STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

August 12, 2016

CERTIFIED MAIL # 7008 1830 0002 8022 0854

Theresa Boyle, SVP Strategy and Business Development
MultiCare Health System
315 Martin Luther King Jr. Way
Tacoma, Washington 98415

RE: Certificate of Need Application #16-22

Dear Ms. Boyle:

We have completed review of the Certificate of Need application submitted by MultiCare Health System proposing to add acute care bed capacity to Good Samaritan Hospital in Puyallup, within Pierce County. Enclosed is a written evaluation of the application.

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

Project Description

This certificate approves the addition of 66 acute care beds to Good Samaritan Hospital. Based on Good Samaritan Hospital's current licensed bed capacity of 286, at project completion, Good Samaritan Hospital will be operating a total of 352 acute care beds.[1]

Type	Total # of Beds
Medical Surgical	316
Level II Intermediate Care Nursery	11
Level I Rehabilitation	25
Total	**352**

[1] Once Certificate of Need #1582 is fully implemented, the total number of beds at Good Samaritan Hospital will be 375. [352 + 23 level 1 rehabilitation beds.]

Conditions

1. Approval of the project description as stated above. MultiCare Health System further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. MultiCare Health System shall finance the project using cash reserves as described in the application.
3. Before providing services in the CUPW program, MultiCare Health System shall provide to the Department of Health with a copy of the executed addendum attached to the Physician Services Agreement. The executed addendum must be consistent with the draft addendum provided in the application.

Approved Costs

The approved capital expenditure for the 66-bed addition is $44,523,918.

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

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

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

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

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

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

Sincerely,

Bart Eggen, Acting Director
Community Health Systems

Enclosure

EVALUATION DATED AUGUST 12, 2016, FOR THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY MULTICARE HEALTH SYSTEM PROPOSING TO ADD ACUTE CARE BEDS TO GOOD SAMARITAN HOSPITAL IN PUYALLUP

APPLICANT DESCRIPTIONS

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

Hospitals	**Home Health/Hospice**
Tacoma General / Allenmore Hospital, Tacoma[1]	MultiCare Home Health, Hospice & Palliative Care
Mary Bridge Children's Hospital, Tacoma[2]	
Good Samaritan Hospital, Puyallup	
Auburn Medical Center, Auburn	

In addition to the four hospitals listed above, on January 7, 2011, MHS received Certificate of Need approval to establish a new, 58-bed hospital in Covington, within King County. The hospital, to be known as Covington Medical Center, is under construction and expected to be operational by the end of December 2017.[3]

PROJECT DESCRIPTION

This project focuses on Good Samaritan Hospital (GSH) located at 401-15th Avenue Southeast in Puyallup, within Pierce County. GSH is licensed for 286 acute care beds. The hospital provides a variety of general medical surgical services, including level II intermediate obstetric services and level I rehabilitation services. The hospital is currently a Medicare and Medicaid provider, holds a three-year accreditation from the Joint Commission[4], holds a three-year CARF accreditation[5], and holds Washington State designation for level III trauma hospital and a level I rehabilitation hospital. [source: Application, p16 and CN historical files]

This project proposes to add acute care beds to GSH. Based on two different planning horizons, MHS proposes to add 66 acute care beds or 42 acute care beds to GSH.

On November 19, 2015, MHS submitted an application to add 23 level I rehabilitation beds to GSH's level I rehabilitation unit. On December 24, 2015, MHS submitted this application to add more acute care beds to GSH. On August 1, 2016, CN #1582 was issued to MHS approving the level I rehabilitation project. The additional rehabilitation beds are expected to be operational in July 2018. As of the writing of this

[1] While 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; the two hospitals are licensed separately.

[3] June 2016 progress report for Certificate of Need #1437E2.

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

[5] Founded in 1966 as the Commission on Accreditation of Rehabilitation Facilities, CARF International is an independent, nonprofit accreditor of health and human services in the several healthcare areas, including medical rehabilitation. [source: CARF International website]

evaluation, GSH continues to be licensed for 286 acute care beds. By the end of July 2018, GSH would have a total of 309 licensed acute care beds, and of those, 48 would be dedicated to level I rehabilitation services.

Since MHS submitted its rehabilitation application 35 days prior to submission of this acute care bed addition project, MHS's application references 286 licensed acute care beds at GSH and of those 250 are used for medical surgical services.

During the screening of this bed addition project, the department required MHS to provide projected information based on two different assumptions: **1)** the rehabilitation project is denied; and **2)** the rehabilitation project is approved. Throughout this evaluation, the department will review MHS's project using the assumption that its rehabilitation project is approved.

The two acute care bed addition options submitted by MHS are described below.

Option One - 66 Bed Addition

Using a 10 year planning horizon, MHS proposed the addition of 66 acute care beds. All 66 beds would be used for general medical/surgical services. If 66 beds are added, GSH would expand its services to include a 'Chemical-Using Pregnant Women' program commonly referred to as CUPW [pronounced 'cup W']. The program is designed to change the behavior of chemically dependent pregnant women and improve birth outcomes. [source: Application, p7 and Washington State Health Care Authority Chemical-Using Pregnant Women Program Provider Guide effective July 1, 2014] Of the 66 acute care beds, MHS proposes 18 would be located in the unit and the remaining 48 beds would be dispersed throughout the medical/surgical unit, the progressive care unit, and the intensive care unit. [source: Application, p7]

Taking into account an additional 23 rehabilitation beds at GSH that would be operational in July 2018, if 66 additional acute care beds are added, GSH would be licensed for 375 acute care beds by the end of year 2018. Table 1 below is a breakdown of 375 acute care beds at GSH.

Table 1
Good Samaritan Hospital
Current and Proposed Licensed Beds

Type	Current # of Beds	Level I Rehab	66 Bed Addition	Total # of Beds
Medical Surgical	250	0	66	316
Level II Intermediate Care Nursery	11	0	0	11
Level I Rehabilitation	25	23	0	48
Total	**286**	**23**	**66**	**375**

If this project is approved, MHS intends that the 66 additional beds would become operational by the end of February 2018. [source: Application p15 and p24]

The estimated capital costs for adding 66 acute care beds to GSH is $44,523,918. The costs include construction, equipment, and associated fees. The costs also include all ancillary and support space necessary to implement the CUPW program. [source: Application, p54 and March 23, 2016, supplemental information, p3, footnote 1]

Option Two - 42 Bed Addition

Using a 7 year planning horizon, MHS proposed the addition of 42 acute care beds. All 42 beds would be used for general medical/surgical services and would be dispersed throughout the medical/surgical unit, the

progressive care unit, and the intensive care unit. With the addition of 42 acute care beds, GSH would not have the bed capacity to establish the CUPW program that was referenced previously in option one. [source: Application, p7]

If 42 acute care beds are added, GSH would be licensed for 351 acute care beds, which includes the 23 additional rehabilitation beds. Table 2 below is a breakdown of 351 acute care beds at GSH.

Table 2
Good Samaritan Hospital
Current and Proposed Licensed Beds

Type	Current # of Beds	Level I Rehab	42Bed Addition	Total # of Beds
Medical Surgical	250	0	42	292
Level II Intermediate Care Nursery	11	0	0	11
Level I Rehabilitation	25	23	0	48
Total	**286**	**23**	**42**	**351**

If this project is approved, MHS intends that the 42 additional beds would become operational by the end of February 2018, which is the same timeline for option one above. [source: Application p15 and 24]

The estimated capital costs for adding 42 acute care beds to GSH is $34,588,294. The costs include construction, equipment, and associated fees. [source: Application, p55]

APPLICABILITY OF CERTIFICATE OF NEED LAW

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

EVALUATION CRITERIA

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

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

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

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

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

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

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

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

(i) Nationally recognized standards from professional organizations;
(ii) Standards developed by professional organizations in Washington State;
(iii) Federal Medicare and Medicaid certification requirements;
(iv) State licensing requirements;
(v) Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to a proposed undertaking; and
(vi) The written findings and recommendations of individuals, groups, or organizations with recognized expertise related to a proposed undertaking, with whom the department consults during the review of an application."

To obtain Certificate of Need approval, each applicant must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); 246-310-240 (cost containment).

TYPE OF REVIEW

This project was reviewed under the regular review schedule outlined in WAC 246-310-160. A chronologic summary of the review is below.

APPLICATION CHRONOLOGY

Action	MultiCare Health System
Letter of Intent Submitted	August 21, 2015
Application Submitted	December 24, 2015
Department's pre-review activities	
• DOH 1st Screening Letter	January 11, 2016
• Applicant's Responses Received	March 23, 2016[6]
• DOH 2nd Screening Letter	April 13, 2016
• Applicant's Responses Received	May 10, 2016
Beginning of Review	May 17, 2016
Public Hearing Conducted	None Requested or Conducted
Public comments accepted through end of public comment	June 21, 2016
Rebuttal Comments Submitted[7]	July 6, 2016
Department's Anticipated Decision Date	August 22, 2016
Department's Actual Decision Date	August 12, 2016

[6] On January 27, 2016, MHS requested, and was granted, a 30-day extension to respond to the department's first screening of the application. As a result, the February 25, 2016, due date was extended to March 28, 2016.
[7] All public comments expressed support for the project; no letters of opposition were submitted. MHS did not provide rebuttal comments.

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."

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

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

During the review of this project, no entities requested interested or affected person status.

SOURCE INFORMATION REVIEWED

- MultiCare Health System's Certificate of Need application received December 24, 2015
- MultiCare Health System's screening responses received March 23, 2016, and May 10, 2016
- Public comments accepted throughout the review
- 1987 Washington State Health Plan
- Year 2006 through 2015 Comprehensive Hospital Abstract Reporting Systems [CHARS] data
- Office of Financial Management Population Data 2012
- Claritas population data obtained in year 2015
- Department of Health Hospital/Finance and Charity Care Program Analysis dated August 10, 2016
- Licensing and/or survey data provided by the Department of Health's Investigations and Inspections Office
- Licensing data provided by the Medical Quality Assurance Commission, Nursing Quality Assurance Commission, and Health Systems Quality Assurance Office of Customer Service
- MultiCare Health System's website at www.multicare.org
- Joint Commission website at www.qualitycheck.org
- CARF International website at www.carf.org
- Certificate of Need historical files

CONCLUSIONS

For the reasons stated in this evaluation, the application submitted by MultiCare Health System proposing to add acute care bed capacity to Good Samaritan Hospital located in Puyallup within Pierce County 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 certificate approves the addition of 66 acute care beds to Good Samaritan Hospital. Based on Good Samaritan Hospital's current licensed bed capacity of 286, at project completion, Good Samaritan Hospital will be operating a total of 352 acute care beds.[8]

Type	Total # of Beds
Medical Surgical	316
Level II Intermediate Care Nursery	11
Level I Rehabilitation	25
Total	**352**

Conditions:

1. Approval of the project description as stated above. MultiCare Health System further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. MultiCare Health System shall finance the project using cash reserves as described in the application.
3. Before providing services in the CUPW program, MultiCare Health System shall provide to the Department of Health with a copy of the executed addendum attached to the Physician Services Agreement. The executed addendum must be consistent with the draft addendum provided in the application.

Approved Costs:

The approved capital expenditure for the 66-bed addition is $44,523,918.

[8] Once Certificate of Need #1582 is fully implemented, the total number of beds at Good Samaritan Hospital will be 375. [352 + 23 level 1 rehabilitation beds.]

CRITERIA DETERMINATIONS

A. Need (WAC 246-310-210)

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that MultiCare Health System **met** the applicable need criteria in WAC 246-310-210.

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

WAC 246-310 does not contain an acute care bed need forecasting method. The 1987 Washington State Health Plan (SHP) that was "sunset" has a numeric methodology for projecting non-psychiatric bed need. As a result, the department uses the Hospital Bed Need Forecasting Method contained in the SHP to assist in its determination of need for acute care capacity.[9]

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

Two Methodologies Submitted by MHS

Within its application, MHS provided two separate versions of the acute care bed methodology. One version is based on historical CHARS[10] data for years 2005 through 2014; the other version is based on historical CHARS data for years 2004 through 2013. Below is MHS's rationale for providing two methodologies. [source: Application, p12-14]

MHS states that in 2014, there were some factors that artificially depressed demand for beds at GSH. Specifically, the '2 Midnight Rule' which refers to the Medicare Recovery Audit Contractor Program that identifies short stay hospitalizations as a potential high-risk area for fraud and abuse. A summary of the 2 Midnight Rule is:

> *"The minimum stay length—a stay that spans two midnights—that CMS expects beneficiaries to be in the hospital during an inpatient stay."*
> [source: Health Policy Brief: the Two-Midnight Rule, Health Affairs, January 22, 2015]

MHS further explains its concerns with the 2014 data.

> *"The rule was first announced on August 2, 2013, to serve as an update to the fiscal year 2014 inpatient Prospective Payment System. Although full implementation was subsequently delayed, providers across the nation who sought to minimize risk began to proactively change admitting protocols for inpatient services. The Health Affairs Policy Brief quoted above also mentions:*
>
> > *'Keeping patients in observation and thus in outpatient status avoids the risk that an inpatient claim might be denied at a future date.'"*

MHS states that GSH's implementation of the 2 Midnight Rule occurred in October 2013. By early 2014, implementation was fully completed and MHS applied it to patients across all payer categories, going beyond that required to meet CMS's program. The result is decreased patient days from year 2013 to year 2014 and then a rebound in year 2015. The decrease and rebound is reflected in the 2014

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

[10] CHARS=Comprehensive Hospital Abstract Reporting System.

CHARS data as a negative percentage of change, followed by a more than 6% positive change. MHS included a table to demonstrate the differences in patient days.

	Year 2013	Year 2014	Year 2015
GSH Acute Care Days	64,094	61,781	65,710
Annual Percentage Change		-3.6%	6.5%

Department Evaluation

The acute care bed methodology relies on 10 years of historical discharge data for Washington State hospitals. A variance in one of the years will affect projected years; however, generally not significantly. The department uses the most current available data in its methodologies. When this application was submitted, year 2014 CHARS data was available. As a result, MHS's methodology based on 2005 through 2014 data will be evaluated in this review. The 2004 through 2013 methodology will not be considered or further discussed in this evaluation.

Below is the assumptions and factors used in MHS's numeric need methodology.

MultiCare Health System

[source: Application, pp40-45 and Exhibit 10A]

MHS proposes to add either 42 or 66 acute care beds to GSH located in Pierce County. For its project, MHS identified its assumptions and factors used in its numeric methodology:

- Hospital Planning Area – East Pierce County
- CHARS data – Historical years 2005 through 2014
- Projected Population – Based on Claritas 2015 for east Pierce; Office of Financial Management medium series data released June 2015 for statewide. For both data sources historical and projected intercensal and postcensal estimates are calculated.
- Excluded MDCs and DRGs
  - MDC[11] 19 – patients, patient days, and DRGs for psychiatric.
  - DRG[12] 385-391/789-795 – patients, patient days, and DRGs for neonates
  - DRG 462/945-946 – patients, patient days, and DRGs for rehabilitation.
- Weighted Occupancy – Calculated consistent with the State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. For hospitals with 200 – 299 acute care beds the weighted occupancy is 70%.
- Existing Acute Care Bed Capacity – GSH in the only acute care hospital in the east Pierce planning area. A total of 250 beds were counted. The 250 beds represent only medical/surgical acute care beds. GSH's 11 beds dedicated to level II intermediate care nursery and the 25 currently licensed level I rehabilitation beds were excluded.

Table 3 on the following page shows the results of MHS's numeric methodology for years 2015 through 2028.

[11] MDC=Major Diagnostic Category
[12] DRG=Diagnosis Related Group

Table 3
MultiCare Health System Acute Care Bed Methodology
Projection Years 2015 through 2028

	2015	2016	2017	2018	2019	2020	2021
Gross Number of Beds Needed	247.99	254.45	261.16	268.16	275.39	283.64	**291.44**
Minus Existing Capacity-GSH	250.00	250.00	250.00	250.00	250.00	250.00	**250.00**
Net Bed Need or (Surplus)	(2.01)	4.45	11.16	18.16	25.39	33.64	**41.44**

7 years

	2022	2023	2024	2025	2026	2027	2028
Gross Number of Beds Needed	299.53	307.94	**316.61**	325.67	335.03	344.71	354.76
Minus Existing Capacity-GSH	250.00	250.00	**250.00**	250.00	250.00	250.00	250.00
Net Bed Need or (Surplus)	49.53	57.94	**66.61**	75.67	85.03	94.71	104.76

10 years

Using a seven-year planning horizon—year 2021—MHS's methodology showed need for an additional 42 acute care beds at GSH. Using a ten-year planning horizon—year 2024—MHS's methodology showed need for an additional 66 acute care beds at GSH. Since MHS was unsure which planning horizon—seven or ten year—is preferred, MHS provided complete information, including financial and staffing, to support the number of beds in either planning horizon.

Public Comments
None

Department Evaluation
The department calculated a numeric methodology used to evaluate this project. Below is the assumptions and factors used in its methodology. The numeric methodology is included in this evaluation as Attachment A.

- Hospital Planning Area – East Pierce County
- CHARS data – Historical years 2006 through 2015
- Projected Population – Based on Claritas 2015 for east Pierce; Office of Financial Management medium series data released June 2015 for statewide. For both data sources historical and projected intercensal and postcensal estimates are calculated.
- Excluded MDCs and DRGs
  - MDC 19 – patients, patient days, and DRGs for psychiatric.
  - DRG 385-391/789-795 – patients, patient days, and DRGs for neonates
  - DRG 462/945-946 – patients, patient days, and DRGs for rehabilitation.
- Weighted Occupancy – Calculated consistent with the State Health Plan. For hospitals with 200 – 299 acute care beds, the weighted occupancy is 70%. For hospitals with 300 + beds, the weighted occupancy is 75%.
- Existing Acute Care Bed Capacity – GSH in the only acute care hospital in the east Pierce planning area. A total of medical/surgical 250 beds were counted.

Below is a summary of the steps in the numeric methodology and a comparison between MHS's and the department's methodology. Any differences in the two methodologies are discussed.

Steps 1 through 4 of the methodology develop trend information on historical hospital utilization. In steps 1 through 4, MHS focused on historical data for years 2005 through 2014 to determine the health

service area [HSA], planning area, and use trends for acute care services. MHS computed a use trend line for the HSA, planning area, and statewide. The use trend line projected an increase in acute care use the HSA and the planning area; and a slight decline in use statewide. The SHP requires use of either the statewide or HSA trend line "*whichever has the slowest change*." MHS used the statewide trend with the slight decline [-0.451] and applied the data derived from those calculations to the projection years in the following steps.

Year 2015 CHARS data became available during the first week of June 2016, almost six months after this application was submitted, but before the end of public comment (June 21, 2016). When possible, the department uses the most recently available data. In its methodology, the department used historical years 2006 through 2015. The department's methodology also shows that the statewide trend line was most statistically reliable with a slight decline [-0.7885]. The department applied the data derived from those calculations to the projection years in the following steps.

The differences in the ten-year historical data used—2005 through 2014 for MHS and 2006 through 2015 for DOH—will impact the results in future steps within the methodology.

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

The department's methodology also applied its use trend line to the projected population to determine a use rate broken down by population ages 0-64 and ages 65 and older. The department multiplied the use rates derived from step 6 by the slopes of the HSA, east Pierce planning area, and statewide ten-year use rate trend line, again for comparison purposes. The most statistically reliable use rate is the planning area. The department also determined the in-migration for residents who do not live within east Pierce County, but obtained acute care services at GSH. Table 4 below shows the use rates, broken down by age group, that MHS and the department each applied to the projected population.

Table 4
MHS and Department
Use Rates Applied to Projected Population

	0- 64 Age Group	65 + Age Group
MultiCare Health System	201.37/1,000	1,245.62/1,000
Department	210.68/1,000	1,199.47/1,000

As shown in Table 4 above, the use rates calculated by MHS and the department are not significantly different. The department's 0-64 age group use rate is higher than MHS's use rate and its 65 and older use rate is lower. The calculated use rates, broken down by age group, and the in-migration ratio are each applied in future steps of this methodology.

When the use rates are applied to the projected population, the result is the projected number of patient days for the planning area. The numeric methodology is designed to project bed need in a specified "target year." It is the practice of the department to evaluate need for a given project through at least

seven years from the last full year of available CHARS data. MHS provided two target projection years from 2014 data: Seven years is 2021; and ten years is 2024.

The department's methodology uses 2015 as the last full year of data. For comparison purposes, the department also calculated for seven years (2022) and ten years (2025).

Steps 10 through 12 are intended to determine the total baseline hospital bed need forecasts, including need for short-stay psychiatric services.
Step 11 projects short-stay psychiatric bed need. Step 12 is the adjustment phase where any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the pure application of the methodology to under-or over-state the need for acute care beds.

In steps 10 through 12, MHS projected the number of acute care beds needed in the planning area, subtracted the existing capacity, resulting in a net need for acute care beds. For existing capacity, MHS subtracted the 250 acute care beds at GSH. The department calculated the same and also used 250 acute care beds as existing capacity.

These steps also allow psychiatric projections, which MHS appropriately did not compute [step 11], and allow for other adjustments in population, use rates, market shares, out-of-area use and occupancy rates [step 12]. MHS did not include any other adjustments than those described in the previous steps. The department did not include any other adjustments than those described above.

Table 5 below shows a comparison of MHS's methodology results and the department's methodology results for years 2017 through 2025. MHS's results are restated from Table 4 on the previous page. The department's complete methodology is included in this evaluation as Attachment A.

Table 5
Comparison of Acute Care Bed Methodology Results
Projection Years 2017 through 2025

MultiCare Health System	2017	2018	2019	2020	2021	2022	2023	2024	2025
Gross Number of Beds Needed	261.16	268.16	275.39	283.64	**291.44**	299.53	307.94	**316.61**	325.67
Minus Existing Capacity-GSH	250.00	250.00	250.00	250.00	**250.00**	250.00	250.00	**250.00**	250.00
Net Bed Need or (Surplus)	11.16	18.16	25.39	33.64	**41.44**	49.53	57.94	**66.61**	75.67
					7 Years			**10 years**	

Department of Health	2017	2018	2019	2020	2021	2022	2023	2024	2025
Gross Number of Beds Needed	280	287	293	299	305	**312**	318	324	**330**
Minus Existing Capacity-GSH	250	250	250	250	250	**250**	250	250	**250**
Net Bed Need or (Surplus)	30	37	43	49	55	**62**	68	74	**80**
						7 Years			**10 years**

As shown in Table 5 above, based on historical years 2006 through 2015, the department's methodology shows need for 62 beds in year seven, or 2022, and MHS shows a need for 50 beds in year 2022. By the end of year 2025, the department's methodology shows need for 80 beds and MHS shows a need for 76 beds in the planning area.

MHS did not provide calculations to show the impact of its proposed bed addition project on the acute care bed need for future years. MHS proposes to add either 42 or 66 beds to GSH. Regardless of the

number of beds added, all beds would be licensed and operational by the end of year 2018. The department calculated the impact of the bed addition for years 2015 through 2025 using its own methodology projects.

Table 6 below shows the calculations using the department's methodology as a base line for years 2017 through 2022 and adding 42 acute care beds to GSH. Table 7 includes a change in weighted occupancy for GSH if 66 beds are added to GSH. The weighted occupancy for GSH increased to 75% with 316 beds.

Table 6
Department of Health Methodology
Projection Years 2017 through 2025 – 42 Bed Addition

	2017	2018	2019	2020	2021	2022	2025
Gross Number of Beds Needed	280	287	293	299	305	312	330
Minus Existing Capacity-GSH	250	250	250	250	250	250	250
Plus 42 Bed at GSH-Year 2018	0	42	42	42	42	42	42
Net Bed Need or (Surplus)	30	(5)	1	7	13	20	38
						7 years	**10 years**

Table 6 above shows that the addition of 42 beds in 2018 results in a surplus of five beds. The surplus quickly becomes a need in the following years. Another 20 beds are projected to be needed in year 2022 which increases to 38 in 2025.

Table 7
Department of Health Methodology
Projection Years 2017 through 2025 – 66 Bed Addition

	2017	2018	2019	2020	2021	2022	2025
Gross Number of Beds Needed	280	287	293	299	305	312	330
Minus Existing Capacity-GSH	250	250	250	250	250	250	250
Plus 66 Bed at GSH-Year 2018	0	66	66	66	66	66	66
Net Bed Need or (Surplus)	11	(48)	(43)	(37)	(31)	(25)	(8)
						7 years	**10 years**

Table 7 shows the increase in weighted occupancy from 70% to 75% when 66 beds are added which results in a decrease the gross number of beds calculated to be needed in the planning area beginning in year 2018. Table 7 shows that a surplus of 8 beds is projected only six years after the beds are added to the planning area, even with the increase in weighted occupancy and the decrease in gross need.

Based on its need methodology alone, MHS demonstrated numeric need for additional acute care beds in east Pierce County. The department's numeric methodology substantiates the need for additional beds in east Pierce County. The numeric methodology demonstrates that the addition of 66 beds to the planning area may be reasonable. To assist in the determination of the number of beds that should be added to GSH, the department must evaluate whether other services and facilities of the type proposed are not or will not be sufficiently available and accessible to meet that need.

MultiCare Health System
[source: Application, pp8-13 and March 23, 2016, screening responses, pp2-3]

MHS stated that four main reasons drive the request for additional acute care beds at GSH. The four reasons and MHS's discussion is below.

Current Capacity Constraints at GSH
MHS states that GSH has recently experienced increases in patients and patient days. Currently GSH has little flexibility regarding the number of beds in specific units. GSH has been experiencing high utilization of its adult intensive care unit (14 beds), adult progressive care unit (40 beds), and adult medical surgical unit (158 beds). These three units alone have a total of 212 or 85% of GSH's 250 general acute care beds. Additional acute care beds would be distributed throughout the hospital, including the three units above.

Planned Expansion or New Programs
MHS is considering expansion of some existing services at GSH that may result in inpatient growth. Those services are joint replacements, spine surgery, surgical oncology, vascular surgery, thoracic surgery, gynecologic surgery, and inpatient epilepsy monitoring.

One new program contemplated by GSH that may result in inpatient growth is a five-bed unit used for cancer treatment research program. GSH is the primary MHS facility that provides chemotherapy services to patients. MHS's Auburn Medical Center and Allenmore Hospital do not provide chemotherapy services; Tacoma General has limited space and trained staff for chemotherapy services.

Another new program contemplated by MHS is a cardiovascular institute at GSH. The institute would expand the type and number of cardiovascular procedures at GSH which could increase the need for additional acute care beds.

An additional 66 beds at GSH would allow the establishment of an 18-bed program for chemically using pregnant women, commonly referred to as CUPW [pronounced 'cup W']. This program provides the following women services on-site:

- Detoxification and stabilization;
- Chemical dependency treatment and support;
- Education about pregnancy, parenting, and infant care; and
- Referrals to support services in the community.

Women in the CUPW program are inpatients for about 17 days. A team of caregivers close to the patient determines the individual length of stay for each patient, as well as the overall treatment plan. Treatment includes individual and group counseling, which helps patients plan for their continued recovery. Patients also participate in behavior groups to understand substance use and the associated problems. Community support groups are also an important part of the treatment process. After patients are in recovery, continued care through an outpatient program is usually recommended.

Often these CUPW patients birth higher risk, or level II, infants. GSH has 11 beds dedicated to its level II intermediate care nursery. Mothers of these infants are encouraged to continue treatment, however, at this time GSH does not have a CUPW program. A large number of these new mothers elect to forego CUPW treatment to stay their infants at GSH, resulting in the loss of continuity of their recovery treatment in the CUPW program.

In Washington State, there are two acute care hospitals that offer the CUPW program. The two hospitals are Swedish Medical Center-Ballard and EvergreenHealth in Monroe. For GSH patients intending to enroll in the CUPW program, Ballard or Monroe are currently the only two options.

East Pierce Planning Area Growth

MHS states that east Pierce area is one of the fastest regions in the state. From 2000 to 2014, the planning area grew 1.8% annually, resulting in 291,723 residents in 2014. The primary age group growth is 65 plus. From 200 to 2014, this age group grew 4.0% each year, and is projected to grow 4.8% each year for years 2025 through 2030. Residents age 65 plus have an inpatient use rate that is more than six times greater than residents under 65. GSH is the only acute care hospital located in east Pierce County.

Public Comments

The department received 35 letters of support for this project. Below are excerpts of statements related to this sub-criterion from three of the letters.

Joachim Pestinger, Mayor, City of Orting

"I am writing to voice my support on behalf of the city of Orting for MultiCare Health Systems' Certificate of Need application to add 66 additional beds to Good Samaritan Hospital's Dally Tower. As the only hospital in Puyallup, Good Samaritan serves as an acute care hub for a large and diverse community both in Puyallup and the surrounding area—including the city of Orting. Good Samaritan is by far the closest hospital to our community. Without it, residents here would have to travel miles to Tacoma or Seattle to get the hospital care they need. Unfortunately, as demand for Good Samaritan's services grows, the chances of patients in our area being able to get care there diminishes if the hospital is unable to grow and expand its services to meet that need."

Scott J. Jones, SVP, Newland [developer of community residential areas]

"Good Samaritan has been a great community partner working with us to bring more health care services to our residents at Tehaleh in Bonny Lake. MultiCare offers outpatient clinic services in Bonney Lake, but for acute hospital care, residents go to Good Samaritan in Puyallup. As the area's only hospital, Good Samaritan serves a large geographic region, from Eatonville to Sumner, Orting, Bonney Lake, and all the areas in between."

Neil Johnson, Jr. Mayor, City of Bonney Lake

"This letter is in support of adding 66 acute care beds at MultiCare Good Samaritan Hospital. As a Bonney Lake resident for the past 25 years, I've served as the mayor since 2006. The City of Bonney Lake is the fifth largest city in Pierce County and has been one of the faster growing cities in Washington State. Today, Bonney Lake is home to more than 19,000 residents, with a service population well in excess of 25,000. As the areas only hospital, Good Samaritan serves a large region, from Eatonville to Sumner, Orting and Bonney Lake, and all areas in between. It is important that our community [have] access to critical health care services, and that access is compromised when the hospital is on divert due to not having enough acute care beds. East Pierce County continues to grow, and more healthcare services are needed in our area to support this growth."

MHS or Good Samaritan Hospital affiliated letters of support

MHS board members, physicians, and other staff also provided letters of support. These letters focused on the need for additional acute care beds from the facility or staff perspective. For example, stressing the importance of single occupancy vs double occupancy rooms; lack of available rooms during peak

capacity; and population growth in the planning area. These letters encouraged the department to approve 66 acute care beds, rather than 42 beds.

Letters of support by entities not affiliated with MHS and Good Samaritan Hospital

- Central Pierce Fire & Rescue, District #6 (Spanaway)
- Rainier Anesthesia Associates
- Gustafson Insurance
- Citation Management Group
- Coldwell Banker Commercial Real Estate Broker
- Rieder Construction, LLC
- Washington State Fair Chief Executive Officer
- Mayor, City of Puyallup
- Chief of Police, Puyallup Police Department
- Associate Director, East Pierce Family Medicine Residency Program
- Mount Rainier Emergency Physicians
- Medical Imaging Northwest
- Mayor, Town of Eatonville
- Puyallup Sumner Chamber of Commerce
- Superintendent Puyallup School District
- Washington State Representative Hans Zeiger
- Washington State Senator Bruce Dammeier
- United States Congressman Denny Heck

These letters of support provided similar information and stressed the importance of adding acute care bed capacity to GSH. The majority of the letters also encouraged the department to approve 66 acute care beds, rather than 42 beds.

Rebuttal Comments
None

Department Evaluation
MHS states that GSH has capacity constraints that would be alleviated with additional beds. If 42 beds are approved, the new beds would be distributed throughout the adult intensive care, adult medical surgical, and adult progressive care units. If 66 beds are approved, GSH could add beds to the three units and expand services to include two programs not currently offered by GSH—cancer treatment research unit with five beds and a CUPW program with 18 beds. Both of these new services would much needed healthcare services to a vulnerable population.

The majority of the 35 letters of support provided for this project focused on the need for additional acute care bed capacity at GSH and many of them encouraged a 66-bed addition over the 42-bed project. The excerpts above provide examples of the common theme throughout the letters.

MHS provided documentation intended to demonstrate additional acute care beds are needed at GSH. The letters of support assist MHS with this demonstration. Based on the information received, the department concludes the existing capacity is not or will not be sufficiently available and accessible to meet the projected need.

Based on the results of the department's acute care bed methodology and the information discussed above, the department concludes that MHS has demonstrated the need for an additional 66 beds at GSH. **This sub-criterion is met.**

As stated in this evaluation, MHS provided complete information to allow the department to evaluate either a 42-bed or 66-bed addition to GSH. Since the department concluded above that MHS demonstrated need for the 66-bed project, information related to the 42-bed addition will not be further evaluated in this document.

(2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

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

The admission policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and assurances regarding access to treatment. The admission policy must also include language to ensure all residents of the planning area would have access to the proposed services. This is accomplished by providing an admission policy that states patients would be admitted without regard to race, ethnicity, national origin, age, sex, pre-existing condition, physical, or mental status.

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

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

A facility's charity care policy should show a willingness of a provider to provide services to patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer.[13] With the passage of the Affordable Care Act (ACA), the amount of charity care is expected to decrease, but not disappear. The policy should also include the process one must use to access charity care at the facility.

MultiCare Health System

Admission Policy

MHS provided copies of the following policies used at all MHS hospitals, including GSH. [source: Application, Exhibits 12 and 19]

- Admission Policy-Approved July 2014
- Patient Non-Discrimination Policy-Approved October 2015
- Discharge Planning Policy-Approved January 2012

[13] WAC 246-453-010(4).

Medicare and Medicaid Programs

GSH is currently Medicare and Medicaid certified. MHS provided its projected source of revenues by payer for GSH. MHS also provided its projected source of revenues by payer for GSH using the assumption that MHS's rehabilitation bed addition application is approved. A breakdown of both revenue sources is shown in Table 8 below. [source: March 23, 2016, screening responses, pp5-6]

Table 8
GSH Payer Mix

Revenue Source	GSH-Current	GSH-Projected with Rehab & Acute
Medicare	43.0%	44.0%
Medicaid	20.0%	20.0%
Commercial	34.0%	33.0%
Other	3.0%	3.0%
Total	**100.0%**	**100.0%**

Charity Care Policy

MHS provided a copy of the following policies used at all MHS hospitals, including GSH.

- Charity Care-Approved April 2015
- Financial Assistance Policy-Approved April 2015

[source: Application, Exhibit 11]

Public Comments

None

Department Evaluation

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

All policies outline the criteria that the hospital uses to admit patients for treatment. The Admission and Non-Discrimination policies include language to ensure all patients would be admitted for treatment without regard to "*race, color, creed, religion, gender, age, disability status, national origin, sexual orientation, marital status, or any other illegal basis*."

For GSH, current Medicare revenues are approximately 43.0% of total revenues. MHS anticipates slight changes in the revenue percentages of Medicare and commercial if additional acute care beds are added and the rehabilitation project is approved. Additionally, financial data provided in the application shows Medicare revenues.

Focusing on Medicaid revenues, MHS expects no change from the 20.0% currently provided at GSH, even with approval of this project and the rehabilitation project. The financial data provided in the application also shows Medicaid revenues.

The Admission Policies and Charity Care Policy are consistent with policies reviewed and approved by the Department of Health. Further, MHS demonstrated that it would continue to be available to serve the Medicare and Medicaid populations.

The Charity Care Policy has been reviewed and approved by the Department of Health's Hospital/Finance and Charity Care Program (HFCCP). The Financial Assistance Policy outlines the process to obtain charity care and is used in conjunction with the charity care policy. The pro forma financial documents provided in the application include a charity care 'line item' as a deduction of revenue

Charity Care Percentage Requirement

For charity care reporting purposes, Washington State is divided into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. MHS proposes additional acute care beds in Pierce County within the Puget Sound Region. Currently there are 19 hospitals operating within the region. Of the 19 hospitals, some did not report charity care data for years reviewed.[14]

Table 9 below compares the three-year historical average of charity care provided by the hospitals currently operating in the Puget Sound Region and GSH's historical charity care percentages for years 2012-2014.[15] The table also compares the projected percentage of charity care. [source: March 23, 2016, screening responses, Revised Exhibit 17C; and HFCCP's 2012-2014 charity care summaries]

Table 9
Charity Care Percentage Comparisons

	Percentage of Total Revenue	Percentage of Adjusted Revenue
Puget Sound Region Historical Average	2.54%	5.99%
Good Samaritan Hospital Historical Average	2.55%	6.39%
Good Samaritan Hospital Projected Average	3.07%	8.30%

As noted in Table 9 above, MHS intends that GSH would provide charity care above the regional average. The three-year historical average shows GSH has been providing charity care above the regional average. MHS has been providing charity care at GSH for many years and intends to continue to provide charity care if this project is approved. Based on the historical data and information provided in the application, the department concludes that a charity care condition for this project is not required.

Based on the information provided in the application and with MHS's agreement to the conditions as described above, the department concludes t**his sub-criterion is met.**

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

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

Department Evaluation

This sub-criterion is not applicable to this application.

[14] Forks Community Hospital in Forks did not report data in years 2012, 2013, and 2014. Whidbey General Hospital in Coupeville did not report data in years 2012, 2013, and 2014. EvergreenHealth-Monroe did not report data in years 2013 and 2014.

[15] As of the writing of this evaluation, charity care data for year 2015 is not available.

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

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

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

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

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

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

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

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

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

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

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

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

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that MultiCare Health System **met** the applicable financial feasibility criteria in WAC 246-310-220.

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

WAC 246-310 does not contain specific WAC 246-310-220(1) financial feasibility criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what the operating revenues and expenses should be for a project of this type and size. Therefore, using its experience and expertise the department evaluates if the

applicant's pro forma income statements reasonably project the proposed project is meeting its immediate and long-range capital and operating costs by the end of the third complete year of operation.

MultiCare Health System

The assumptions used by MHS to determine the projected number of admissions, patient days, and occupancy of GSH are summarized below. [source: Application, pp50-53 and pp59; March 23, 2016, screening responses, pp2-4 and Exhibit 17A]

- The additional beds would be licensed and operational in early year 2018. The recently approved rehabilitation beds would be licensed and operational in mid-year 2018. Occupancy projections for calendar years 2019 through 2021 show 66.4%, 70.2%, and 72.8% for the entire hospital with 375 acute care beds.
- The average length of stay [ALOS] is not expected to change from current (2014). Projected ALOS is 4.4 days.
- GSH's average daily census [ADC] is projected at 211 in years 2019; 223 in year 2020; and 231 in year 2021.
- An annual growth rate of 1.2% was applied to the projected admissions and patient days for years 2016 and 2017. The is the growth rate observed for the planning area population for the period 2010-2015.
- The annual growth rate was increased 2.7% in 2018 as additional bed become operational. This rate of growth is the same as east Pierce planning area resident days over 2014-2028 as defined by the acute care bed model.
- The annual growth of admissions and patient days are projected to increase to 5.4% in year 2019. This is a reflection of fewer internal diseconomies of scale as additional capacity opens as well as continued growth in new programs, most notably CUPW.
- MHS also based its utilization projections on the assumption that its 23-bed rehabilitation project is approved.

Using the assumptions stated above, MHS's projected number of inpatient discharges, patient days, average length of stay, and occupancy percentages for GSH. The projections are shown in Table 10 below. [source: March 23, 2016, screening responses, Revised Exhibit 17B]

Table 10
Good Samaritan Hospital
Projections for Years 2017 through 2021

	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Total Licensed Beds	286	375	375	375	375
Total Discharges	17,126	17,716	18,748	19,692	20,444
Total Patient Days	80,626	84,976	90,924	96,040	99,701
Average Daily Census	4.7	4.8	4.9	4.9	4.9
Occupancy Percentages	77.2%	81.4%	66.4%	70.2%	72.8%

The assumptions MHS used to project revenue, expenses, and net income for GSH for projection years 2017 through 2021 are summarized below. [source: Application, pp59-60 and March 23, 2016, screening response, Revised Exhibit 17B]

- The hospital information includes both inpatient and outpatient revenues and expenses. The projections are based on 2014 actuals.
- Payer mix is based on current 2014 actuals and is not expected to change with the additional 66 beds. Projected hospital-wide payer mix is shown in Table 11 on the following page.

Table 11
GSH Payer Mix

Source	GSH
Medicare	44.0%
Medicaid	20.0%
Commercial	33.0%
Other	3.0%
Total	**100.0%**

- No inflation was assumed for gross revenues.
- Reimbursement percentages were based on actuals January to September 2015 and held constant throughout the projections years.
- Deductions from revenues for bad debt is based on actuals January to September 2015 at 0.93% of gross revenues.
- Charity care is forecast at 3.07% of gross revenues, which is consistent with the Puget Sound Regional average in year 2013.
- Expenses are estimated using 2014 actuals as a baseline.
- Expenses include salaries and wages for FTEs. Direct patient care FTEs are 'flexed' with increased patient days.
- Salaries and wages for ancillary FTEs and services are also included.
- All costs associated with physician staffing are included.
- MHS also based its financial projections on the assumption that its 23-bed rehabilitation project is approved.

MHS's projected revenue, expenses, and net income for GSH for projection years 2017 through 2021 are shown in Table 12 below. [source: March 23, 2016, screening responses, Revised Exhibit 17B]

Table 12
Good Samaritan Hospital
Projected Years 2017 through 2021

In Thousands	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Net Revenue	$ 454,972	$ 470,792	$ 491,535	$ 509,902	$ 522,489
Total Expenses	$ 405,200	$ 419,411	$ 432,703	$ 443,417	$ 450,852
Net Profit / (Loss)	$ 49,772	$ 51,381	$ 58,834	$ 66,485	$ 71,637

The 'Net Revenue' line item is gross inpatient and outpatient hospital revenue. Beginning in year 2018, revenue from the CUPW program and the expanded rehabilitation services are included. The 'Total Expenses' line item includes all expenses related to hospital operations, including all staff salaries/wages and allocated costs from GSH to MHS. Allocated costs for years 2017 through 2021 are approximately $68 million.

Public Comments
None

Department Evaluation
To evaluate this sub-criterion, the department first reviewed the assumptions used by MHS to determine the projected number of admissions, patient days, and occupancy of GSH with 66 additional acute care beds. When compared to the three year historical data [years 2012-2014] provided in the application, the

department notes that overall admissions are expected to increase with the increase in beds. The occupancy percentages are expected to decrease in calendar year 2019 when all 66 beds are licensed and operational. In year 2021—the third year of operation with a 48-bed rehabilitation unit and 66 new acute care beds—GSH's projected occupancy is expected to be between 72-73%. After reviewing MHS's admission and patient day assumptions, the department concludes they are reasonable.

MHS based its revenue and expenses for GSH on the assumptions referenced above. MHS also used its current operations as a base-line for the revenue and expenses shown in Table 11. Historical information shows that MHS operates GSH at a profit. With an additional 23 level I rehabilitation beds and 66 medical/surgical beds, GSH will continue operating at a profit.

To assist the department in its evaluation of this sub-criterion, staff from the Department of Health's HFCCP[16] also provided a financial analysis. To determine whether MHS would meet its immediate and long range capital costs, HFCCP reviewed 2014 historical balance sheets for MHS as a whole. The information is shown in Table 13 below. [source: HFCCP analysis, p2]

Table 13
MultiCare Health System Balance Sheet for Year 2014

Assets		**Liabilities**	
Current Assets	$ 458,183,000	Current Liabilities	$ 344,102,000
Board Designated Assets	$ 1,453,160,000	Other Liabilities	$ 206,786,000
Property/Plant/Equipment	$ 1,298,230,000	Long Term Debt	$ 878,393,000
Other Assets	$ 88,791,000	**Equity**	**$ 1,869,083,000**
Total Assets	**$ 3,298,364,000**	**Total Liabilities and Equity**	**$ 3,298,364,000**

After reviewing the balance sheet above, HFCCP concluded that the capital expenditure of $44,523,918 would have little financial effect on MHS. [source: HFCCP analysis, p2]

For hospital projects, HFCCP provides a financial ratio 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. Projected balance sheet data is used in the analysis. HFCCP notes that MHS does not maintain or prepare separate pro forma balance sheets for each of its hospitals; however, historical balance sheets are submitted to DOH, Community Health System. As a result, MHS did not provide the pro forma balance sheet data for GSH needed to complete the financial ratio analysis.

GSH's 2014 balance sheet was used to review applicable ratios and pro forma financial information was used to review projected ratios. Table 14 on the following page shows historical year 2014 and projected years 2018 through 2020. [source: HFCCP analysis, p3]

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

Table 14
Current and Projected Debt Ratios for Good Samaritan Hospital

Category	Trend *	State 2014	MHS 2014	GSH 2018	GSH 2019	GSH 2020
Long Term Debt to Equity	B	0.448	0.470	N/A	N/A	N/A
Current Assets/Current Liabilities	A	2.702	1.332	N/A	N/A	N/A
Assets Funded by Liabilities	B	0.385	0.371	N/A	N/A	N/A
Operating Expense/Operating Revenue	B	0.954	0.892	0.747	0.741	0.735
Debt Service Coverage	A	4.990	9.795	6.084	6.635	7.133

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

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

When comparing GSH's projected years total operating expense to total operating revenue ratio with the most current statewide ratio, HFCCP states that GSH is in a strong financial position. [source: HFCCP analysis, p3]

Based on the information above, the department concludes that the immediate and long-range operating costs of the project can be met. **This sub-criterion is met.**

(2) *The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.*

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

MultiCare Health System

The capital expenditure associated with the addition of 66 acute care beds at GSH is $44,523,918. A breakdown of the capital expenditure is shown in Table 15 below. [source: Application, p54]

Table 15
Good Samaritan Hospital
Estimated Capital Expenditure Breakdown

Item	Cost
Building Construction/Minor Remodel	$ 24,990,236
Moveable Equipment	$ 11,429,388
Architect/Engineering/Consulting Fees	$ 1,990,425
Site Preparation/Supervision/Inspection	$ 2,654,005
Sales Tax	$ 3,459,864
Total	**$ 44,523,918**

Since GSH is currently operational, no start-up costs are required. MHS provided a contractor's estimate attesting that the construction costs identified above is reasonable. [source: Application, Exhibit 15A]

MHS stated that no changes in costs or charges for acute care services at GSH are anticipated. The addition of 66 beds will allow the hospital to grow and better meet the community need. [source: March 23, 2016, screening responses, pp4-5]

Public Comments
None

Department Evaluation
MHS provided a letter from a contractor, attesting that the construction estimate within the application is reasonable. MHS confirmed that GSH would continue full operations during the construction required to add 66 beds. As a result, no start-up costs are required.

In the financial review, HFCCP confirmed that the rates proposed by MHS for GSH are similar to Washington statewide averages. [source: HFCCP analysis p5]

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

Based on the above information, the department concludes that the addition of 66 acute care beds at GSH would probably not have an unreasonable impact on the costs and charges for healthcare services in Pierce County. **This sub-criterion is met.**

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

MultiCare Health System
The capital expenditure associated with the addition of 66 acute care beds at GSH is $44,523,918. [source: Application, p54]

MHS intends to fund the project using cash reserves and provided a letter of financial commitment from MultiCare Health System's chief financial officer. In addition to the financial commitment letter, MHS provided its fiscal years 2012, 2013, and 2014 audited financial statements to demonstrate it has sufficient reserves to finance the project. [source: Application, Exhibit 16 and Exhibit 18]

Public Comments
None

Department Evaluation
Based on the audited financial statements reviewed, the department concludes that MHS's 66 bed addition project can be appropriately financed. Since MHS was recently approved to add rehabilitation beds to the GSH, the department also considered the approved costs of that project. The total approved

costs for the rehabilitation project is $568,793. Taking into account the costs for both projects, MHS would be approved for $45,092,711 in capital costs within the last 60 days. A review of the audited financial statements shows that MHS has the funds to support both projects.

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

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

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that MultiCare Health System **met** the applicable structure and process of care criteria in WAC 246-310-230.

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

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

As stated on page 2 of this evaluation, on August 1, 2016, CN #1582 was issued to MHS approving the addition of 23 level I rehabilitation beds to GSH's level I rehabilitation unit. The level I rehabilitation project is expected to be completed in July 2018. The FTE information below takes into account the additional staff required for the increase in rehabilitation capacity at GSH.

MultiCare Health System

GSH currently provides acute care services with 286 licensed beds. With the addition of 66 acute care beds and the 23 additional rehabilitation beds, GSH would be operating as a 375-bed acute care hospital beginning in February 2018. [source: Application, p15 and 24]

Table 16 below provides a breakdown of current and projected FTEs [full time equivalents] for the hospital. Current year is 2015. Projected years begin with 2016 through 2021, which is the third year following project completion of this project. [source: March 23, 2016, screening response, Revised Exhibit 17B]

Table 16
Good Samaritan Hospital
Current and Proposed FTEs for Years 2015-2021

FTE by Type	CY 2015 Current	CY 2016 Increase	CY 2017 Increase	CY 2018 Increase	CY 2019 Increase	CY 2020 Increase	CY 2021 Increase	Total FTEs
Management	102.0	0.0	0.0	3.0	0.0	0.0	0.0	**105.0**
Provider	89.0	0.0	0.0	1.0	0.0	0.0	0.0	**90.0**
Nursing	986.0	22.0	14.0	49.0	59.0	52.0	37.0	**1,219.0**
Tech/Specialists	567.0	13.0	7.0	28.0	35.0	30.0	21.0	**701.0**
Support	556.0	6.0	4.0	10.0	17.0	15.0	11.0	**619.0**
Total FTEs	**2,300.0**	**41.0**	**25.0**	**91.0**	**111.0**	**97.0**	**69.0**	**2,734.0**

MHS provided the following description of the FTEs referenced in the table.

- Management = supervisors and above
- Providers = physicians
- Nursing = registered nurses, licensed practice nurses, and certified nursing assistants
- Techs/Specialists = physical, occupational, speech, and therapist; physical and occupational therapy assistants, and psychologists.
- Support = housekeeping, security, laundry, and business office

[source: March 23, 2016, screening response, p9]

MHS states it does not expect difficulty recruiting the additional staff needed for GSH's recently approved rehabilitation project or this 66 bed addition project. MHS has been providing acute care services, including rehabilitation services, for many years. MHS states it has extensive recruiting resources, including specific MHS staff known as the Talent Acquisition Team. The team is made up of MHS nursing staff and employment coordinators. MHS states its turnover and vacancy rates are lower than other healthcare providers because it devotes internal resources to the task. To ensure an adequate flow of new healthcare workers, MHS partners with local universities, community colleges, and trade schools. MHS also hosts or helps develop several residency and apprenticeship programs for its behavioral health, cardiovascular, and other programs. MHS states it spends more than $15,000,000 annually on employee education. [source: Application, pp63-64]

Public Comments
None

Department Evaluation
As shown in Table 16 above, GSH has the majority of its staff in place; however, with the increase in both level I rehabilitation and general acute care beds, MHS proposes to add more than 300 FTEs by the end of year 2021. The majority of the additional FTEs would be in the categories of nursing and tech/specialists which are direct patient care positions. The table shows that the FTEs would be added incrementally based on the projected utilization and average daily census of the hospital.

Information provided in the application demonstrates that MHS is a well-established provider of healthcare services in King and Pierce counties. Specific to GSH, it has been part of MHS since 2006. GSH has been providing acute care services since approximately 1954 and services have expanded to meet the needs of the community. [source: MHS-Good Samaritan Hospital website] Based on the above information, the department concludes that MHS has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project. **This sub-criterion is met.**

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

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

MultiCare Health System

MHS states that GSH has been providing healthcare services in Puyallup for many years, and all ancillary and support services are already in place. This project proposes an expansion of beds throughout the medical/surgical unit, the progressive care unit, and the intensive care unit. MHS does not expect the existing ancillary and support services to change. [source: Application, p64]

MHS states that since GSH is the only hospital in the east Pierce County planning area, it has already established extensive referral relationships with the healthcare community. MHS expects these relationships to continue if this project is approved. [source: Application, p64y 29, 2016, screening response, pp7-8]

MHS provided a copy of the function program to be used for the CUPW program. The functional program requires medical director oversight for the CUPW program and assistance by a second physician. Specific to the medical director, MHS identified Abigail Plawman, MD. Since Dr. Plawman is an employee of MHS, no separate medical director contact is necessary. MHS provided a copy of the physician employment agreement with Dr. Plawman. The Physician Employment Agreement identifies roles and responsibilities for both MHS and Abigail Plawman, MD. Included in the Employment Agreement is a draft addendum specific to the CUPW program. The addendum clarifies that 25% of Dr. Plawman's time will be dedicated to medical directorship of the CUPW program with no additional compensation specific to the CUPW services. MHS identified the second physician referenced in the CUPW functional program as William Kriegsman, MD. No additional compensation for Dr. Kriegsman for his 'back up' role in the CUPW program is expected. [source: May 10, 2016, screening responses, pp1-2 and Exhibit 24]

Public Comments

None

Department Evaluation

The department acknowledges that GSH has been providing acute care services in the planning area for many years and all ancillary and support agreements are already place for an acute care hospital. For new programs contemplated at GSH, additional ancillary and support services may be established for GSH. As a long-time provider of acute care services, the department expects MHS would not have difficultly establishing new relationships as needed.

The Physician Employment Agreement is signed and dated; the addendum is a draft. If this project is approved, the department would attach a condition requiring MHS to provide a copy of the executed addendum to be used for the CUPW program.

Based on the information reviewed in the application, the department concludes that there is reasonable assurance that MHS will continue to maintain the necessary relationships with ancillary and support services with additional 66 beds at GSH. The department concludes that approval of 66 acute care beds at GSH would not negatively affect existing healthcare relationships. **This sub-criterion is met.**

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

WAC 246-310 does not contain specific WAC 246-310-230(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that a facility must meet when it is to be Medicare certified and Medicaid eligible. Therefore, using its

experience and expertise the department assessed the applicant's history in meeting these standards at other facilities owned or operated by the applicant.

MultiCare Health System

MHS owns and operates a variety of healthcare facilities in Washington State, including four hospitals, a home health and a hospice agency, and a residential treatment facility. MHS does not own or operate any out-of-state facilities. [source: CN historical files, MultiCare Health System website]

MHS states that GSH operates a CARF accredited rehabilitation program and is designated as a level I trauma rehabilitation center for Washington State. [source: Application, p50]

Public Comments

None

Department Evaluation

As part of this review, the department must conclude that the proposed services provided by an applicant would be provided in a manner that ensures safe and adequate care to the public.[17] To accomplish this task, the department reviewed the quality of care compliance history for all healthcare facilities owned, operated, or managed by MHS.

The four hospitals owned and operated by MHS are Tacoma General/Allenmore located in Tacoma, Mary Bridge Children's Hospital located in Tacoma, Auburn Medical Center located in Auburn, and Good Samaritan Hospital located in Puyallup. All four hospitals are accredited by the Joint Commission.[18] Specific to Good Samaritan Hospital, the hospital has also achieved special certification in year 2014 from the Joint Commission.[19] [source: Joint Commission website]

Using the department's internal database, the department reviewed survey data for each of the four hospitals, MHS's home health agency, and its residential treatment facility.[20] Since 2012, a total of 14 surveys have been conducted and completed by Washington State surveyors.[21] All surveys resulted in no significant non-compliance issues. [source: ILRS survey data]

In addition to the facilities owned and operated by MHS, the department also reviewed the compliance history for the two physicians that would be associated with the CUP W program. In this process, the Certificate of Need program used compliance data from the Medical Quality Assurance Commission (MQAC). This review found that both physicians are licensed and in good standing.

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

[18] Tacoma General/Allenmore is accredited through year 2017; Mary Bridge Children's Hospital is accredited through year 2017; Auburn Medical Center is accredited through year 2018, and Good Samaritan Hospital is accredited through year 2019.

[19] The 2014 certification identifies the hospital as a primary stroke center.

[20] Defined in WAC 246-337-005(33) a residential treatment facility or 'RTF' means a facility for purposes of evaluation and treatment or evaluation and referral of any individual with a chemical dependency or mental disorder.

[21] Quality of care surveys conducted in February 2012, December 2012, and March 2013 for the Good Samaritan Outreach RTF; December 2012 and March 2015 for the home health and hospice agency; November 2012, March 2014, and September 2015 for Tacoma General/Allenmore Hospital; February 2013 and February 2014 for Mary Bridge Children's Hospital and Health Center; November 2013 and September 2014 for Auburn Medical Center; and March 2013 and August 2015 for Good Samaritan Hospital.

Given the compliance history of the health care facilities owned and operated by MHS, including the proposed CUPW medical director and assistant physician, there is reasonable assurance that GSH would continue to be operated and managed in conformance with applicable state and federal licensing and certification requirements 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.

MultiCare Health System

MHS states that continuity in the provision of health care services will be accomplished in a variety of ways. The additional beds will allow more east Pierce County patients to receive services in a GSH, rather than travelling outside the planning area. [source: Application, p64]

MHS also states that if 66 additional acute care beds are approved, MHS intends to establish a CUPW program at GSH using 18 of the new beds. MHS asserts that the proposed CUPW program would promote continuity in healthcare services for the mothers and infants at GSH. [source: Application, p64]

Public Comments

The department received 35 letters of support for this project. Many of the letters provided general support for GSH's bed addition, however some also focused on the ancillary and support services either offered by GSH or referred by GSH. Below are excerpts of statements related to this sub-criterion.

Dan Beckman, Assistant Chief EMS Central Pierce Fire & Rescue #6

"Central Pierce provides 24-hour emergency medical and fire suppression protection to nearly 200,000 citizens and covers an 84-square mile area encompassing the communities of Parkland, Midland, Spanaway, South Hill, Puyallup, Summit, and Frederickson. Eight of our twelve stations house paramedic units to provide emergency medical services and transport patients to emergency care centers, including Good Samaritan Hospital. Good Samaritan's emergency department is among the busiest in the state, with more than 75,000 visits last year. The hospital has been at or near capacity during busy winter months for the past few years and has had to go on divert status several times in the past 12 months. This negatively impacts our organization and the citizens that we protect, as 61 percent of Central Pierce Fire & Rescue's transports are to Good Samaritan Hospital."

Bryan Jeter, Chief of Police Puyallup Police Department

"The east Pierce County region relies heavily on Good Samaritan Hospital for its hospital and emergency department needs. As a result, the hospital is often very full and the emergency department in particular is one of the busiest in the state. Not having enough beds to admit patients from the emergency department can be a real problem for people needing care immediately. Sometimes, the Good Samaritan emergency department has to go on divert status which forces local residents to have to leave the area for hospital care."

Bret Lambert, MD, Medical Director for Good Samaritan Emergency Department
Ari Malka, MD Chair of Good Samaritan Emergency Medical Services Committee
"Last year, Good Samaritan had 75,923 visits to the emergency department. Early this year, we had record-breaking numbers coming into the emergency department, with 290 patients in a single day. …The emergency department is the front door to the hospital, and about 25 percent of those who come to the emergency department need to be admitted to the hospital. If there are no beds available, this completely messes up the flow of the entire facility."

Hans Zeiger, Washington State Representative, District 25
"Good Samaritan serves a large geographic region, which continues to grow year after year, as the hospital has seen record numbers of patients. It's important that residents have access to critical health care services. Critical care access is compromised when patients are sent out of the area if the hospital is on divert because of capacity issues."

Department Evaluation
The letters sent by the Puyallup police chief, fire and rescue, and emergency room doctors provide valuable perspectives related to this sub-criterion. The excerpts above demonstrate the importance of GSH's availability to accept emergent patients during transport or referral by law enforcement. As a long-time provider of acute care services services, GSH has the basic infrastructure in place to expand its beds and services.

As a Level I Trauma Rehabilitation Center, patients come to GSH with a variety of diagnoses and acuities. The additional acute care beds will allow GSH to continue to provide the necessary care to these patients with co-morbidities.

GSH also holds CARF accreditation associated with its rehabilitation services. The accreditation requires extensive referral relationships to ensure a continuum of care necessary for rehabilitation patient recoveries to the fullest extent possible. Examples of these relationships include behavioral health, assisted living centers, skilled nursing centers, and community-based healthcare providers.

The department substantiated that there are currently two acute care hospitals that offer a CUPW program. The two hospitals are Swedish Medical Center located in Ballard and EvergreenHealth located in Monroe. For GSH patients intending to enroll in the CUPW program, Ballard or Monroe are the only two options. The proposed CUPW program would be an appropriate complement to GSH's level II intermediate care nursery.

Based on the information provided in the application, the department concludes there is reasonable assurance that this project will continue to promote continuity in the provision of health care services in the community with additional rehabilitation beds at GSH. **This sub-criterion is met.**

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

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

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that MultiCare Health System **met** the applicable cost containment criteria in WAC 246-310-240.

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

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

If there are multiple applications, the department's assessment is to apply any service or facility superiority criteria contained throughout WAC 246-310 related to the specific project type. The superiority criteria are objective measures used to compare competing projects and make the determination between two or more approvable projects which is the best alternative. If WAC 246-310 does not contain any service or facility type superiority criteria as directed by WAC 246-310-200(2)(a)(i), then the department would use 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, MHS met the applicable review criteria under WAC 246-310-210, 220, and 230. Therefore, the department moves to step two below.

Step Two

Before submitting this application, MHS considered the option of 'do nothing or status quo.' This option means that GSH would continue to operate with a total of 286 licensed beds, and 250 of them used for medical/surgical services; 11 dedicated to level II intermediate care nursery; and 25 level I rehabilitation services. While CN #1582 was issued to expand the level I rehabilitation unit from 25 to 48, the number of medical surgical beds would remain at 250. MHS rejected this option because it does nothing to improve patient access to healthcare services at GSH. Status quo also means that the emergency department would continue to be on 'divert' regularly and many planning area patients would continue to be forced to receive health services out of the planning area. MHS rejected this option. [source: Application, pp66-69]

Once MHS concluded that acute care beds must be added to GSH, MHS then determined the appropriate number of beds to be added. Under this option, MHS evaluated the addition of 42 beds and the addition of 66 beds. This application included all of the necessary need, financial, and staffing information to approve either 66 beds or 42 beds. [source: Application, pp66-69; March 23, 2016, screening responses, Exhibits 15A &15B, Revised Exhibits 17B & 17C, and Exhibit 23]

Below is a summary of MHS's evaluation of the two options. [source: Application, pp66-69]

Addition of 66 beds

The addition of 66 beds would result in 375 licensed acute care beds at GSH. Of those, 316 would be used for general medical surgical services. MHS states this option allows sufficient expansion space for the units/services that would be receiving additional beds—medical/surgical unit, the progressive care unit, and the intensive care unit. This option also allows GSH to have enough bed capacity to begin a CUPW program with 18 of the new beds.

MHS also provided a cost per bed analysis and concluded that the 66 bed project has a lower cost per bed than the 42 bed project. The analysis is summarized below.

	66 Bed Addition	**42 Bed Addition**
Capital Costs	$ 44,523,918	$ 34,588,295
Cost/Bed	$ 674,604.82	$ 823,530.83

After identifying each of the two bed addition options, MHS stated that the addition of 66 acute care beds is its preferred option for all of the reasons summarized above.

Addition of 42 beds

The addition of 42 beds would result in 351 licensed acute care beds at GSH. Of those, 292 would be used for general medical surgical services. MHS states that the addition of 42 beds does not correct for the one-time downturn in planning area patient days in year 2014 due to the implementation of the '2 Midnight Rule.' MHS states that this option adds much needed beds to GSH, but does not leave enough beds to expand services or begin a CUPW program.

MHS acknowledged that the addition of 42 acute care beds is better than not adding any beds to GSH. The 42 bed addition project is MHS's second choice.

Step Three

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

Public Comments

None

Department Evaluation

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

Once it was determined that additional acute care bed capacity needed to be added to the planning area, MHS had to determine the number to be added—either 42 or 66. MHS applied the numeric methodology and used the results as guidance to determine the right-size number for the planning area. The department's methodology was based on most recent utilization data [2006-2015] and demonstrated that the addition of 66 beds is reasonable in the east Pierce planning area.

MHS also took into account the services that would be expanded with the additional acute care beds. The medical/surgical unit, the progressive care unit, and the intensive care unit all need additional beds to continue efficient operations.

MHS intends to begin a CUPW program with 18 of the new beds. This program is designed to change the behavior of chemically dependent pregnant women and improve birth outcomes. MHS states that the CUPW program would fit well with its 11 bed level II nursery.

MHS expects some of its inpatient services to experience inpatient growth in upcoming years. The services are joint replacements, spine surgery, surgical oncology, vascular surgery, thoracic surgery, gynecologic surgery, and inpatient epilepsy monitoring. Additionally, MHS is contemplating the establishment of a 5-bed unit used for cancer treatment research since GSH is the primary MHS facility that provides chemotherapy.

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

Taking into account the public comments related to need for additional acute care beds at GSH and the options considered by MHS, the department concurs that a 66-bed expansion at GSH is reasonable and the best available option for the planning area and surrounding communities. **This sub-criterion is met.**

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

MultiCare Health System
This project involves completion of the 7th and 8th floors of the Dally Tower at GSH.[22] MHS states that the two floors are directly above, and would be configured the same as, the 6th floor of the tower. This means that patient room layouts at the perimeter (where windows already exist) is pre-determined by column locations and plumbing phases. The core areas for support resource spaces that serve the inpatient units are also pre-determined in the same way. The design has been used to minimize space needed and where possible, this pre-determined space process has been used successfully throughout the tower. [source: Application, p70]

Public Comments
None

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

"*The costs of the project are the cost for construction, planning and process. MultiCare Good Samaritan Hospital projections are below."*

Total Capital	$44,524,000*
Beds/Stations/Other (Unit)	66
Total Capital per Unit	$674,606

*capital expenditure rounded from $44,523,918

[22] GSH's new patient tower opened in February 2011 and was named the Dally Tower in June 2011.

"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. MultiCare Health System is adding to an existing building in a facility it currently occupies for healthcare services and will construct the new area to the latest energy and hospital standards. Staff is satisfied the applicant plans are appropriate." [source: HFCCP analysis, p4]

Based on the information provided in the application, the demonstrated need for additional acute care beds at GSH, and the analysis from HFCCP, the department concludes **this sub-criterion is met.**

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

MultiCare Health System
MHS stated that this project allows expansion of some services and establishment of a CUPW program. MHS states there is no impact to the costs and charges to the public.

Public Comments
None

Department Evaluation
This project involves construction, regardless of whether 66 or 42 beds are added to GSH. With need for additional acute care beds at GSH and the assumptions related to the costs and charges discussed under the Financial Feasibility section of this evaluation, the department does not anticipate this project would have an unreasonable impact on the costs and charges to the public. Therefore, the department concludes **this sub-criterion is met.**

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

MultiCare Health System
MHS asserts that the addition of 66 acute care beds to GSH would improve the delivery of health services to east Pierce County and surrounding communities. This rationale is primarily based on the current out-migration of Pierce County patients that is anticipated to continue without the additional beds at GSH.

Public Comments
None

Department Evaluation
This project has the potential to improve delivery of acute rehabilitation services to the residents of Pierce County and surrounding communities with the addition of 66 beds to GSH. The department is satisfied the project is appropriate and needed. **This sub-criterion is met.**

APPENDIX A

2006-2015 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**10-YEAR TOTAL**
HSA #1	1,235,319	1,282,804	1,328,827	1,321,575	1,313,342	1,295,164	1,346,550	1,415,214	1,338,474	1,556,819	**13,434,088**
											0
STATEWIDE TOTAL	**2,007,868**	**2,068,766**	**2,135,745**	**2,130,225**	**2,118,577**	**2,058,360**	**2,045,526**	**2,159,060**	**2,107,773**	**2,328,958**	**21,160,858**
2006-2015 CHARS no MDC1519 or Rehab.xlsx											

2006-2015 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**10-YEAR TOTAL**
HSA #1	1,235,319	1,282,804	1,328,827	1,321,575	1,313,342	1,295,164	1,346,550	1,415,214	1,338,474	1,556,819	**13,434,088**
STATEWIDE TOTAL	2,007,868	2,068,766	2,135,745	2,130,225	2,118,577	2,058,360	2,045,526	2,159,060	2,107,773	2,328,958	**21,160,858**

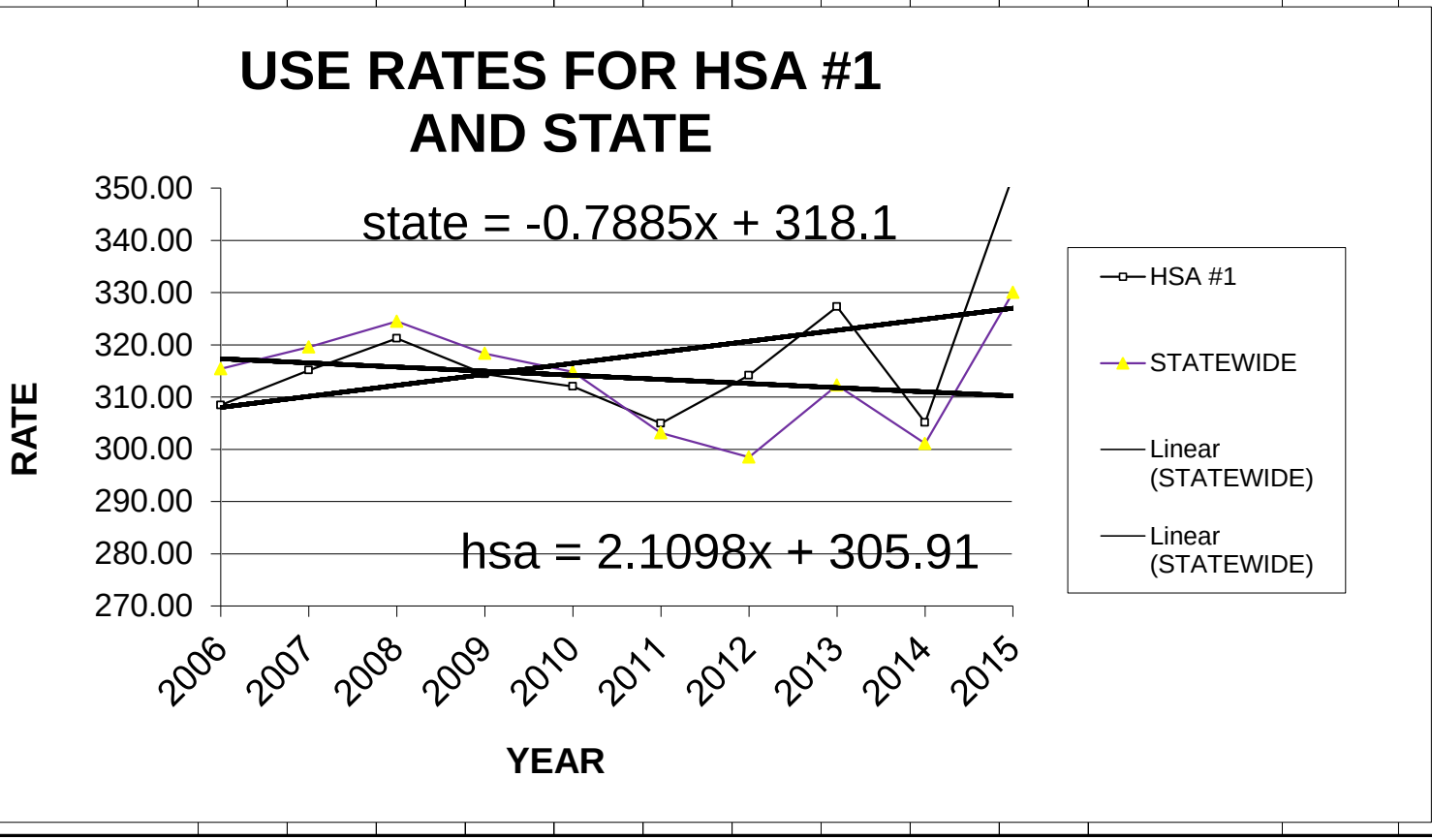
2006-2015 HSA TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS											
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**10-YEAR TOTAL**
HSA #1	616	805	1,067	1,713	1404	1758	2674	3104	10950	17763	**41,854**
STATEWIDE TOTAL	**716**	**954**	**1,152**	**2,006**	**1,527**	**1,939**	**2,825**	**3,413**	**11,326**	**17,937**	**43,795**

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

2006-2015 HSA TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS											
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**10-YEAR TOTAL**
HSA #1	1,234,703	1,281,999	1,327,760	1,319,862	1,311,938	1,293,406	1,343,876	1,412,110	1,327,524	1,539,056	**13,392,234**
STATEWIDE TOTAL	**2,007,152**	**2,067,812**	**2,134,593**	**2,128,219**	**2,117,050**	**2,056,421**	**2,042,701**	**2,155,647**	**2,096,447**	**2,311,021**	**21,117,063**

2006-2015 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS MINUS PSYCH DAYS												
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	10-YEAR TOTAL	
HSA #1	1,234,703	1,281,999	1,327,760	1,319,862	1,311,938	1,293,406	1,343,876	1,412,110	1,327,524	1,539,056	**13,392,234**	
STATEWIDE TOTAL	**2,007,152**	**2,067,812**	**2,134,593**	**2,128,219**	**2,117,050**	**2,056,421**	**2,042,701**	**2,155,647**	**2,096,447**	**2,311,021**	**21,117,063**	
TOTAL POPULATIONS												
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	10-YEAR TOTAL	
HSA #1	4,003,059	4,068,118	4,133,178	4,198,237	4,204,534	4,241,101	4,277,669	4,314,372	4,350,804	4,367,371	**42,158,443**	
STATEWIDE TOTAL	**6,363,584**	**6,470,767**	**6,577,951**	**6,685,134**	**6,724,540**	**6,784,072**	**6,843,604**	**6,903,272**	**6,962,668**	**7,002,200**	**67,317,792**	
USE RATE PER 1,000												
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	10-YEAR TOTAL	
HSA #1	308.44	315.13	321.24	314.38	312.03	304.97	314.16	327.30	305.12	352.40	**3,175**	
STATEWIDE	**315.41**	**319.56**	**324.51**	**318.35**	**314.82**	**303.12**	**298.48**	**312.26**	**301.10**	**330.04**	**3,138**	

RESIDENT USE RATE PER 1,000													
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**10-YEAR TOTAL**		**Trendline**
HSA #1	308.44	315.13	321.24	314.38	312.03	304.97	314.16	327.30	305.12	352.40	**3,175.19**		2.1098
STATEWIDE	**315.41**	**319.56**	**324.51**	**318.35**	**314.82**	**303.12**	**298.48**	**312.26**	**301.10**	**330.04**	**3,137.67**		**-0.7885**



STEP #5										
2010 CHARS										
	# of Pat days	Less OOS	TOTAL LESS OOS							
Good Sam				%						
0-64	34,565	314	**34,251**	0.91%						
65+	33,950	313	**33,637**	0.92%						
TOTAL	**68,515**	**627**	**67,888**							
WA - Good Sam										
0-64	1,199,823	63,660	**1,136,163**	5.31%						
65+	954,095	42,238	**911,857**	4.43%						
TOTAL	**2,153,918**	**105,898**	**2,048,020**							
	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	22,738	32,566			55,304	149	55,453			
65+	24,704	18,311			43,015	47	43,062			
TOTAL	**47,442**	**50,877**			**98,319**	**196**	**98,515**			
Patients FROM WA										
0-64	11,513	1,103,597			1,115,110	39,923	1,155,033			
65+	8,933	893,546			902,479	19,900	922,379			
TOTAL	**20,446**	**1,997,143**			**2,017,589**	**59,823**	**2,077,412**			
	67,888	**2,048,020**			** 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	41.00%	58.73%		0.27%						
65+	57.37%	42.52%		0.11%						
TOTAL										
% OF WA - E Pierce RESIDENTS										
0-64	1.00%	95.55%		3.46%						
65+	0.97%	96.87%		2.16%						
TOTAL										
2015 POPULATIONS OF PLANNING AREA										
	E Pierce	**TO WA**								
0-64	263,213	5,769,863								
65+	35,901	953,223								
TOTAL	**299,114**	**6,723,086**								
STEP #6										
USE RATE BY PLANNING AREA										
	E Pierce	**TO WA**								
USE RATES										
0-64	210.68	200.18								
65+	1,199.47	967.64								

USE RATE BY PLANNING AREA FROM STEP 6							
	E Pierce						
YEAR 2010 USE RATES							
0-64	210.68						
65+	1,199.47						
PROJECTED POPULATION	YEAR 2022						
	E Pierce						
0-64	280,902						
65+	46,318						
TOTALS	**327,220**						
PROJECTED 2022 USE RATE							
	E Pierce						
USE RATES*							
0-64 using HSA Trend	225.45						
0-64 using Statewide Trend	**205.16**						
65+ using HSA Trend	1,214.23						
65+ using Statewide Trend	**1,193.95**						
* Projected by applying either HSA trend or Statewide trend, whichever trend would result in the smaller adjustment							
Bold Print indicates use rate closest to current value							

USE RATE BY HSA FROM STEP 7A	
PROJECTED USE RATE - 2022	**E Pierce**
USE RATES	
0-64	205.16
65+	1,193.95
PROJECTED POPULATION - 2022	
	E Pierce
0-64	280,902
65+	46,318
TOTALS	**327,220**
PROJECTED # OF PATIENT DAYS	YEAR 2022
	E Pierce
0-64	57,629
65+	55,302
TOTALS	**112,931**

PROJECTED # OF PATIENT DAYS					
YEAR 2022	**E Pierce**	**WA - E Pierce**		**TOTAL**	
0-64	57,629	1,140,810		1,198,439	
65+	55,302	1,252,877		1,308,179	
TOTALS	**112,931**	**2,393,687**		**2,506,618**	
MARKET SHARE % OF PATIENT DAYS FROM STEP 5					
% OF E Pierce RESIDENTS	**E Pierce**	**WA - E Pierce**		**TO OREGON**	
0-64	41.00%	58.73%		0.27%	
65+	57.37%	42.52%		0.11%	
% OF WA - E Pierce RESIDENTS	**E Pierce**	**WA - E Pierce**		**TO OREGON**	
0-64	1.00%	95.55%		3.46%	
65+	0.97%	96.87%		2.16%	
# OF E Pierce RESIDENTS	**E Pierce**	**WA - E Pierce**		**TO OREGON**	**Total**
0-64	23,630	33,844		155	57,629
65+	31,726	23,516		60	55,302
					112,931
# OF WA - E Pierce RESIDENTS	**E Pierce**	**WA - E Pierce**		**TO OREGON**	**Total**
0-64	11,371	1,090,007		39,431	1,140,810
65+	12,134	1,213,713		27,030	1,252,877
					2,393,687

# OF RESIDENT PAT DAYS PROJECTED IN E Pierce					
0-64	35,002				
65+	43,859				
# OF RESIDENT PAT DAYS PROJECTED IN WA - E Pierce					
0-64	1,123,851				
65+	1,237,229				
# OF WA RESIDENT PAT DAYS PROJECTED IN OREGON					
0-64	39,586				
65+	27,091				
OUT OF STATE % OF PATIENT DAYS FROM STEP 5					
E Pierce	%				
0-64	0.92%				
65+	0.93%				
WA - E Pierce					
0-64	5.60%				
65+	4.63%				
PROJECTED # OF PATIENT DAYS 2022					
PLUS OUT OF STATE RESIDENTS					
E Pierce					
0-64	35,322	0.612925985			
65+	44,268	0.80047537			
TOTAL	**79,590**				

East Pierce Acute Care Bed Need
Appendix 10a

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
E Pierce Planning Area											
Population 0-64(1)	263,213	265,740	268,267	270,794	273,321	275,848	278,375	280,902	283,429	285,956	288,483
0-64 Use Rate	210.68	209.89	209.10	208.31	207.52	206.73	205.95	205.16	204.37	203.58	202.79
Population 65+(1)	35,901	37,389	38,877	40,366	41,854	43,342	44,830	46,318	47,807	49,295	50,783
65+ Use Rate	1,199.47	1198.68	1197.89	1197.10	1196.31	1195.52	1194.73	1193.95	1193.16	1192.37	1191.58
Total Population	299,114	303,129	307,144	311,160	315,175	319,190	323,205	327,220	331,236	335,251	339,266
Total E Pierce Res Days	98,515	100,593	102,665	104,731	106,791	108,844	110,890	112,931	114,965	116,993	119,014
Total Days in E Pierce Hospitals (2)	68,459	70,062	71,661	73,255	74,845	76,431	78,013	79,590	81,163	82,732	84,296
Available Beds (3)											
Good Samaritan	250	250	250	250	250	250	250	250	250	250	250
Total	**250**	**250**	**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	**268**	**274**	**280**	**287**	**293**	**299**	**305**	**312**	**318**	**324**	**330**
Net Bed Need/(Surplus)	**18**	**24**	**30**	**37**	**43**	**49**	**55**	**61.5**	**68**	**74**	**80**
								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 & CN Historical Files											
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,											

East Pierce Acute Care Bed Need
Appendix 10b w 42 beds

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
E Pierce Planning Area											
Population 0-64(1)	263,213	265,740	268,267	270,794	273,321	275,848	278,375	280,902	283,429	285,956	288,483
0-64 Use Rate	210.68	209.89	209.10	208.31	207.52	206.73	205.95	205.16	204.37	203.58	202.79
Population 65+(1)	35,901	37,389	38,877	40,366	41,854	43,342	44,830	46,318	47,807	49,295	50,783
65+ Use Rate	1,199.47	1198.68	1197.89	1197.10	1196.31	1195.52	1194.73	1193.95	1193.16	1192.37	1191.58
Total Population	299,114	303,129	307,144	311,160	315,175	319,190	323,205	327,220	331,236	335,251	339,266
Total E Pierce Res Days	98,515	100,593	102,665	104,731	106,791	108,844	110,890	112,931	114,965	116,993	119,014
Total Days in E Pierce Hospitals (2)	68,459	70,062	71,661	73,255	74,845	76,431	78,013	79,590	81,163	82,732	84,296
Available Beds (3)											
Good Samaritan	250	250	250	292	292	292	292	292	292	292	292
Total	**250**	**250**	**250**	**292**	**292**	**292**	**292**	**292**	**292**	**292**	**292**
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	**268**	**274**	**280**	**287**	**293**	**299**	**305**	**312**	**318**	**324**	**330**
Net Bed Need/(Surplus)	**18**	**24**	**30**	**(5)**	**1**	**7**	**13**	**19.5**	**26**	**32**	**38**
								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 & CN Historical Files											
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,											

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
E Pierce Planning Area											
Population 0-64(1)	263,213	265,740	268,267	270,794	273,321	275,848	278,375	280,902	283,429	285,956	288,483
0-64 Use Rate	210.68	209.89	209.10	208.31	207.52	206.73	205.95	205.16	204.37	203.58	202.79
Population 65+(1)	35,901	37,389	38,877	40,366	41,854	43,342	44,830	46,318	47,807	49,295	50,783
65+ Use Rate	1,199.47	1198.68	1197.89	1197.10	1196.31	1195.52	1194.73	1193.95	1193.16	1192.37	1191.58
Total Population	299,114	303,129	307,144	311,160	315,175	319,190	323,205	327,220	331,236	335,251	339,266
Total E Pierce Res Days	98,515	100,593	102,665	104,731	106,791	108,844	110,890	112,931	114,965	116,993	119,014
Total Days in E Pierce Hospitals (2)	68,459	70,062	71,661	73,255	74,845	76,431	78,013	79,590	81,163	82,732	84,296
Available Beds (3)											
Good Samaritan	250	250	250	316	316	316	316	316	316	316	316
Total	**250**	**250**	**250**	**316**	**316**	**316**	**316**	**316**	**316**	**316**	**316**
Wtd Occ Std(4)	70.00%	70.00%	70.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
Gross Bed Need	**268**	**274**	**280**	**268**	**273**	**279**	**285**	**291**	**296**	**302**	**308**
Net Bed Need/(Surplus)	**18**	**24**	**30**	(48)	(43)	(37)	(31)	(25.3)	(20)	(14)	(8)
								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 & CN Historical Files											
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,											