 246-310 does not contain specific WAC 246-310-240(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 how to measure cost containment. Therefore, using its experience and expertise the department assessed the materials in the application.

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 a 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 review, the applicant met all the review criteria under WAC 246-310-210, 220 and 230 for a 10-bed expansion. For completeness, the options considered by MultiCare are included below.

Step Two

MultiCare
Before submitting this application to expand the hospital, MultiCare considered three options. The options included: [source: Application, p61]

1. Propose no project, do nothing.
2. Propose the addition of 10 general acute care pediatric beds.
3. Propose the addition of 15 general acute care pediatric beds.

The criteria MultiCare applied in this sub-section included, in order of importance, 1) maximizing quality of patient care, including maintaining access; 2) choosing the most efficient and cost effective option over the next 3-5 years; and 3) legal restrictions. Once the 'do nothing' option was eliminated, the applicant considered issues such as costs, service lines, and location to determine the options that were the most appropriate. [source: Application, p64]

In the description of the comparison of the remaining two options, MultiCare determined that the 10-bed and 15-bed options were not sufficient to meet the expected demand in the projection years. The applicant states that the 20-bed project addresses the need for beds in the planning area and is better suited for the build-out options and that the expansion will meet community need, align departments to optimize patient care, and provide adaptable space. [source: Application, p64]

In the need section of this analysis, the department concluded the 20-bed project was not supported by the application; therefore it cannot be considered the best available alternative. However, considering the forecasted need and the proposals available to evaluate, the department concludes that, the proposal to add 10 general acute care pediatric beds to the hospital is supported for the accessibility and availability of pediatric acute care beds and is the best available option and **this sub-criterion has been met**.

Step Three
This step is used to determine between two or more approvable projects which is the best alternative. This step is not applicable to this review.

(2) In the case of a project involving construction:
WAC 246-310 does not contain specific WAC 246-310-240(2) 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 cost containment in construction. Therefore, using its experience and expertise the department assessed the materials in the application.

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

MultiCare states that the pavilion was constructed within the framework of AIA Design Guidelines and 2006 Guidelines for Design and Construction of Healthcare Facilities. As part of this proposed project, MultiCare has retained an architectural firm to "*ensure the latest and most innovative design and construction techniques are implemented*." [source: Application, p67]

An examination of the construction costs of this project in relation to the proposed number of beds is shown below.

Table 15
MultiCare Total Project Projections

Acute Care Bed Expansion	Totals
Total Construction	$ 22,603,848
General acute care pediatric Beds	10
Total Capital per Bed	$ 2,260,385

As HPDS determined, when considering the complete costs of the 20-bed expansion, "The costs shown are within past construction costs reviewed by this office. Also construction cost can vary quite a bit due to type of construction, quality of material, custom vs. standard design, building site and other factors." This is not expected to change with a 10-bed expansion approval. [source: HPDS MultiCare Analysis, p5]

Based upon this information and the results detailed in the financial feasibility criterion under WAC 246-310-220(2), the department is satisfied the applicant's plans, if approved, are appropriate. **This sub-criterion is met**.

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

This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2) and **has been met**.

(3) The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

WAC 246-310 does not contain specific WAC 246-310-240(3) 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 cost containment. Therefore, using its experience and expertise the department assessed the materials in the application.

As HPDS concludes, "adding a new 20 acute care servicing a bed need area which has bed need will not have an unreasonable impact of the costs and charges to the public of providing services by other persons." This is not expected to change with a 10-bed expansion approval. [source: HPDS MultiCare Analysis, p5]

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

EXHIBIT A

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Step 1

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**
Mary Bridge 0-17 yrs	13,144	12,839	12,862	14,067	14,440	13,648	12,998	14,376	14,360	13,912	**136,646**
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 CHARS wo all MDC19 and MDC15											

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Step 2

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**
Mary Bridge 0-17 yrs	13,144	12,839	12,862	14,067	14,440	13,648	12,998	14,376	14,360	13,912	**136,646**
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	1,067	1,713	1,713	**9,028**
Mary Bridge 0-17 yrs	-	-	-	-	-	-	-	-	-	-	**0**
STATEWIDE TOTAL	608	530	970	898	799	716	954	1,152	2,006	2,006	**10,639**

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	1,311,629	**12,412,210**
Mary Bridge 0-17 yrs	13,144	12,839	12,862	14,067	14,440	13,648	12,998	14,376	14,360	13,912	**136,646**
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**	**2,116,571**	**19,972,048**

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Step 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	1,311,629	**12,412,210**	
Mary Bridge 0-17 yrs	13,144	12,839	12,862	14,067	14,440	13,648	12,998	14,376	14,360	13,912	**136,646**	
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**	**2,116,571**	**19,972,048**	
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**	
Mary Bridge 0-17 yrs	1,519,104	1,524,284	1,529,465	1,534,645	1,539,826	1,545,006	1,550,187	1,555,367	1,560,548	1,565,728	**15,424,158**	
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	307.66	**3,107**	
Mary Bridge 0-17 yrs	8.65	8.42	8.41	9.17	9.38	8.83	8.38	9.24	9.20	8.89	**89**	
STATEWIDE	**313.81**	**310.82**	**310.00**	**309.00**	**314.64**	**315.41**	**319.56**	**324.51**	**318.35**	**311.61**	**3,148**	
* Claritas data												

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Step 4

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	307.66	**3,107.27**		0.8375
Mary Bridge 0-17 yrs	8.65	8.42	8.41	9.17	9.38	8.83	8.38	9.24	9.20	8.89	**88.58**		**0.0535**
STATEWIDE	**313.81**	**310.82**	**310.00**	**309.00**	**314.64**	**315.41**	**319.56**	**324.51**	**318.35**	**311.61**	**3,147.71**		0.8360

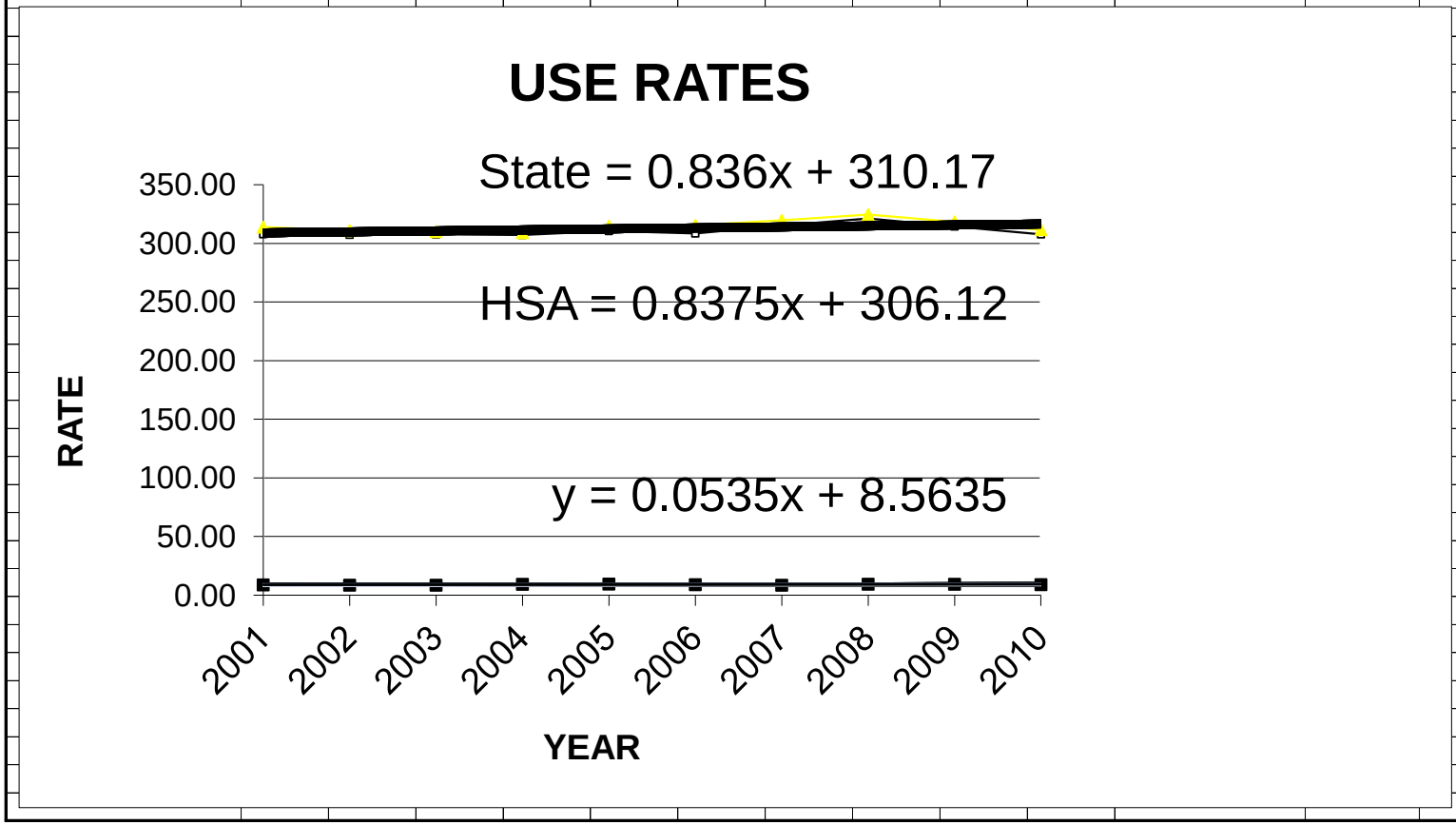

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Steps 5 & 6

STEP #5									
2010 DATA									
	# of Pat days	Less OOS	TOTAL LESS OOS						
Mary Bridge				%					
0-17	13,912	109	**13,803**	0.78%					
-	0	0	**0**						
TOTAL	**13,912**	**109**	**13,803**						
WA - Mary Bridge									
0-17	125,579	9,101	**116,478**	7.25%					
-			**0**						
TOTAL	**125,579**	**9,101**	**116,478**						
	TO Mary Bridg	**TO WA**				**TOTAL # OF DAYS FOR**	**DAYS**	**TOTAL # OF DAYS FOR**	
						RESIDENTS BY HSA	**PROVIDED IN**	**RESIDENTS BY HSA**	
FROM Mary Bridge						**(LESS PATS FROM OOS)**	**OREGON**		
0-17	13,803	0				13,803		13,803	
-	0	0				0		0	
TOTAL	**13,803**	**0**				**13,803**	**0**	**13,803**	
FROM WA									
0-17	0	116,478				116,478		116,478	
-	0	0				0		0	
TOTAL	**0**	**116,478**				**116,478**	**0**	**116,478**	
	13,803	**116,478**							

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Steps 5 & 6

MARKET SHARE									
PERCENTAGE OF PATIENT DAYS									
	TO Mary Bridg	**TO WA**		**TO OREGON**					
% OF Mary Bridge RESIDENTS									
0-17	100.00%	0.00%		0.00%					
-	#DIV/0!	#DIV/0!		#DIV/0!					
TOTAL									
% OF WA - Mary Bridge RESIDENTS									
0-17	0.00%	0.00%		0.00%					
-	#DIV/0!	#DIV/0!		#DIV/0!					
TOTAL									
2010 POPULATIONS BY PLANNING AREA									
	Mary Bridge	**TO WA**							
0-17	1,565,728								
-									
TOTAL	**1,565,728**	**0**							
STEP #6									
USE RATE BY PLANNING AREA									
	Mary Bridge	**TO WA**							
USE RATES									
0-17	8.82								
-									

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need
Step 7A

USE RATE BY PLANNING AREA FROM STEP 6		
	Mary Bridge	
YEAR 2010 USE RATES		
0-17	8.82	
-	0.00	
PROJECTED 2017 USE RATE		
	Mary Bridge	
USE RATES*		
0-17 using Mary Bridge Trend	9.19	
* Projected by applying the Mary Bridge Growth Trend		

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need
Step 8

USE RATE BY HSA FROM STEP 7A	
PROJECTED USE RATE - 2017	**Mary Bridge**
USE RATES	
0-17	9.19
-	0.00
PROJECTED POPULATION - 2017	
	Mary Bridge
0-17	1,650,823
-	
TOTALS	**1,650,823**
PROJECTED # OF PATIENT DAYS	YEAR 2017
	Mary Bridge
0-17	15,171
-	0
TOTALS	**15,171**

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Step 9

PROJECTED # OF PATIENT DAYS					
YEAR 2017	**Mary Bridge**	**WA - Mary Bridge**		**TOTAL**	
0-14	15,171	0		15,171	
15-17	0	0		0	
TOTALS	**15,171**	**0**		**15,171**	
MARKET SHARE % OF PATIENT DAYS FROM STEP 5					
% OF Mary Bridge RESIDENTS	**Mary Bridge**	**WA - Mary Bridge**		**TO OREGON**	
0-14	100.00%	0.00%		0.00%	
15-17	#DIV/0!	#DIV/0!		#DIV/0!	
% OF WA - Mary Bridge RESIDEN	**Mary Bridge**	**WA - Mary Bridge**		**TO OREGON**	
0-14	0.00%	0.00%		0.00%	
15-17	#DIV/0!	#DIV/0!		#DIV/0!	
# OF Mary Bridge RESIDENTS	**Mary Bridge**	**WA - Mary Bridge**		**TO OREGON**	**Total**
0-14	15,171	0		0	15,171
15-17	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!
					#DIV/0!
# OF WA - Mary Bridge RESIDENT	**Mary Bridge**	**WA - Mary Bridge**		**TO OREGON**	**Total**
0-14	0	0		0	0
15-17	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!
					#DIV/0!

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Step 9

# OF RESIDENT PAT DAYS PROJECTED IN Mary Bridge					
0-14	15,171				
15-17	#DIV/0!				
# OF RESIDENT PAT DAYS PROJECTED IN WA - Mary Bridge					
0-14	0				
15-17	#DIV/0!				
# OF WA RESIDENT PAT DAYS PROJECTED IN OREGON					
0-14	0				
15-17	#DIV/0!				
OUT OF STATE % OF PATIENT DAYS FROM STEP 5					
Mary Bridge	%				
0-14	0.79%				
15-17	#DIV/0!				
WA - Mary Bridge					
0-14	7.81%				
15-17	#DIV/0!				
PROJECTED # OF PATIENT DAYS 2017					
PLUS OUT OF STATE RESIDENTS					
Mary Bridge					
0-14	15,291	1.01			
15-17	#DIV/0!	#DIV/0!			
TOTAL	**#DIV/0!**				

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need

Step 10a

	2010	2011	2012	2013	2014	2015	2016	2017
Mary Bridge Planning Area								
Population 0-17(1)	1,565,728	1,577,884	1,590,041	1,602,197	1,614,354	1,626,510	1,638,666	1,650,823
MB Use Rate & Trend increase	8.82	8.87	8.92	8.98	9.03	9.08	9.14	9.19
Total Population	1,565,728	1,577,884	1,590,041	1,602,197	1,614,354	1,626,510	1,638,666	1,650,823
Total Mary Bridge Res Days	13,803	13,995	14,187	14,382	14,577	14,774	14,972	15,171
Total Days in Mary Bridge Hospital (2)	13,912	14,105	14,300	14,495	14,692	14,891	15,090	15,291
Available Beds (3)								
Mary Bridge	72	72	72	72	72	72	72	72
Total	**72**	**72**	**72**	**72**	**72**	**72**	**72**	**72**
Wtd Occ Std(5)	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%
Gross Bed Need	**64**	**64**	**65**	**66**	**67**	**68**	**69**	**70**
Net Bed Need/Surplus	(8)	(8)	(7)	(6)	(5)	(4)	(3)	(2)
(1) Source: Claritas 0-17 yrs.								
(2) Based upon State planning area - No Adjusted to reflect referral patterns into and out of Mary Bridge Planning Area to other planning areas								
(3) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,								

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need
Step 10a

2018	2019	2020
1,662,979	1,675,136	1,687,292
9.24	9.30	9.35
1,662,979	1,675,136	1,687,292
15,372	15,574	15,777
15,493	15,697	15,902
72	72	72
72	**72**	**72**
60.00%	60.00%	60.00%
71	**72**	**73**
(1)	(0)	**1**

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need
Pop Data

Claritas 0-14 Total Pop Worksheet

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
1,255,042	1,258,831	1,262,621	1,266,410	1,270,200	1,273,989	1,277,778	1,281,568	1,285,357	1,289,147	**1,292,936**	1,305,711	1,318,486

Claritas 15-17 Total Pop Worksheet

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
258,881	260,272	261,663	263,054	264,445	265,837	267,228	268,619	270,010	271,401	**272,792**	272,173	271,555

1,513,923	**1,519,104**	**1,524,284**	**1,529,465**	**1,534,645**	**1,539,826**	**1,545,006**	**1,550,187**	**1,555,367**	**1,560,548**	**1,565,728**	**1,577,884**	**1,590,041**

Exhibit A

Mary Bridge Pediatric Acute Care Bed Need
Pop Data

2013	2014	2015	2016	2017	2018	2019	2020
1,331,261	1,344,036	**1,356,811**	1,369,586	1,382,361	1,395,136	1,407,911	1,420,686

2013	2014	2015	2016	2017	2018	2019	2020
270,936	270,318	**269,699**	269,080	268,462	267,843	267,225	266,606

1,602,197	**1,614,354**	**1,626,510**	**1,638,666**	**1,650,823**	**1,662,979**	**1,675,136**	**1,687,292**