

EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF OF FRANCISCAN HEALTH SYSTEM PROPOSING TWO SEPARATE PROJECTS AT ST. JOSEPH HOSPITAL IN TACOMA:

- 1) ESTABLISH A 23-BED DEDICATED PSYCHIATRIC UNIT; AND**
- 2) REALLOCATE 16 PSYCHIATRIC BEDS TO MEDICAL SURGICAL USE**

APPLICANT DESCRIPTION

Catholic Health Initiatives is the parent corporation of Franciscan Health System (FHS). Through one of its subsidiaries, Catholic Health Initiatives owns 118 health care facilities in 22 states. For Washington State, FHS is the subsidiary that owns or operates 12 health care facilities—five hospitals, three dialysis centers, a skilled nursing facility, an ambulatory surgery center, a Medicare certified hospice agency, and a hospice care center. The health care facilities are listed below. [source: CN historical files and Application, Appendix 1]

HOSPITALS

Enumclaw Regional Hospital, Enumclaw
St. Anthony Hospital, Gig Harbor
St. Clare Hospital, Lakewood
St. Frances Hospital, Federal Way
St. Joseph Medical Center, Tacoma

DIALYSIS CENTERS

Greater Puyallup Dialysis Center, Puyallup
St. Joseph Dialysis Facility, Tacoma
Gig Harbor Dialysis Center, Gig Harbor

SKILLED NURSING FACILITY

Franciscan Care Center, Tacoma

AMBULATORY SURGERY CENTER

Gig Harbor Ambulatory Surgery Center

HOSPICE AGENCY

Franciscan Hospice, Tacoma

HOSPICE CARE CENTER

FHS Hospice Care Center

PROJECT DESCRIPTION

FHS proposes to add bed capacity to St. Joseph Medical Center (SJMC) located at 1717 South J Street in Tacoma, within Pierce County. Currently, SJMC is licensed for 320 acute care beds, of those 16 are dedicated to psychiatric services, 26 are dedicated rehab beds with a PPS exemption¹, and 18 are

¹ Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups [DRGs] for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. Since October 1, 1983, most hospitals have been paid under the hospital inpatient PPS. However, certain types of specialty hospitals and units were excluded from PPS because the PPS diagnosis related groups do not accurately account for the resource costs for the types of patients treated in those facilities. Facilities originally excluded from PPS included rehabilitation, psychiatric, children's, cancer, and long term care hospitals, rehabilitation and psychiatric hospital distinct part units, and hospitals located outside the 50 states and Puerto Rico. These providers continued to be paid according to Section 1886(b) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. They are frequently referred to as TEFRA facilities or PPS exempt. These facilities are paid on the basis of Medicare reasonable costs per case, limited by a hospital specific target amount per discharge. Each hospital has a separate payment limit or target amount which was calculated based on the hospital's cost per discharge in a base year. The base year target amount is adjusted annually by an update factor. [source: CMS website]

dedicated to intermediate care nursery/level 2 obstetric services, and the remaining 260 beds are used for general medical/surgical care.

This application proposes two separate projects:

- 1) Currently, SJMC operates a 16-bed dedicated psychiatric unit and St. Francis Hospital in Federal Way, within King County, operates a 10-bed dedicated psychiatric unit. This portion of the project proposes to consolidate the two psychiatric programs into one at SJMC. SJMC would establish a new, 23-bed dedicated inpatient psychiatric unit; and St. Francis Hospital would cease providing psychiatric services in its 10-bed unit. This action would increase the total number of beds at SJMC from 320 to 343; and decrease the total number of beds at St. Francis Hospital by 10.

On June 27, 2007, FHS received approval for two separate projects at St. Francis Hospital. One project was the approval of a six-bed intermediate care nursery/level 2 obstetric service; the second project was the addition of 36 acute care beds for medical/surgical use. This approval increased the license for St. Francis Hospital from 110 to 152. As of the writing of this evaluation, St. Francis Hospital has added 24 of the 36 additional beds to the facility, for a total license of 134 acute care beds. Of those 10 are dedicated to psychiatric services, 6 are dedicated to intermediate care nursery/level 2 obstetric services, and 118 are medical/surgical beds. The remaining 18 medical/surgical beds to be added under the June 27, 2007, approval are expected to be operational by January 2012. If this SJMC project is approved, FHS proposes to reduce St. Francis Hospital's current number of beds from 134 to 124 and no longer have a dedicated psychiatric unit. The 18 additional beds would still be added to St. Francis Hospital by January 2012, bringing its total license capacity to 142, rather than the 152 previously approved.

- 2) Reallocate SJMC's existing 16 dedicated psychiatric beds to medical/surgical use. This would increase the number of medical/surgical beds at SJMC from 260 to 276. Since the 16 dedicated psychiatric beds are already included in SJMC's license, the total number of licensed beds for SJMC would not change.

If both projects are approved, SJMC would be licensed for 343 total acute care beds. Table 1 on the following page shows the 'before' and 'after' bed configuration of the two projects for both SJMC and St. Francis Hospital. [source: Initial Application, p9]

**Table 1
Current and Proposed Configurations for St. Joseph Medical Center and St. Francis Hospital**

CURRENT CONFIGURATION			
St. Joseph Medical Center	# of Beds	St. Francis Hospital	# of Beds
General Medical/Surgical	260	General Medical/Surgical	118
Level 2 intermediate care nursery	18	Level 2 intermediate care nursery	6
Dedicated Psychiatric	16	Dedicated Psychiatric	10
Dedicated Rehab PPS Exempt	26	Dedicated Rehab PPS Exempt	0
Total	320	Total	134

PROPOSED CONFIGURATION			
St. Joseph Medical Center	# of Beds	St. Francis Hospital	# of Beds
General Medical/Surgical	276	General Medical/Surgical	118
Level 2 intermediate care nursery	18	Level 2 intermediate care nursery	6
Dedicated Psychiatric	23	Dedicated Psychiatric	0
Dedicated Rehab PPS Exempt	26	Dedicated Rehab PPS Exempt	0
Total	343	Total (before January 2012)	124

FHS states that this project will consolidate all psychiatric services at SJMC and St. Francis Hospital will no longer be providing psychiatric services.²

The estimated capital expenditure associated with the establishment of the 23-bed dedicated inpatient psychiatric unit at SJMC is \$2,500,000. FHS proposes that the project would be funded through its reserves. [source: Initial Application, p12] There are no costs associated with converting the 16 dedicated psychiatric beds to medical/surgical use. [source: Amended Application, p16]

If this project is approved, FHS anticipates the beds for both projects would become licensed in December 2010 and operational in January 2011. Under this timeline, year 2011 would be the hospital's first full calendar year of operation with 343 licensed beds and 2013 would be year three. [source: Initial Application, p17]

APPLICABILITY OF CERTIFICATE OF NEED LAW

The application proposes two separate projects. One project is the relocation/consolidation of existing psychiatric services from St. Francis Hospital in Federal Way to SJMC in Tacoma. This would be accomplished by establishing a 23-bed dedicated psychiatric unit at SJMC and closing the 10-bed psychiatric unit at St. Francis Hospital. This project is an increase in acute care bed capacity to SJMC and the planning area of central Pierce County. It is a decrease of acute care bed capacity at St. Francis Hospital located in the southeast King County planning area. As a result, the relocation/consolidation of existing psychiatric services is subject to Certificate of Need review as the change in bed capacity of a healthcare facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

² The application does not address the 26-bed dedicated rehab unit at SJMC. As a result, the department assumes this unit will remain operational and FHS will maintain its PPS exemption for the 26 dedicated rehab beds.

The second project proposes that the existing 16 acute care beds currently dedicated to psychiatric services at SJMC would be reallocated to SJMC's medical/surgical bed supply. While this project does not propose to add bed capacity to SJMC as a whole, it proposes to increase the medical/surgical bed capacity at SJMC by 16 beds. As a result, this project is also subject to review as the change in bed capacity of a healthcare facility under the provisions of RCW 70.38.105(4)(e) and WAC 246-310-020(1)(c).

For these projects, FHS is the applicant and SJMC is the facility where the proposed additional general medical surgical and/or psychiatric beds would be located. To avoid confusion in this evaluation, the two projects will be evaluated separately. The 23-beds dedicated to psychiatric care is evaluated on pages 7 through 24. The 16-bed addition is addressed on pages 25 through 43 and Appendix A. .

CRITERIA EVALUATION

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

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

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

- (i) The consistency of the proposed project with service or facility standards contained in this chapter;
- (ii) In the event the standards contained in this chapter do not address in sufficient detail for a required determination the services or facilities for health services proposed, the department may consider standards not in conflict with those standards in accordance with subsection (2)(b) of this section; and
- (iii) The relationship of the proposed project to the long-range plan (if any) of the person proposing the project.”

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

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

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

To obtain Certificate of Need approval, Franciscan Health System must demonstrate compliance with the applicable criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment).³ Additionally, WAC 246-310 does not contain service or facility specific criteria for hospital projects. For the psychiatric portion of this project, the department evaluates the applicant’s methodology; for the general medical surgical portion of the project, the department uses the acute care bed forecasting method from the 1987 State Health Plan as part of its need assessment.

APPLICATION CHRONOLOGY

February 13, 2009	Letter of Intent Submitted
April 1, 2009	Initial Application Submitted
April 2, 2009 - June 14, 2009	Department’s Pre-Review Activities <ul style="list-style-type: none"> • 1st screening activities and responses • 2nd screening activities and responses
June 15, 2009	Department Begins Review of the Application <ul style="list-style-type: none"> • public comments accepted throughout the review • public hearing requested
September 1, 2009	Amendment Application Submitted
September 2, 2009 - November 19, 2009	Department’s Pre-Review Activities <ul style="list-style-type: none"> • 1st screening activities and responses
November 20, 2009	Department Begins Review of the Amended Application <ul style="list-style-type: none"> • public comments accepted throughout the review
January 12, 2010	Public Hearing Conducted/End of Public Comment ⁴
January 28, 2010	Rebuttal Documents Received at Department
March 15, 2010	Department's Anticipated Decision Date
April 15, 2010	Department’s Anticipated Decision Date w/ 30 Day Extension
July 2, 2010	Department's Actual Decision Date

AFFECTED PERSONS

Throughout the review of this project, only MultiCare Health System sought and received interested and affected person status under WAC 246-310-010. MultiCare Health System operates a variety of healthcare facilities within King and Pierce counties.

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

⁴ During the public comment of the initial review, the department determined that FHS was required to amend the application to address the reallocation of the 16 dedicated psychiatric beds. During this time, the department also received a request for public hearing. Once the amendment application was submitted and the department began review of the amended application, the public hearing request was honored. Based on the timing, the hearing would have been conducted on December 24, 2009. The applicant requested that the public hearing be conducted on January 12, 2010, which extended the 35-day public comment period an additional 18 days.

SOURCE INFORMATION REVIEWED

- Franciscan Health System's Initial Certificate of Need application received April 1, 2009
- Franciscan Health System's supplemental information received June 8, 2009
- Franciscan Health System's supplemental information received June 23, 2009
- Franciscan Health System's Amended Certificate of Need application received September 1, 2009
- Franciscan Health System's supplemental information received November 13, 2009
- Franciscan Health System's supplemental information received November 17, 2009
- Public comments submitted during the initial and amendment review of this project
- Financial feasibility and cost containment evaluation prepared by the Department of Health's Hospital and Patient Data Systems received February 24, 2010
- November 26, 2008, hospital license application submitted by Franciscan Health System for St. Joseph Medical Center
- October 2008 completed acute care bed survey submitted by Franciscan Health System for St. Joseph Medical Center
- January 27, 2009, hospital license application submitted by Franciscan Health System for St. Anthony Hospital
- November 27, 2007, hospice license application submitted by MultiCare Health System for Tacoma General/Allenmore Hospital
- October 2008 completed acute care bed survey submitted by MultiCare Health System for Tacoma General/Allenmore Hospital
- November 26, 2008, hospital license application submitted by MultiCare Health System for Mary Bridge Children's Health Center
- October 2008 completed acute care bed survey submitted by MultiCare Health System for Mary Bridge Children's Health Center
- Department of Health's Hospital and Patient Data Systems hospital financial database (<http://www.doh.wa.gov/EHSPHL/hospdata/Financial>)
- Comprehensive Hospital Abstract Reporting System (CHARS) data for psychiatric services
- Licensing and/or survey data provided by the Department of Health's Investigations and Inspections Office
- United States Department of Health and Human Services / CMS website (www.medicare.gov/nhcompare)
- Office of Financial Management population data released November 2007
- 1987 State Health Plan
- 1980 State Health Plan
- Centers for Medicare and Medicaid Services (CMS) webpage (cms.hhs.gov/inpatientpsychfacilpps)

CONCLUSION

For the reasons stated in this evaluation, Franciscan Health System’s proposal to:

- 1) Establish a 23-bed dedicated inpatient psychiatric unit at St. Joseph Medical Center by adding 23 new acute care beds to the hospital’s total licensed beds; and
- 2) Reallocate 16 dedicated psychiatric beds to medical surgical use at St. Joseph Medical Center

is consistent with application criteria of the Certificate of Need Program, provided Franciscan Health System agrees to the following condition.

St. Joseph Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Puget Sound Region. Currently, this amount is 1.93% of gross revenue and 4.20% of adjusted revenue. St. Joseph Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

At project completion, Franciscan Health System’s campus configuration at St. Joseph Medical Center and St. Francis Hospital is shown below:

PROPOSED CONFIGURATION			
St. Joseph Medical Center	# of Beds	St. Francis Hospital	# of Beds
General Medical/Surgical	276	General Medical/Surgical	118
Level 2 intermediate care nursery	18	Level 2 intermediate care nursery	6
Dedicated Psychiatric	23	Dedicated Psychiatric	0
Dedicated Rehab PPS Exempt	26	Dedicated Rehab PPS Exempt	0
Total	343	Total (before January 2012)	124

The total approved capital expenditure for this project is \$2,500,000.

PSYCHIATRIC BED ADDITION PROJECT

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

Based on the source information reviewed and the applicant's agreement to the condition identified in the "Conclusion" section of this evaluation, the department concludes Franciscan Health System has met the need criteria in WAC 246-310-210(1) and (2).

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

WAC 246-310 does not contain an acute care bed forecasting method. The determination of numeric need for acute care hospital beds is performed using the Hospital Bed Need Forecasting method contained in the 1987 Washington State Health Plan (SHP). Though the SHP was "sunset" in 1989, the department has concluded that this methodology remains a reliable tool for predicting baseline need for acute care beds. The 1987 SHP also has a numeric methodology for projecting psychiatric bed need, however the department is unable to obtain the required data to apply this methodology. As a result, the evaluation of the need criterion for psychiatric beds begins with an evaluation of the methodology provided by the applicant.

SUMMARY OF APPLICANT'S METHODOLOGY AND ASSUMPTIONS

FHS clarifies that while this project proposes the addition of 23 psychiatric beds at SJMC, it is essentially the relocation and consolidation of existing psychiatric services. Currently, both SJMC in Tacoma and St. Francis Hospital in Federal Way provide psychiatric services. SJMC has 16 dedicated psychiatric beds and St. Francis has 10 dedicated psychiatric beds, for a combined total of 26. This project proposes to consolidate psychiatric beds, as well as reduce the total number of psychiatric beds from 26 to 23.⁵ As a result, FHS did not provide a need methodology to demonstrate 'need' for the 23 new psychiatric beds. Rather, FHS provided the following rationale for relocation and consolidation of the psychiatric services:

- The need for inpatient psychiatric beds as an integrated system for residents of south King and Pierce County, rather than at two separate sites;
- FHS has a commitment to address "regional" need for inpatient psychiatric services; and
- Problems inherent in the current practice for FHS to operate two separate psychiatric units at two separate sites that result in delays in care, duplication of services, unnecessary transports, and other inefficiencies.

Below is a summary of FHS's discussion related to the three topics above.

South King and Pierce County Need for Psychiatric Services [source: Initial application, p21]

FHS asserts that there has been a significant decrease in psychiatric bed availability in south King and Pierce County. Until late year 2003, a total of 176 psychiatric beds were available in two separate settings for Pierce County residents—Puget Sound Behavioral Health in Tacoma operated 160

⁵ Historical Certificate of Need records indicate that SJMC received approval on April 15, 1981, for the establishment of a 20-bed dedicated psychiatric unit. This application under review indicates that only 16 beds are dedicated to psychiatric services. Historical Certificate of Need records are unclear whether all 20 beds were ever dedicated to psychiatric services or whether a lesser number was ultimately established. For purposes of this evaluation, the Certificate of Need Program will acknowledge that only 16 beds are dedicated to psychiatric services.

psychiatric beds and SJMC operated 16 dedicated psychiatric beds. For south King County, a total of 30 psychiatric beds were available at two separate settings—Valley Medical Center operated 20 dedicated psychiatric beds and FHS’s own St. Francis Hospital operated 10 dedicated psychiatric beds.

Valley Medical Center closed its dedicated psychiatric unit in 2004, leaving only St. Francis Hospital to provide psychiatric services to the residents of south King County. In 2006, Puget South Behavioral Health closed the entire 160 bed facility, leaving SJMC as the sole provider of psychiatric services in Pierce County.

FHS asserts that since it is the only provider of psychiatric services in both south King and Pierce County, it is critically important to the community and FHS that this service remains available locally.

FHS also provided a table comparing various psychiatric beds per 100,000 population for the northwest states—Alaska, Idaho, Montana, Oregon, and Washington. Table 2 below is a replica of the applicant’s comparison table.

**Table 2
Psychiatric Care Beds per 100,000 Populations**

Alaska	Idaho	Montana	Oregon	Avg. Other NW States	Washington
20.4	29.0	30.8	28.8	27.3	8.2

FHS also calculated the average psychiatric beds per 100,000 population for all fifty United States to be 29.9. Washington’s comparison of 8.2 is significantly below when compared to all states and the four other northwest states. [source: Application, p21]

FHS also asserts that Washington State’s 8.2 psychiatric beds per 100,000 population [8.2/100,000] as shown in Table 2 may be artificially low for two reasons. 1) the number is based on actual CHARS⁶ data, which only includes patients that were placed in a psychiatric bed, rather than patients who should have been placed, but no bed was available; and 2) there are only two licensed psychiatric hospitals located in the state, and CHARS does not collect data on care provided at either of them.⁷

For year 2013, FHS determined a total of 238 psychiatric beds would be needed in Pierce County if it were to achieve the average psychiatric bed-to-population ratio of the northwestern states of 27.3/100,000. This would require another 222 dedicated psychiatric beds in addition to the 16 beds currently operating at SJMC.

FHS also acknowledges that the 1987 State Health Plan discusses a “normative” bed to population ratio of 13/100,000. To achieve this ratio in year 2013, an additional 98 beds would have to be added to the 16 dedicated psychiatric beds operating at SJMC.

FHS Commitment to Address “Regional” Need [source: Initial Application, p20]

FHS considers itself a ‘regional’ provider of health care services. To address the regional need, FHS

⁶ Comprehensive Hospital Abstract Reporting System data obtained from the Department of Health’s Hospital and Patient Data Systems office.

⁷ A hospital that solely provides psychiatric care is licensed as a psychiatric hospital under RCW 71.12.

provided a table showing the number of discharges and percentage of total discharges based on patient origin (hospital planning area) for year 2007. The table shows acute care discharges for SJMC and psychiatric only for both SJMC and St. Francis Hospital. Using this table, FHS concludes that 83% of SJMC general acute care patients are residents of Pierce County and 6.5% are residents of southeast King County. These percentages are compared to SJMC and St. Francis Hospital's combined psychiatric discharges of 61% for Pierce County and 23.7% for southeast King County. The table also shows percentages for combined psychiatric services of SJMC and St. Francis Hospital for southwest King County (4%), Kitsap County (2%), and Thurston County (2%).

Inherent Problems with Operating Two Separate Psychiatric Units in Two FHS Hospitals

[source: Initial Application, pp22-23]

FHS states that the consolidation of the psychiatric services will be significantly more functional, accessible, and efficient than two existing unit for several reasons, including:

- FHS has experienced difficulty securing psychiatric physician coverage to staff both psychiatric units. This difficulty includes both retaining existing physicians and recruiting new psychiatric physicians.
- Consolidation of the two psychiatric units will assist in stabilizing FHS's psychiatric services related to operational efficiencies and staffing.

Based on the comparison table [Table 2] and the fact that the 16 beds are already in use in Pierce County and 10 are in use in south King County, FHS asserts that need for the beds is established. With the current difficulties in psychiatric physician recruitment and retention, FHS asserts that the consolidation of psychiatric services is necessary. [source: Application, pp20-23]

THE DEPARTMENT'S DETERMINATION OF NEED

The department's need review will begin with the underlying assumptions used by FHS in its demonstration of need. The two main assumptions used by FHS are 1) Pierce County, south King County, and "regional" need for psychiatric beds; and 2) current difficulties and inefficiencies of operating two separate and small psychiatric units.

Pierce County, South King County, and Regional Need for the Psychiatric Beds

FHS identifies its psychiatric service area to be primarily Pierce County and the southern portion of King County. This conclusion is based on 2007 patient discharge zip codes. The majority of its psychiatric patients reside in Pierce County (60.9%) and the second largest percentage is southeast King County where St. Francis Hospital is located (23.7%).

SJMC is the only hospital providing dedicated psychiatric services in Pierce County. St. Francis Hospital is located in southeast King County, and is one of two hospital's providing psychiatric services in that area. Auburn Regional Medical Center—located within 10 miles of St. Francis Hospital—also provides psychiatric services. On December 8, 2009, Certificate of Need #1402 was issued to Auburn Regional Medical Center approving the addition of 13 psychiatric beds to the facility's existing 25 psychiatric beds, for a facility total of 38 dedicated psychiatric beds. Auburn Regional Medical Center provides psychiatric services to patients aged 55 and older, generally referenced as 'gero-psychiatric services.' Within its application, Auburn Regional Medical Center did not propose to modify the current psychiatric referral patterns, market shares, or expand its psychiatric services to patients younger than 55. For this application under review, FHS does not propose to modify the current psychiatric referral patterns or market share for either St. Francis Hospital or

SJMC, nor does SJMC intend to provide psychiatric care for involuntary patients. As a result, in southeast King County, the two hospitals providing psychiatric services appear to work together—with little duplication—to ensure residents of the area have access to psychiatric services.

Based on the rationale provided by FHS, the planning area of Pierce County is reasonable, with the recognition that SJMC also provides some psychiatric services to residents of portions of the adjacent counties of King, Kitsap, and Thurston.

Once the planning area is established, the department considered FHS's approach of relying on the basic concept that the beds are needed if they are: 1) already located in the planning area; and 2) already providing psychiatric services.

The department recognizes that FHS's application adds psychiatric bed capacity to the planning area by consolidation of psychiatric beds in two planning areas. The consolidation reduces the total number of psychiatric beds by three for the combined planning areas.

Additionally, the Department of Social and Health Services' Mental Health Division contracted for a study on capacity and demand for inpatient psychiatric hospital and community residential beds for adults and children. One conclusion reached in the study is the number of adult inpatient psychiatric beds has been declining since 2000.⁸ This information substantiates FHS's data provided in Table 2.

FHS's approach to its demonstration of need is sound when coupled with the comparison information provided by FHS and summarized in Table 2 and substantiated by the department.

Inherent Problems with Operating Two Separate Psychiatric Units in Two FHS Hospitals

FHS focuses this discussion on the consolidation of two separate psychiatric services into one service located at SJMC in Tacoma, and the resulting benefits and efficiencies. One of the benefits that FHS anticipates is recruitment and retention of psychiatric physicians. Even though SJMC and St. Francis Hospital are located less than 12 miles apart, operating two separate, smaller psychiatric units, is inefficient for FHS. With two smaller units many services and staff are required on both sites, resulting in duplication of some staff and services. For these reasons, the rationale provided by FHS for the consolidation of its psychiatric services is reasonable, provided that FHS does not continue to provide psychiatric services at St. Francis Hospital once the 23 dedicated psychiatric beds are operational at SJMC.

During the review of this application, the department received 17 letters of support related to the psychiatric bed addition project. The letters of support were primarily submitted by local mental health providers expressing concern about the lack of psychiatric beds in Pierce County. While the letters recognized that the consolidation project would ultimately reduce the number of available psychiatric beds in the combined planning area by three (from 26 to 23), the mental health providers were grateful that SJMC would continue to be providing the much needed psychiatric services. Mental health providers that submitted letters of support include Greater Lakes Mental Healthcare in Lakewood, Pierce County Human Services Department in Tacoma, Rainier Associates in Tacoma, and Comprehensive Mental Health in Tacoma. [source: public comments]

⁸ Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds Adults & Children, Public Consulting Group, November 2004

MultiCare Health System (MHS) submitted a letter expressing concerns with the ultimate reduction of psychiatric beds in the two planning areas. The concerns are restated below. [source: public hearing document, p1]

“We remain concerned about the potential net-loss of 3 inpatient psychiatric beds in the South Sound region that will result from the unit closure contemplated at St. Francis Hospital (SFH), and the significant loss of inpatient psychiatric beds in the Southeast King Hospital planning area. This closure and proposed “consolidation” of services at SJMC will result in patients being transported from the Southeast King Hospital Planning area to the Central Pierce Planning area, assuming adequate transportation and beds are available. The proposed consolidation of services at SJMC will undoubtedly significantly increase the complexity of providing care in stabilizing and transferring psychiatric patients that show up unnecessarily at emergency departments in South King and other parts of Pierce County.”

In response to MHS’s concern, FHS provided the following statements. [source: FHS rebuttal, received January 28, 2010, pp2-3]

“Despite the fact that they have chosen not to establish an inpatient program, MultiCare expresses concern over a loss of three psychiatric beds in the county. The current reality is that over the past decade, due to declining reimbursements, there was a significant reduction in the number of adult psychiatric beds statewide, and as a result Washington now has the fewest psychiatric beds per 1,000 population of any state in the nation. ...As noted in our [initial] application, operating two separate, relatively small psychiatric units at SJMC and SFH is likely not sustainable because of our increasing concern over securing sufficient MD/ARNP (psychiatric) coverage to staff both units. FHS, in conjunction with our current psychiatrists, has tried unsuccessfully for nearly 3 years now to recruit new psychiatrists willing to take call coverage and work in an inpatient unit. This experience is reflective of an industry-wide trend that is destabilizing psychiatric unit operations across the state and nations. ...because FHS is a health system, it offers a unique and obvious alternative: consolidation. Bringing FHS’ inpatient psychiatric operations together under one roof at SJMC will not only ensure the stability of the system’s overall psychiatric service, it will, in fact, revitalize this important service by permitting new economies of scale through increased patient volumes, new efficiencies through combined staffing, and an even more seamless FHS mental health care delivery system, with the inpatient component housed at a single, central location.”

The department understands MHS’s concerns related to the overall reduction of psychiatric beds after consolidation of psychiatric services in the southeast King and Pierce County planning areas. However, it is clear from FHS’s application, psychiatric services are important to the mental health community within the planning areas. FHS states that it cannot sustain the operation of two separate psychiatric units. As a result, consolidation of the two units allows FHS to maintain the much needed services in the community and assists with staffing and operational woes.

The support provided in the community underscores the continued need for psychiatric services in the planning area and supports FHS’s proposal to continue providing those services at SJMC. FHS indicates that continued operation of two small psychiatric units may eventually result in closure of both units and no psychiatric services in both planning areas.

The department concludes that continued access to a combined psychiatric unit with a three bed reduction is better than no psychiatric services in the planning area. Therefore, the consolidation of psychiatric services at SJMC is reasonable. Further, the addition of 23 acute care beds dedicated to psychiatric services is also reasonable. This sub-criterion is met.

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

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

To demonstrate compliance with this sub-criterion, FHS provided a copy of its current Admission Policy used at SJMC. The policy outlines the process/criteria that FHS uses to admit patients for treatment or care at its hospitals. The applicant states that any patient requiring care will be accepted for treatment SJMC regardless of race, color, creed, sex, national origin, or disability. [source: Initial Application, Exhibit 4]

To determine whether low-income residents would have access to the proposed services, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. To determine whether the elderly would have access or continue to have access to the proposed services, the department uses Medicare certification as the measure to make that determination.

For its Washington State healthcare facilities, FHS currently provides services to Medicare and Medicaid eligible patients. Information provided in the application demonstrates that FHS intends to maintain this status for its existing facilities. [source: Initial Application, Exhibit 4 and June 8, 2009, supplemental information, Attachment 4]

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

To demonstrate compliance with this sub-criterion, FHS submitted its current charity care policy that outlines the process one would use to access this service. Further, FHS included a 'charity care' line item as a deduction from revenue within the pro forma financial documents. [source: Initial Application, Exhibit 6 and June 8, 2009, supplemental information, Attachment 4]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. SJMC is located in Pierce County within the Puget Sound

Region. Currently there are 18 hospitals located within the region, including the applicant's hospital. According to 2005-2007 charity care data obtained from HPDS, SJMC has historically provided less than the average charity care provided in the region. SJMC's most recent three-year (2005-2007) percentages of charity care for gross and adjusted revenues are 1.75% and 3.49%, respectively. [source: Initial Application, p12 & p42; June 8, 2009, supplemental information, Attachment 4, p29] The 2005-2007 average for the Puget Sound Region is 1.93% for gross revenue and 4.20% for adjusted revenue. [source: HPDS 2005-2007 charity care summaries]

SJMC's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 1.98% of gross revenue and 3.46% of adjusted revenue. RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. Since SJMC's historical charity care is less than the average for the region, the department concludes a charity care condition is necessary.

Provided FHS agrees to the condition stated below, the department concludes that the applicant has demonstrated all residents of the service area are likely to have adequate access to the proposed health service. This sub-criterion is met.

St. Joseph Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Puget Sound Region. Currently, this amount is 1.93% of gross revenue and 4.20% of adjusted revenue. St. Joseph Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

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

Based on the source information reviewed and the applicant's agreement to the condition identified in the "Conclusion" section of this evaluation, the department concludes Franciscan Health System has met the financial feasibility criteria in WAC 246-310-220.

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

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

If this project is approved, FHS anticipates the beds for both projects would become licensed in December 2010 and operational in January 2011. Under this timeline, year 2011 would be the hospital's first full calendar year of operation with 343 licensed beds and 2013 would be year three. [source: Initial Application, p17]

To demonstrate compliance with this sub-criterion, FHS provided its Statement of Operations for the 23-bed dedicated psychiatric unit for years 2011 through 2013. Using the financial information provided in the application, Table 3 illustrates the projected revenue, expenses, and net income for the psychiatric unit only. [source: June 8, 2009, supplemental information, Attachment 4, p27]

Table 3
St. Joseph Medical Center’s 23-bed Dedicated Psychiatric Unit
Projected Revenue and Expenses for Years 2011 – 2013

	Year 1 - 2011	Year 2 - 2012	Year 3 - 2013
# of set up/licensed beds	23	23	23
# of admissions (inpatient only)	1,632	1,632	1,632
# of patient days (inpatient only)	7,636	7,636	7,636
Average Length of Stay	4.68	4.68	4.68
Occupancy of set up/licensed beds	91.0%	91.0%	91.0%
Total Operating Revenue (in/out patient)	\$ 6,631,000	\$ 6,631,000	\$ 6,631,000
Total Expenses	\$ 6,058,000	\$ 6,058,000	\$ 6,058,000
Net Profit or (Loss) w/o allocated costs	\$ 573,000	\$ 573,000	\$ 573,000
Allocated costs/overhead (subtract)	\$ 2,595,000	\$ 2,595,000	\$ 2,595,000
Net Profit or (Loss) w/ allocated costs	(\$ 2,022,000)	(\$ 2,022,000)	(\$ 2,022,000)

The ‘total operating revenue’ line item in Table 3 is the result of gross inpatient and outpatient psychiatric revenue minus any deductions for contractual allowances and charity care directly related to the psychiatric services. The ‘total expenses’ line item includes staff salaries/wages and bad debt for SJMC. As shown in Table 3, FHS anticipates SJMC will relocate its psychiatric services, and based on the historical patients and patient days, the unit’s average occupancy will be 91%. Since, the 91% occupancy does not allow for much growth in both admissions and patient days, FHS projected zero growth through 2013. As shown in Table 3, FHS expects the psychiatric unit would cover its direct expenses without allocated costs beginning in year one.

FHS appropriately includes approximately \$2.5 million in allocated costs for the psychiatric unit. These costs represent the behavioral health services’ fair share of hospital non-revenue producing expenses (such as administration). With these costs included, operating revenues do not cover operating expenses for all three projected years. FHS states that the consolidated psychiatric program has lower allocated costs than the individual programs combined, and is projected to perform better financially than the two separate units are currently performing. Finally, FHS notes that “*because of payer mix and low Medicaid reimbursement, as long as allocated overhead costs are included, even at 100% occupancy, the psychiatric cost center is not projected to break even.*” [source: Initial application, pp40-41; June 8, 2009, supplemental information, p5]

Generally, the department has determined that a profit by the third full year of operation is necessary to indicate financial feasibility of a project. In this instance, the psychiatric unit cannot demonstrate it would ever operate at a profit with allocated costs. With this application, FHS identified an opportunity to reduce those losses. Although, the psychiatric unit would continue to operate at a loss with allocated costs, FHS has determined the loss is less than the projected loss if FHS continued to operate two, smaller

psychiatric units. This project could retain the psychiatric services in the service area longer than might otherwise be possible.

To determine whether FHS would meet its immediate and long-range capital costs, HPDS reviewed its most recent balance sheet [year 2008] which is shown in Table 4 below. [source: HPDS analysis, p2 and June 8, 2009, supplemental information, p24]

**Table 4
Franciscan Health System-Tacoma Balance Sheet for Year 2008**

Assets		Liabilities	
Current Assets	\$ 187,651,000	Current Liabilities	\$ 123,614,000
Fixed Assets	\$ 400,842,000	Long Term Debt / Other	\$ 114,117,000,
Board Designated Assets	\$ 12,321,000	Total Liabilities	\$ 237,731,000
Other Assets	\$ 148,847,000	Equity	\$ 511,930,000
Total Assets	\$ 749,661,000	Total Liabilities and Equity	\$ 749,661,000

To assist the department in its evaluation of this sub-criterion, the HPDS provided a summary of the short and long-term financial feasibility of the project, which includes a financial ratio analysis. Generally, HPDS’s financial ration analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios typically analyzed are **1)** long-term debt to equity; **2)** current assets to current liabilities; **3)** assets financed by liabilities; **4)** total operating expense to total operating revenue; and **5)** debt service coverage. If a project’s ratios are within the expected value range, the project can be expected to be financially feasible. For this project, the department did not require FHS to provide a projected balance sheet for SJMC alone.

In lieu of the historical ratio review described above, HPDS compared SJMC’s current ratios to the statewide ratio, and calculated its projected total operating expense to total operating revenue ratio based on the projected statement of operations provided in the application. The abbreviated ratio review is shown in Table 5 below. [source: February 24, 2010, HPDS analysis, p3]

**Table 5
Current and Projected HPDS Debt Ratios for St. Joseph Medical Center**

Category	Trend ⁹	State 2008	Current 2009	Projected 2011	Projected 2013
Long Term Debt to Equity	B	0.527	0.111	n/a	n/a
Current Assets/Current Liabilities	A	1.946	2.129	n/a	n/a
Assets Funded by Liabilities	B	0.432	0.287	n/a	n/a
Operating Expense/Operating Revenue	B	0.949	0.893	0.900	0.900
Debt Service Coverage	A	4.717	9.221	n/a	n/a
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			

⁹ A is better if above the ratio, and B is better if below the ratio.

After evaluating the hospital’s current and projected ratios and statement of operations for years 2011 through 2013, staff from HPDS provided the following analysis. [source: HPDS analysis, p3]

“The hospital notes the psychiatric unit will not breakeven [with allocated costs]. However, they note that the costs center will cover its operating expenses, but not the overhead allocation. They also note they will be losing less money under this arrangement. ...A review of the financial and utilization information shows that the immediate and long-range operating costs can be met.”

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

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

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

The cost to consolidate FHS’s psychiatric services to SJMC by adding 23 dedicated psychiatric beds is \$2,500,000. The costs are broken down in Table 6 below. [source: Initial Application, p35]

Table 6
St. Joseph Medical Center Hospital
Psychiatric Bed Project Estimated Capital Costs

Item	Total
Construction Costs	\$ 1,465,000
Fixed & Moveable Equipment	\$ 600,000
Fees, Permits, Supervision, Inspections	\$ 255,000
Washington State Sales Tax	\$ 180,000
Total Estimated Capital Costs	\$ 2,500,000

FHS provided a signed letter from its project planning and management contractor—Kirk Associates, LLC—to demonstrate that the costs identified above are accurate and reasonable for this type of project. [source: June 8, 2009, supplemental information, Attachment 2]

HPDS also provided a construction cost per bed breakdown and comparison with past construction projects reviewed by that office. Table 7 on the following page is a summary of that review. [source: HPDS analysis, p6]

**Table 7
Psychiatric Bed Project Construction Cost/Bed**

Item	Total
Construction Costs	\$ 1,465,000
Number of Psychiatric Beds Added	23
Total Construction Cost/Bed	\$ 63,696

HPDS provided the following analysis related to the construction cost comparison. [source: HPDS analysis, p6]

“Construction costs can vary quite a bit due to the type of construction, quality of material, custom vs. standard design, building site, and other factors. The costs show are within the past construction costs reviewed by this office.”

To further demonstrate compliance with this sub-criterion, FHS provided the sources of patient revenue shown in Table 8 below for its psychiatric unit. [source: Initial Application, p12]

**Table 8
St. Joseph Medical Center-Psychiatric Unit
Sources and Percentages of Revenue**

Source of Revenue	Inpatient
Medicare	21.5%
State (Medicaid)	21.4%
Commercial/HMO	42.4%
Other	14.7%
Total	100%

As shown above, for the psychiatric unit, the Medicare and State (Medicaid) entitlements are projected to equal 43% of the revenue at the facility. The department concludes that this revenue is dependent upon entitlement sources that are not cost based reimbursement and are not expected to have an unreasonable impact on charges for services.

The remaining percentages will be derived through other or private insurance reimbursements. Based on information provided in the application, the department concludes that the consolidation of two smaller psychiatric units may reduce the costs for any non Medicare/Medicaid payers.

Based on the information provided, the department concludes that the costs of this project would not result in an unreasonable impact to the costs and charges for health care services. This sub-criterion is met.

(3) The project can be appropriately financed.

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

FHS states that this portion of the project would be funded with reserves. To demonstrate that FHS has the funds to finance this portion of the project, FHS provided its most recent un-audited June 2008 balance sheet for FHS. The financial statement demonstrates that the reserves are available. Additionally, FHS submitted a letter from its chief financial officer confirming FHS's commitment to fund the project. [source: June 8, 2009, supplemental information, Attachment 3, p23]

Based on the 2008 un-audited financial report, the \$2,500,000 capital costs is approximately 1.7% of FHS's board designated assets. [source: Application, Appendix 2] FHS's financial health is also verified by HPDS financial database. [source: HPDS financial data]

The department considers this information a reasonable demonstration that the funding for the project would be available and use of the reserves would not adversely affect the financial stability of FHS as a whole.

Based on the information provided, the department concludes the project can be appropriately financed. This sub-criterion is met.

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

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

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

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

This project proposes to consolidate psychiatric services from St. Francis Hospital and SJMC, and relocate the services approximately 12 miles away to SJMC in Tacoma. Because SJMC currently provides behavioral health services at both locations, all core staff is expected to remain in the unit after the services relocate. SJMC anticipates a slight change in staff which is attributed to the consolidation of the two separate units. A breakdown of the current and proposed FTEs is shown in Table 9 on the following page. [source: June 8, 2009, supplement information, p7]

Table 9
Franciscan Health System's Behavioral Health Current and Projected FTEs

	Current Combined Staff Year (2009)	Year 2011 Increases	Total
Clinical Director	1.00	0.00	1.00
Clinical Manager	0.00	1.00	1.00
RN	18.80	(2.94)	15.86
LPN	1.03	0.00	1.03
Nursing Assistants	0.63	0.00	0.63
Medical Social Workers	3.45	0.48	3.93
Clerical	4.62	(0.86)	3.76
Mental Health Counselor	13.10	(1.40)	11.70
OT/RT	1.00	0.40	1.40
Administrative Assistant	1.00	0.00	1.00
Nurse Educator	0.80	0.00	0.80
Care Manager/Screenener	0.00	1.00	1.00
FTE Total	45.43	(2.32)	43.11

Since this project proposes to consolidate and relocate existing psychiatric services, FHS expects a smooth transition for staff and patients. Once the behavioral health unit is relocated and operational at SJMC, as shown in Table 9 above, FHS expects an overall reduction of 2.32 FTEs in 2011, and then no change in the number of FTEs through 2013.

Based on this information above, the department concludes that adequate staffing for the behavioral health unit is available or can be recruited. This sub criterion is met.

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

WAC 246-310 does not contain specific WAC 246-310-230(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that a facility must meet when it is to be Medicare certified and Medicaid eligible. Therefore, using its experience and expertise the department assessed the applicant's history in meeting these standards at other facilities owned or operated by the applicant.

Documentation provided in past FHS applications confirms that it maintains appropriate relationships with ancillary and support services for its existing hospitals and other health care facilities. For this project, FHS states that none of its ancillary or support relationships will change. The only difference is that two behavioral health units would be consolidated and located at SJMC, where ancillary services it routinely uses, such as laboratory, radiology, and pharmacy, are also located. [source: June 8, 2009, supplemental information, pp8-9]

Based on this information above, the department concludes that FHS would have appropriate ancillary and support services at SJMC, and 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.

As stated earlier, FHS is a provider of a variety of health care services in Washington State. Currently FHS owns or operates 12 healthcare facilities in Pierce and King counties. As part of its review, the department must conclude that the proposed service would be operated in a manner that ensures safe and adequate care to the public.¹⁰

For Washington State, regular surveys are conducted by the Department of Health's Investigations and Inspections Office. Records indicate that the department has completed at least two compliance surveys each for FHS healthcare since 2007. Each compliance survey revealed deficiencies typical for the facility and FHS submitted an acceptable plan of corrections and implemented the required actions. Additionally, all five of FHS's hospitals hold current accreditations from the Joint Commission. [source: facility survey data provided by the Investigations and Inspections Office and Joint Commission website]

FHS also owns a skilled nursing facility in Pierce County.¹¹ Quality of care surveys for nursing homes in Washington State are conducted by the Department of Social and Health Services. Survey records indicate that the skilled nursing facility has been operating in compliance with no significant survey deficiencies. [source: CMS compare data]

Given the compliance history of FHS, the department concludes that there is reasonable assurance that its behavioral health unit would continue to operate in compliance with state and federal regulation. This sub-criterion is met.

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

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

In response to this sub-criterion, FHS provided the following statements. [source: Initial Application, p48]

¹⁰ WAC 246-310-230(5).

¹¹ Franciscan Care Center located in Tacoma.

“SJMC has a long and documented history of working closely with the medical and provider community (physicians, nursing homes, home care, etc) to ensure timely and seamless patient transitions. These working relationships will be continued under the consolidated psychiatric unit. Although St. Francis Hospital’s psychiatric unit will be closing, SJMC will continue to work with the mental health, skilled nursing, assisted living, home health, and hospice providers in south King County [where St. Francis Hospital is located] to ensure smooth and efficient patient transfers. The consolidated psychiatric program will continue to work with the same entities that the two programs currently work/refer to. This will not change with the consolidated program.”

The department acknowledges that FHS intends to consolidate its behavioral health services at SHMC. The rationale provided for this project is reasonable. The department also considered FHS’s history of providing care to residents in Washington State. The department concludes that the applicant has been providing acute care services to the residents of Washington State for several years and has been appropriately participating in relationships with community facilities to provide a variety of medical services. Nothing in the materials reviewed by staff suggests that approval of this project would change these relationships. [source: CN historical files]

Therefore, the department concludes that this project would not have the potential of fragmentation of psychiatric services within the planning area. This sub-criterion is met.

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

This sub-criterion is addressed in sub-section (3) above and is considered met.

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

Based on the source information reviewed and the applicant’s agreement to the condition identified in the “Conclusion” section of this evaluation, the department concludes Franciscan Health System has met the cost containment criteria in WAC 246-310-240.

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

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

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

Step three of this assessment is to apply any service or facility specific criteria (tie-breaker) contained in WAC 246-310. The tiebreaker criteria are objective measures used to compare competing projects and make the determination between two or more approvable projects which is the best alternative. If WAC 246-310 does not contain any service or facility criteria as directed by WAC 246-310-200(2)(a)(i), then the department would look to WAC 246-310-240(2)(a)(ii) and (b) for criteria to make the assessment of the competing proposals. If there are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b), then using its experience and expertise, the department would assess the competing projects and determine which project should be approved.

Step One

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

Step Two

Within the application, FHS identified two options before submitting this application. A summary of each option and FHS's rationale for rejection is below. [source: Application, pp51-52]

Option 1-Do nothing or 'status quo'

This option means continuing to operate two psychiatric units at two separate hospitals and includes duplication of some key staff. This option does nothing to address the difficulties FHS has experienced with recruitment and retention of key psychiatric staff for two small behavioral health units. Ultimately, this option may lead to closure of both units and elimination of mental health services in both King and Pierce counties. As a result, this option was rejected by FHS.

Option 2-Consolidate both units and establish a 26-bed psychiatric unit at SJMC

FHS states it initially considered consolidation of both units and not downsizing the number of psychiatric beds from 26 to 23, however, SJMC facility design constraints limit the size of the psychiatric unit. While downsizing the unit was not the ideal scenario, FHS states that its commitment to provide these much needed services at SJMC far outweighs the impact of losing three psychiatric beds. This option was rejected in favor of the project under review.

Taking into account FHS's dedication to continue providing the much needed behavioral health services in the Pierce County and south King County, the department concludes that the consolidation and relocation of behavioral health services to SJMC is the best available alternative for the community. This sub-criterion is met.

Step Three

For this project, only FHS submitted an application to add or establish acute care bed capacity to the planning area. As a result, step three is not evaluated under this sub-criterion.

(2) In the case of a project involving construction:

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

As stated in the project description portion of this evaluation, this project involves construction. This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that this sub-criterion is met.

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

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

ACUTE CARE BED ADDITION PROJECT

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

Based on the source information reviewed and the applicant’s agreement to the condition identified in the “Conclusion” section of this evaluation, the department concludes Franciscan Health System has met the need criteria in WAC 246-310-210(1) and (2).

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

Summary of Franciscan Health System’s Numeric Methodology – central Pierce County

This project proposes to reallocate 16 dedicated psychiatric beds to medical surgical use. If approved, these 16 beds would increase the number of medical/surgical beds at SJMC, but would not increase the total number of licensed beds at SJMC.

FHS used the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP) to assist in its determination of numeric need. The department’s methodology uses population and healthcare use statistics on several levels: statewide, Health Service Area (HSA)¹², and planning area. While Pierce County is included in HSA #1, the county is divided into three separate planning areas—central, west, and east. SJMC is one of four hospitals located in the central Pierce planning area.

Table 10 below is a summary of SJMC’s bed need projections for central Pierce planning area for years 2010 through 2015. [source: November 13, 2009, supplemental information, Attachment 2]

**Table 10
Summary of Franciscan Health System’s Central Pierce Planning Area
Numeric Methodology Without the Project**

	2010	2011	2012	2013	2014	2015
Number of Beds Needed/(Surplus)	(60)	(40)	(20)	(1)	24	46

Note: negative number indicates a surplus of beds.

As shown in Table 10 above, FHS projects a surplus of acute care beds through 2013, and a 24 bed need beginning in year 2014, which increases to 46 beds in 2015.

The Department’s Determination of Numeric Need

The department also uses the Hospital Bed Need Forecasting Method contained in the 1987 SHP to assist in its determination of need for acute care bed capacity. Though the SHP was “sunset” in 1989, the department has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds.

¹² The state is divided into four HSA’s by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, **Pierce**, San Juan, Skagit, Snohomish, and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum counties. HSA 3 is composed of Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan, and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman counties.

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

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

The completed methodology is presented as a series of appendices to this evaluation identified as 'Exhibit A.' The methodology presented here incorporates all adjustments that were made following preparation of the methodology. Where necessary, both adjusted and un-adjusted computations are provided. The methodology uses population and healthcare use statistics on several levels: statewide, HSA, and planning area. As previously stated, the planning area for this evaluation is the central Pierce County.

The 1980 State Health Plan identifies central Pierce County as one planning area. When preparing acute care bed need projections, the department relies upon population forecasts published by the Washington State Office of Financial Management (OFM). OFM publishes a set of forecasts known as the "intermediate-series" county population projections, based on the 2000 census, updated November 2007.¹³

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

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

For this step, attached as Appendix 1, the department obtained planning area resident utilization data for 1999 through 2008 from the Department of Health's Hospital and Patient Data Systems' CHARS (Comprehensive Hospital Abstract Reporting System) database. Total resident patient days were identified for the central Pierce Planning Area, HSA #1, and the state of Washington as a whole, excluding psychiatric patient days [Major Diagnostic Category (MDC) 19] and normal newborns, level 2 intermediate care, and level 3 neonatal intensive care patient days [MDC 15]. Resident patient days include patients that are residents (by zip code) of the planning area, regardless of where the patient received services.

¹³ The November 2007 series is the most current data set available during the production of the state acute care methodology following the release of the 2008 CHARS data.

FHS also relied on 1999 through 2008 CHARS data. FHS used provider patient days for the central Pierce planning area. Provider patient days include patients that received services in central Pierce hospitals regardless of where the patient resides. FHS excluded psychiatric patient days [MDC 15] and normal newborn days [Diagnostic Related Group (DRG) 391]. FHS included level 2 intermediate care and level 3 neonatal intensive care patient days. These two deviations had an effect on FHS's bed need projections.

Step 2: Subtract psychiatric patient days from each year's historical data.

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

FHS followed this step as described above, however, since Step 1 above was based on provider days at the HSA and state level, FHS subtracted psychiatric provider days in this step.

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

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days of the HSA by the HSA's population and multiplied by 1,000. For the purposes of this application, the average use rate was also determined for the state and the central Pierce planning area and is attached as Appendix 3. Actual and projected population figures for this analysis were derived from OFM population projections for Washington State and HSA 1. For central Pierce planning area population figures, the department relied on the applicant's population figures.

FHS followed this step with no deviations using OFM population projections for Washington State and HSA 1. For central Pierce planning area population figures, FHS used Claritas population data.

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

The department computed trend lines for the state, HSA 1, and the central Pierce planning area based upon the trends in use rates from these ten years and included them as Appendix 4. The resulting trend lines for the HSA, the planning area, and the state uniformly exhibit a mild upward slope. This mild upward slope is supported by increasing utilization reported by hospitals throughout the state in recent years, and is indicative of a growing population. More significant than overall population growth is the fact that the state's population is growing older as the large number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations.

FHS followed this step with no deviations. The HSA, planning area, and statewide trend lines also resulted in a slight upward slope.

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live. (The psychiatric patient day data are used separately in the short-stay psychiatric hospital bed need forecasts.)

The previous four steps of the methodology uses data particular to the residents of the central Pierce planning area. In order to forecast the availability of services for the residents of a given region, patient days must also be identified for the facilities available within the planning area. Step 5, included as Appendix 5, identifies referral patterns in and out of the planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also used reported discharge data for Washington residents that receive health care in Oregon.

As has been noted earlier, the original purpose for this methodology was to create comprehensive, statewide resource need forecasts. Typically the state is broken into only two planning areas—the planning area under review and the state as a whole minus the planning area. Appendix 5 illustrates the age-specific patient days for residents of the planning area and for the rest of the state, identified here as “WA – CP.”

FHS followed this step with no deviations.

Step 6: Compute each hospital planning area’s use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+).

Appendix 6 illustrates the age-specific use rates for the year 2008, as defined in Step 3, for the central Pierce planning area and for the rest of the state. The use rates are broken down by ages 0-64 and 65 and older.

FHS followed this step as described above with no deviations.

Step 7A: Forecast each hospital planning area’s use rates for the target year by “trend-adjusting” each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the appropriate health planning region’s ten-year use rate trend, whichever trend would result in the smaller adjustment.

As discussed in Step 4, the department used the ten-year use rate trends for 1999-2008 to reflect the use patterns of Washington residents. The 2008 use rates determined in Step 6 were multiplied by the slopes of both the HSA’s ten-year use rate trend line and by the slope of the statewide ten-year use rate trend line for comparison purposes. The statewide trend has a lower projected rate (an annual increase of 2.9610) than the HSA trend rate of 3.3497. As directed in Step 7A, the department applied the statewide trend to project future use rates.

The methodology is designed to project bed need in a specified “target year.” It is the practice of the department to evaluate need for a given project through at least seven years from the last full year of available CHARS data. For this application, the last full year of available CHARS data is 2008; therefore, the target year is 2015.

FHS followed this step as described above using its HSA trend rate calculated in its step 6.

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.

Using the forecasted use rate for the target year 2015 and population projections, projected patient days for central Pierce planning area residents are illustrated in Appendix 8. As noted in Step 7, above, forecasts have been prepared for a series of years and are presented in summary in Appendix 10 as "Total Central Pierce Res Days."

FHS followed this step as described above resulting in projections through year 2015.

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

Using the patient origin study developed for Step 5, Appendix 9 illustrates how the projected patient days for the central Pierce planning area and the remainder of the state were allocated from county of residence to the area where the care is projected to be delivered in the target year 2015. The results of these calculations are presented in Appendix 10 as "Total Days in central Pierce Hospitals."

FHS followed this step as described above with no deviations.

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

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

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

This step identifies the number of available beds in the planning area and determines a weighted occupancy standard for the planning area. Below is a discussion of each factor and both the department's and FHS's application of this step.

AVAILABLE BEDS IN THE PLANNING AREA

Department's Count

SHP determines the number of available beds in each planning area, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. For central Pierce planning area, SJMC is one of four hospitals operating in the planning area. This information was gathered through

a thorough review of Certificate of Need files, hospital licensing facility files, and capacity survey data submitted by each hospital in year 2008. Below is a summary of the number of licensed beds at each of the four hospitals.

FHS-St. Joseph Medical Center, Tacoma

This hospital is owned and operated by FHS and is the hospital where the additional 16 medical/surgical beds will be located. SJMC is licensed for 320 acute care beds. Of those, 18 are dedicated to level 2 intermediate care. The patient days and beds are not counted in the methodology or bed supply. Additionally, 26 beds are dedicated to rehab care with a PPS exclusion. The patient days and the 26 beds also would not be counted in the methodology or bed supply. SJMC also has 16 dedicated psychiatric beds. These are the 16 beds that are proposed to be reallocated to general medical surgical use. The patient days and the 16 psychiatric beds would not be counted in the methodology or the bed supply. As a result, of the 320 licensed acute care beds, 260 will be counted at SJMC. [320 – 60 = 260]

FHS-St. Anthony Hospital, Gig Harbor

Another hospital owned and operated by FHS. It became operational in year 2008 with 80 acute care beds. All 80 beds are set up and licensed. St. Anthony Hospital does not have any level 2 or level 3 nursery beds, dedicated psychiatric beds, or dedicated rehab beds. The number of beds counted at this facility is 80.

MultiCare Health System-Mary Bridge Children's Hospital

Owned and operated by MultiCare Health System, this 72-bed children's hospital is located in Tacoma, on the same campus as Tacoma General Hospital. [see below] Mary Bridge Children's Hospital is licensed for 72 acute care beds and all 72 beds meet the requirements of #1 or #2 above to be counted in the methodology. All 72 beds will be counted at this facility.

MultiCare Health System-Tacoma General/Allenmore Hospital

Another hospital owned and operated by MultiCare Health System. Tacoma General/Allenmore is licensed for 521 acute care beds. Of those 72 are licensed to Mary Bridge Children's Hospital and will not be counted as part of the Tacoma General/Allenmore bed supply. Of the remaining 449 beds, 130 are located at the Allenmore campus and 319 are located at the Tacoma General campus. All 130 beds at the Allenmore campus will be counted in the bed supply for this project. Of the 319 located at the Tacoma General site, 26 are dedicated level 2 intermediate care and 37 are dedicated to level 3 neonatal intensive care. The patient days and 63 beds would not be counted in the methodology or bed supply. As a result, of the 521 licensed acute care beds at Tacoma General Allenmore, 130 will be counted for the Allenmore campus and 256 will be counted at Tacoma General campus, for a combined total of 386.

For its methodology, the department counted a total of 798 beds in the central Pierce planning area as shown below.

- FHS-St. Joseph Medical Center – 260
- FHS-St. Anthony Hospital – 80
- MHS-Mary Bridge Children's Hospital – 72
- MHS-Tacoma General campus – 256
- MHS Allenmore Hospital campus – 130

Franciscan Health System's count

While FHS applied this step with no deviations, the patient days and corresponding number of beds counted is greater than the patient days and count used by the department. FHS does not provide a breakdown of the number of beds its counts. Below is a comparison table of the number of beds counted at each facility for the department and FHS.

**Table 11
Central Pierce Planning Area Acute Care Bed Capacity Totals**

Hospital	FHS Counts	Department Count
FHS-St. Joseph Medical Center	304	260
FHS-St. Anthony Hospital	80	80
MHS-Mary Bridge Children's Hospital	67	72
MHS-Tacoma General/Allenmore Hospital	404	386
Planning Area Capacity	855	798

As shown in Table 11 above, for its methodology, FHS counted 57 more beds—at a total of 855—in the central Pierce planning area.

WEIGHTED OCCUPANCY

Department's Calculation

The weighted occupancy standard for a planning area is defined by the SHP as the sum, across all hospitals in the planning area, of each hospital's expected occupancy rate times that hospital's percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected in the 1987 SHP are higher than can be maintained by hospitals under the current models for provision of care. As a result, the department adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds).

The chart below shows the average annual occupancy rates, based on the number of acute care beds, used by the department in its calculations.

Facility	# of Beds	Average Occupancy Rate
FHS-St. Joseph Medical Center	260	70%
FHS-St. Anthony Hospital	80	60%
MHS-Mary Bridge Children's Hospital	72	60%
MHS-Tacoma General/Allenmore Hospital	386	75%
DOH - Average Weighted Occupancy Standard		72.42%
FHS - Average Weighted Occupancy Standard		70.51%

The difference in average occupancy rates shown above will also affect the outcome of this step.

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

FHS is not proposing to provide any psychiatric services in the 16 beds once they are re-allocated to medical/surgical use. For that reason, the department concluded that psychiatric services should not be forecast while evaluating this project.

FHS also did not provide psychiatric forecasts within its methodology.

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

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

FHS’s deviations and adjustments were all described within its methodology. Below is a summary of FHS’s deviations in the methodology.

- Counted and calculated provider days rather than resident days (step 1).
- Included level 2 intermediate care days and level 3 neonatal intensive care days (step 1).
- Counted 855 acute care beds in the planning area, rather than 798 (step 10).

The acute care bed methodology builds upon itself, and when considered together the deviations described above would have an effect on the end result. A summary of the department’s methodology is shown in Table 12 below. The detailed results for years 2008 through 2015 are available in Appendix A as Appendix 10A attached to this evaluation. [source: Appendix A]

**Table 12
Department Methodology
Appendix 10A – Bed Need Summary**

	2009	2010	2011	2012	2013	2014	2015
Number of Beds Needed	(23.0)	(6.53)	10.02	26.65	43.37	60.17	77.05

Note: negative number indicates a surplus of beds.

As shown above in Table 12, for current year 2010, the planning area has a bed surplus of 6 acute care beds. With projected population growth and applicable use rates, the planning area is expected to show need in 2011 for 10 beds, and the need is expected to increase by another 67 beds to 77 in year 2015. [source: department’s methodology, Appendix 10A]

For comparison purposes, below is a replica of the applicant’s methodology results shown in Table 10 of this evaluation. [source: November 13, 2009, supplemental information, Attachment 2]

**Summary of Franciscan Health System’s Central Pierce Planning Area
Numeric Methodology Without the Project**

	2010	2011	2012	2013	2014	2015
Number of Beds Needed/(Surplus)	(60)	(40)	(20)	(1)	24	46

Note: negative number indicates a surplus of beds.

The difference in the department's projections shown in Table 12 and FHS's projections shown above can be attributed to the deviations discussed in each of the 10 steps in the methodology. The most significant factors/deviations that affected FHS's numeric methodology is bed count and patient days associated with those beds. Based on these factors, the department considers its own numeric methodology summarized in Table 12 above to be more reliable than the applicant's methodology. As a result, numeric need for 16 additional acute care beds at SJMC in the central Pierce planning area has been demonstrated.

During the review of this application, the department received 21 letter of support related to the medical/surgical bed addition. The letters of support were primarily submitted by local physicians expressing concern about the lack of available beds at SJMC. Many of the letters also expressed concerns with SJMC's overcrowded emergency department and the wait times experienced by patients when admitted from the emergency department. One SJMC emergency department physician provided documentation on "one evening in the SJMC emergency department" to demonstrate the typical issues confronted by ED physicians as they scramble to admit patients from the ED when medical surgical beds are unavailable at SJMC. All of the letters of support stated that the addition of 16 more medical/surgical beds at SJMC would help to alleviate the lack of bed space at SJMC.

MHS submitted a letter expressing concerns with the 16 bed addition at SJMC. The concerns are restated below. [source: public hearing document, p1]

"In March of 2009, FHS opened St. Anthony Hospital (SAH) in Gig Harbor, which is also part of central Pierce County planning area. The intent of this brand new facility in Gig Harbor was to address need in the central Pierce County planning area, including relieving stress on SJMC in Tacoma. As SAH has not been open for even a full year, it is premature to add additional capacity in the planning area until the impact of SAH can be fully evaluated."

In response to MHS's concern, FHS provided arguments in support of this portion of its project. Excerpts from FHS's responses are below. [source: FHS rebuttal received January 28, 2010, pp1-2]

"...The answers to [MHS's] argument were contained in the data provided within our August 2009 amendment application, as well as that updated and presented at the January 12, 2010 public hearing.

- Excluding Harborview Medical Center, SJMC has operated at the single highest general acute occupancy level of any hospital in the state...since 2003. Our nearly 90% midnight occupancy in 2009 was almost 20% above the target DOH has established for a hospital of our size.*
- SAH opened in March of 2009 and is already operating above its projected start-up census; it was estimated to run an average midnight census of 39 at the end of year 1, and data for the 4th quarter of 2009 indicates that average midnight census as actually 46, or 17% higher.*
- SJMC has not realized the census reductions that we projected as a result of SAH's opening. In our application to secure approval of SAH, we estimated a reduction of 28 patients per day. The reality is there has been no reduction.*
- Because SJMC is a regional tertiary provider, our high occupancy has negative implications on the entirety of the Pierce Kitsap and South King County communities.*

Last year alone, SJMC was on ‘divert’ 9% of the time, and we transferred more than 1,002 patients needing admissions from our hospital to another facility.’

FHS opened SAH in March 2009, and six months later (September 2009), submitted this application to add medical/surgical capacity at SJMC. FHS provides statements related to the occupancy of St. Anthony Hospital’s first nine months of operation. Data obtained from HPDS shows that St. Anthony Hospital operated at 52.6% average occupancy in 2009, which is higher than the 49% occupancy projected by FHS for year one in its CN application to establish SAH. [source: HPDS Quarterly Report Input Forms and department’s evaluation related to CN #04-12, St. Anthony Hospital]

FHS also states that SJMC has not experienced the expected decrease in utilization and occupancy that was anticipated once SAH opened. Comparing SJMC’s utilization before and after St. Anthony Hospital’s opening in March 2009 substantiates FHS’s statement. In 2008, SJMC operated at 84.24% occupancy; in 2009, SJMC operated at 87.96% occupancy even though SAH had been operational for six months of the time period.¹⁴

FHS also states SJMC has not realized the census reductions it expected once SAH became operational. Again, comparing SJMC census data for full year 2008 and 9 months of 2009, substantiates this statement. In 2008, SJMC’s average daily census calculated to 269.6, compared to nine months of 2009 average daily census of 281.5.

The department also reviewed historical data for MHS-Tacoma General/Allenmore for full years 2008 and 2009. This review demonstrates that the opening of SAH also did not substantially affect utilization or census at Tacoma General/Allenmore. Both occupancy and average daily census of the hospital increased from year 2008 to 2009.

In conclusion, the addition of 16 medical/surgical acute care beds is supported by the numeric methodology. FHS was able to demonstrate a need for the additional medical/surgical beds to alleviate overcrowding at the hospital.

The department also evaluated the impact of adding 16 beds to SJMC in year 2011, which is summarized in Table 13 below. [source: Appendix A, Appendix 10B]

Table 13
Department Methodology
Appendix 10B – Bed Need Summary

	2009	2010	2011	2012	2013	2014	2015
Number of Beds Needed	(23.0)	(6.53)	(5.86)	10.77	27.49	44.27	61.18

Note: negative number indicates a surplus of beds.

As demonstrated by the department’s methodology summarized in Table 13 above, even with 16 beds added in year 2011, the central Pierce planning area shows a need for additional acute care bed capacity beginning in year 2012. [Exhibit A, Appendix 10b]

¹⁴ Year 2009 data is based on 9 months data.

In summary, the addition of 16 beds to the planning area has been demonstrated by FHS. The number of beds requested by FHS is conservative when compared to the results of the department's methodology. As a result, this bed addition is both prudent and warranted. This sub-criterion is met.

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

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

To demonstrate compliance with this sub-criterion, FHS provided a copy of its current Admission Policy used at SJMC. The policy outlines the process/criteria that FHS uses to admit patients for treatment or care at the hospital. The applicant states that any patient requiring care will be accepted for treatment SJMC regardless of race, color, creed, sex, national origin, or disability. [source: Initial Application, Exhibit 4]

To determine whether low-income residents would have access to the proposed services, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. To determine whether the elderly would have access or continue to have access to the proposed services, the department uses Medicare certification as the measure to make that determination.

For its Washington State healthcare facilities, FHS currently provides services to Medicare and Medicaid eligible patients. Information provided in the application demonstrates that FHS intends to maintain this status for its existing facilities. [source: Initial Application, Exhibit 4 and June 23, 2009, supplemental information, Attachment 4]

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

To demonstrate compliance with this sub-criterion, FHS submitted its current charity care policy that outlines the process one would use to access this service. Further, FHS included a 'charity care' line item as a deduction from revenue within the pro forma financial documents. [source: Initial Application, Exhibit 6 and June 23, 2009, supplemental information, Attachment 4]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. SJMC is located in Pierce County within the Puget Sound Region. Currently there are 18 hospitals located within the region, including the applicant's hospital. According to 2005-2007 charity care data obtained from HPDS, SJMC has historically provided less

than the average charity care provided in the region. SJMC's most recent three-year (2005-2007) percentages of charity care for gross and adjusted revenues are 1.75% and 3.49%, respectively. [source: Initial Application, p12 & p42; June 23, 2009, supplemental information, Attachment 4, p29] The 2005-2007 average for the Puget Sound Region is 1.93% for gross revenue and 4.20% for adjusted revenue. [source: HPDS 2005-2007 charity care summaries]

SJMC's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 1.98% of gross revenue and 3.46% of adjusted revenue. RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. Since SJMC's historical charity care is less than the average for the region, the department concludes a charity care condition is necessary.

Provided FHS agrees to the following condition, the department concludes that the applicant has demonstrated all residents of the service area are likely to have adequate access to the proposed health service. This sub-criterion is met.

St. Joseph Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Puget Sound Region. Currently, this amount is 1.93% of gross revenue and 4.20% of adjusted revenue. St. Joseph Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

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

Based on the source information reviewed and the applicant's agreement to the condition identified in the "Conclusion" section of this evaluation, the department concludes Franciscan Health System has met the financial feasibility criteria in WAC 246-310-220.

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

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

If this project is approved, FHS anticipates the beds for both projects would become licensed in December 2010 and operational in January 2011. Under this timeline, year 2011 would be the hospital's first full calendar year of operation with 343 licensed beds and 2013 would be year three. [source: Initial Application, p17]

For this project, HPDS reviewed the hospital's overall three-year projected statement of operations to evaluate SJMC's immediate and long term ability to sustain the service. Table 14 below summarizes the projected revenue, expenses, and net income for the hospital. This table includes the psychiatric unit and the reallocation of 16 beds from psychiatric care to medical/surgical care. [source: June 8, 2009, supplemental information, Attachment 4; Amendment Application, p4]

Table 14
St. Joseph Medical Center Projected Revenue and Expenses for Years 2011 – 2013

	Year 1 - 2011	Year 2 - 2012	Year 3 - 2013
# of set up/licensed beds	343	343	343
# of patient days	103,467	105,384	107,339
Occupancy of set up/licensed beds	82.6%	84.2%	85.7%
Total Net Revenue	\$ 614,135,000	\$ 649,224,000	\$ 687,410,000
Total Expenses	\$ 552,842,000	\$ 583,708,000	\$ 618,582,000
Net Profit or (Loss)	\$ 61,293,000	\$ 65,516,000	\$ 68,828,000

The ‘total net revenue’ line item in Table 14 is the result of gross revenue minus any deductions for contractual allowances and charity care. The gross revenue includes patient and non-patient revenue from joint ventures and rental properties, but does not include investment income. The ‘total expenses’ line item includes staff salaries/wages and bad debt. As shown in Table 14, with SJMC providing all psychiatric services and begins using the 16 additional medical surgical beds, the hospital’s average occupancy will still be above 80%. This occupancy allows SJMC minimal growth in both admissions and patient days and some flexibility during peak census. FHS expects the hospital would operate at a profit beginning in year one.

To determine whether FHS would meet its immediate and long-range capital costs, HPDS reviewed its most recent balance sheet [year 2008] which is shown in Table 15 below. [source: HPDS analysis, p2 and June 8, 2009, supplemental information, p24]

Table 15
Franciscan Health System-Tacoma Balance Sheet for Year 2008

Assets		Liabilities	
Current Assets	\$ 187,651,000	Current Liabilities	\$ 123,614,000
Fixed Assets	\$ 400,842,000	Long Term Debt / Other	\$ 114,117,000,
Board Designated Assets	\$ 12,321,000	Total Liabilities	\$ 237,731,000
Other Assets	\$ 148,847,000	Equity	\$ 511,930,000
Total Assets	\$ 749,661,000	Total Liabilities and Equity	\$ 749,661,000

To assist the department in its evaluation of this sub-criterion, the HPDS provided a summary of the short and long-term financial feasibility of the project, which includes a financial ratio analysis. Generally, HPDS’s financial ration analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios typically analyzed are **1)** long-term debt to equity; **2)** current assets to current liabilities; **3)** assets financed by liabilities; **4)** total operating expense to total operating revenue; and **5)** debt service coverage. If a project’s ratios are within the expected value range, the project can be expected to be financially feasible. For this project, the department did not require FHS to provide a projected balance sheet for SJMC alone.

There is no capital expenditure associated with this project. In lieu of the historical ratio review described above, HPDS compared SJMC’s current ratios to the statewide ratio, and calculated its projected total operating expense to total operating revenue ratio based on the projected statement of

operations provided in the application. The abbreviated ratio review is shown in Table 16 below. [source: February 24, 2010, HPDS analysis, p3]

**Table 16
Current and Projected HPDS Debt Ratios for St. Joseph Medical Center**

Category	Trend ¹⁵	State 2008	Current 2009	Projected 2011	Projected 2013
Long Term Debt to Equity	B	0.527	0.111		
Current Assets/Current Liabilities	A	1.946	2.129		
Assets Funded by Liabilities	B	0.432	0.287		
Operating Expense/Operating Revenue	B	0.949	0.893	0.900	0.900
Debt Service Coverage	A	4.717	9.221		
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				

After evaluating the hospital’s current and projected ratios and statement of operations for years 2011 through 2013, staff from HPDS provided the following analysis. [source: HPDS analysis, p3]

“The hospital’s operating expense/operating revenue ratio will be slightly weaker with the psychiatric unit than without, however the ratio still remains very strong. ...A review of the financial and utilization information shows that the immediate and long-range operating costs can be met.”

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

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

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

There is no cost associated with reallocating the 16 dedicated psychiatric beds to medical surgical use. FHS states that the 16 medical/surgical beds would be located in current medical/surgical space. [source: Initial Application, p10]

FHS also provided the sources of patient revenue shown in Table 17 on the following page for SJMC as a whole. [source: Application, p42]

¹⁵ A is better if above the ratio, and B is better if below the ratio.

Table 17
St. Joseph Medical Center-Acute Care Hospital
Sources and Percentages of Revenue

Source of Revenue	Percentages
Medicare	21.5%
State (Medicaid)	21.4%
Commercial/HMO	42.4%
Other	14.7%
Total	100.0%

As shown above, for the acute care hospital as a whole, the Medicare and State (Medicaid) entitlements are projected to equal 43% of the revenue at the facility. The department concludes that the this revenue is dependent upon entitlement sources that are not cost based reimbursement and are not expected to have an unreasonable impact on charges for services. The remaining percentages will be derived through other or private insurance reimbursements.

Based on the information provided, the department concludes that this project would not result in an unreasonable impact to the costs and charges for health care services. This sub-criterion is met.

(3) The project can be appropriately financed.

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

There is no cost associated with reallocating 16 dedicated psychiatric beds to medical surgical use at SJMC. As a result, this sub-criterion does not apply to this project.

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

Based on the source information reviewed and the applicant’s agreement to the condition identified in the “Conclusion” section of this evaluation, the department concludes Franciscan Health System has met the structure and process (quality) of care criteria in WAC 246-310-230.

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

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

This project proposes to reallocate 16 dedicated psychiatric beds at SJMC to medical surgical use. With the additional 16 beds, FHS expects SJMC would simply operate at a lower occupancy percentage rather than experience an increase in medical/surgical patients. As a result, all staff is in place and FHS does not anticipate any increase in staff for the 16 beds.

Based on this information above, the department concludes that adequate staffing is available. This sub criterion is met.

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

WAC 246-310 does not contain specific WAC 246-310-230(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that a facility must meet when it is to be Medicare certified and Medicaid eligible. Therefore, using its experience and expertise the department assessed the applicant's history in meeting these standards at other facilities owned or operated by the applicant.

Documentation provided in past FHS applications confirms that FHS maintains appropriate relationships with ancillary and support services for its existing hospitals and other health care facilities. For this project, FHS states that none of its ancillary or support relationships will change. [source: June 8, 2009, supplemental information, p8]

Based on this information above, the department concludes that SJMC would have appropriate ancillary and support services, and 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.

As stated earlier, FHS is a provider of a variety of health care services in Washington State. Currently FHS owns or operates 12 healthcare facilities in Pierce and King counties. As part of its review, the department must conclude that the proposed service would be operated in a manner that ensures safe and adequate care to the public.¹⁶

For Washington State, regular surveys are conducted by the Department of Health's Investigations and Inspections Office. Records indicate that the department has completed at least two compliance surveys each for FHS healthcare since 2007. Each compliance survey revealed deficiencies typical for the facility and FHS submitted an acceptable plan of corrections and implemented the required actions. Additionally, all five of FHS's hospitals hold current accreditations from the Joint

¹⁶ WAC 246-310-230(5).

Commission. [source: facility survey data provided by the Investigations and Inspections Office and Joint Commission website]

FHS also owns a skilled nursing facility in Pierce County.¹⁷ Quality of care surveys for nursing homes in Washington State are conducted by the Department of Social and Health Services. Survey records indicate that the skilled nursing facility has been operating in compliance with no significant survey deficiencies. [source: CMS compare data]

Given the compliance history of FHS, the department concludes that there is reasonable assurance that its behavioral health unit would continue to operate in compliance with state and federal regulation. This sub-criterion is met.

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

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

In response to this sub-criterion, FHS provided the following statements. [source: Amended Application, pp5-6]

“Without more inpatient beds, SJMC’s ability to provide effective, timely, and accessible emergency department care to the community will become increasingly compromised. Additionally, SJMC operates at one of the highest occupancy rates of any non-level I trauma hospital in the state.”

Through CHARS data, the department verified FHS’s occupancy at SJMC and determines that the rationale provided for this project is reasonable. The department also considered FHS’s history of providing care to residents in Washington State. The department concludes that the applicant has been providing acute care services to the residents of Washington State for several years and has been appropriately participating in relationships with community facilities to provide a variety of medical services. Nothing in the materials reviewed by staff suggests that approval of this project would change these relationships. [source: CN historical files]

Therefore, the department concludes that this project would not have the potential of fragmentation of psychiatric services within the planning area. This sub-criterion is met.

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

This sub-criterion is addressed in sub-section (3) above and is considered met.

¹⁷ Franciscan Care Center located in Tacoma.

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

Based on the source information reviewed and the applicant's agreement to the condition identified in the "Conclusion" section of this evaluation, the department concludes Franciscan Health System has met the cost containment criteria in WAC 246-310-240.

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

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

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

Step three of this assessment is to apply any service or facility specific criteria (tie-breaker) contained in WAC 246-310. The tiebreaker criteria are objective measures used to compare competing projects and make the determination between two or more approvable projects which is the best alternative. If WAC 246-310 does not contain any service or facility criteria as directed by WAC 246-310-200(2)(a)(i), then the department would look to WAC 246-310-240(2)(a)(ii) and (b) for criteria to make the assessment of the competing proposals. If there are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b), then using its experience and expertise, the department would assess the competing projects and determine which project should be approved.

Step One

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

Step Two

FHS did not consider any options before submitting this application to add medical surgical bed capacity to SJMC. Within its initial application, FHS concluded that Certificate of Need approval was not required to reallocate the 16 beds from dedicated psychiatric to medical surgical use. One the department notified FHS that prior approval was required for the bed reallocation, FHS submitted its amendment application to incorporate this portion of the project.¹⁸ [source: Initial Application, pp9-19; Certificate of Need letter dated July 2, 2009, and Amendment Application, pp1-19]

Since, submission of its amendment application was the only option for FHS if it did not want to relinquish its 16 dedicated psychiatric beds at SJMC, FHS appropriately submitted its application for

¹⁸ FHS also assumed that it could reallocate the 10 dedicated psychiatric beds to medical surgical use at St. Francis Hospital without prior Certificate of Need approval. The department notified FHS of the review requirement for that project as well. [source: Certificate of Need letter dated April 22, 2009;]

review. Taking into account the results of the acute care bed methodology, the department concludes that the project is the best available alternative for the community. This sub-criterion is met.

Step Three

For this project, only FHS submitted an application to add or establish acute care bed capacity to the central Pierce planning area. As a result, step three is not evaluated under this sub-criterion.

(2) In the case of a project involving construction:

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

As stated in the project description portion of this evaluation, this project involves no construction. This sub-criterion does not apply.

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

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