STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

June 6, 2019

CERTIFIED MAIL # 7018 2290 0001 8591 9145

Medrice Coluccio, Chief Executive
Providence Health & Services – Washington
dba Providence St Peter Hospital
413 Lilly Road NE
Olympia, WA 98506-5166

RE: Certificate of Need Application #18-34

Dear Ms. Coluccio:

We have completed review of the Certificate of Need application submitted by Providence Health & Services - Washington. The application proposes the addition of 52 acute care beds to Providence St. Peter Hospital Medical Center in Olympia, within Thurston County. Enclosed is a written evaluation of the application.

For the reasons stated in the enclosed decision, the application is consistent with the applicable criteria of the Certificate of Need Program, provided Providence Health & Services - Washington agrees to the following in its entirety.

Project Description

This certificate approves the addition of 52 general medical/surgical acute care beds to Providence St Peter Hospital located in Olympia. The project will be completed in two phases. Below is the number of beds by phase, as well as a configuration of acute care beds at completion of this project.

Phase	Number of Beds	Timeline for Occupancy	Location of Beds
1	4	Immediately following approval	4th Floor – Main Tower
2	24	July 2021	2nd Floor – Emilie Gamelin Pavilion
	24		3rd Floor – Emilie Gamelin Pavilion
TOTAL	**52**		

Services Provided	Total Beds-Current	Total Beds-Following Completion
General Medical Surgical	285	337
Intermediate Care Nursery - Level II	13	13
Alcohol and Chemical Dependency	50	50
Psychiatric [dedicated]	20	20
Total	**368**	**420**

Conditions:

1. Providence Health & Services – Washington agrees with the project description as stated above. Providence Health & Services – Washington further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.

2. Providence Health & Services – Washington will provide charity care in compliance with its charity care policy for Providence St Peter Hospital. Providence Health & Services – Washington will use reasonable efforts to provide charity care consistent with the regional average or the amount identified in the application – whichever is higher. The regional charity care average from 2015-2017 was 1.03% of gross revenue and 3.27% of adjusted revenue. Providence Health & Services – Washington will maintain records of charity care applications received and the dollar amount of charity care discounts granted. The department requires that these records be available upon request.

3. Providence Health & Services – Washington will finance the project using cash reserves as stated in the application

4. Providence Health & Services – Washington agrees that the hospital will maintain Medicare and Medicaid certification, regardless of facility ownership.

Approved Costs:

The approved capital expenditure for this project is $34,484,554

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

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

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

Mailing Address:	Physical Address:
Department of Health	Department of Health
Certificate of Need Program	Certificate of Need Program
Mail Stop 47852	111 Israel Road SE
Olympia, WA 98504-7852	Tumwater, WA 98501

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

Sincerely,

Nancy Tyson, Executive Director
Health Facilities and Certificate of Need

Enclosure

EVALUATION DATED JUNE 6, 2019 FOR THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY PROVIDENCE HEALTH & SERVICES – WASHINGTON PROPOSING TO ADD 52 ACUTE CARE BEDS TO PROVIDENCE ST. PETER HOSPITAL IN OLYMPIA, WITHIN THURSTON COUNTY

APPLICANT DESCRIPTION

Providence Health & Services is a not-for-profit Catholic network of hospitals, care centers, health plans, physicians, clinics, home health care, and affiliated services. The health system includes 27 hospitals in five states, more than 35 non-acute facilities and numerous other health, supportive housing and educational services in the states of Alaska, Washington, Montana, Oregon, and California. [source: Providence Health & Services website]

On July 1, 2016, Providence Health & Services and St. Joseph Health System, a California non-profit corporation, became affiliated. The new affiliation created a new "super-parent," Providence St. Joseph Health, a Washington non-profit corporation. After the affiliation, Providence Health & Services remained a viable corporation, as well as any and all subsidiaries and d.b.a.'s of Providence Health & Services that fall under that corporate umbrella. This new affiliation does not change the name or corporate structure of Providence Health & Services. [source: Application, p8]

The applicant for this project is Providence Health & Services – Washington, who will be referenced as "Providence" in this evaluation. Since St. Peter Hospital is the 'face' of Providence in Thurston County, during the review of this project, existing providers, community members, and even the applicant, referred to the applicant as Providence St. Peter Hospital or abbreviated as PSPH. As a result, while the applicant is Providence, public comments in this evaluation may suggest St. Peter Hospital is the applicant.

PROJECT DESCRIPTION

This project focuses on St. Peter Hospital (PSPH) located in Olympia. The hospital has been in operation for many years and provides a variety of healthcare services to the residents of Thurston County and surrounding communities. As of the writing of this evaluation, PSPH is licensed for a total of 368 beds located at 413 Lilly Road Northeast in Olympia [98506]. Table 1 below shows 368 beds broken down by service. [source: CN historical files and PSPH hospital license application submitted on November 26, 2018 for license HAC.FS.00000159]

Table 1
St. Peter Hospital
Current Configuration of Licensed Acute Care Beds

Services Provided	Total Beds
General Medical Surgical	285
Intermediate Care Nursery - Level II	13
Alcohol and Chemical Dependency [see below]	50
Psychiatric [dedicated] [see below]	20
Total	**368**

St. Peter Hospital provides a variety of general medical surgical services, including intensive care, emergency services, obstetric services, and cardiac care. Tertiary services[1] provided at the hospital include open heart surgery, percutaneous coronary intervention, and a 13-bed intermediate care nursery, The hospital is currently a Medicare and Medicaid provider, holds a level III adult trauma designation from the Department of Health's Emergency Medical Services and Trauma office. PSPH holds a three-year accreditation from the Joint Commission[2]. [source: CN historical files]

The estimated capital expenditure associated with both phases for the 52 bed addition is $34,484,554. Of that amount, approximately 70.4% is related to construction; 20.6% is related to equipment, and the remaining 20.0% is for sales tax and fees (consulting, architect, and engineering). [source: Application, p46]

This project proposes the addition of 52 acute care beds in two phases. The first phase is expected to commence immediately following Certificate of Need approval. The second phase requires remodel and construction and is expected to commence in July 2019 and be complete by the end of July 2021. The table below shows the 52 bed addition broken into phases. [source: Application, p7 and pp21-22]

Table 2
St. Peter Hospital
52 Bed Addition and Phases

Phase	Number of Beds	Timeline for Occupancy[3]	Location of Beds
1	4	December 2018	4th Floor – Main Tower
2	24	July 2021	2nd Floor – Emilie Gamelin Pavilion
	24		3rd Floor – Emilie Gamelin Pavilion
TOTAL	**52**		

Psychiatric Beds

On December 11, 2017, the Certificate of Need Program issued an "Intent to Issue" a Certificate of Need to Olympia Behavioral Health, LLC.[4] The "Intent to Issue" approves the establishment of an 85-bed psychiatric hospital in Lacey, within Thurston County. Of the 85 psychiatric beds, 65 are new beds and 20 beds will be relocated from St. Peter Hospital. The project description associated with the approval requires St. Peter Hospital to relinquish its 20 psychiatric beds identified in the table above. As of the writing of this evaluation, the new psychiatric hospital is not operational and the 20 psychiatric beds remain licensed at St. Peter Hospital.

[1] Tertiary services are defined in Washington Administrative Code 246-310-010(58) as "*a specialized service meeting complicated medical needs of people and requires sufficient patient volume to optimize provider effectiveness, quality of service, and improved outcomes of care*."

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

[3] Due to workload constraints, this decision was significantly delayed from October 2018 to March 2019. The timelines above are reflective of Providence's estimates assuming an October decision. The department fully expects that each of these phases would be delayed by approximately 4-5 months.

[4] Olympia Behavioral Health, LLC is a joint venture between Providence Health & Services dba Providence St. Peter Hospital and Universal Health Services, Inc. – BHC Fairfax Hospital.

Alcohol and Chemical Dependency Beds

Prior to March 4, 2009, St. Peter Hospital operated a 50-bed alcohol and chemical dependency unit (ACDU) at a separate site from the hospital and under a separate license.[5] The ACDU was located at 4800 College Street Southeast in Lacey [98503], within Thurston County. On March 4, 2009, Certificate of Need #1394 was issued to Providence Health System Washington approving the consolidation of the 50 ACDU beds with St. Peter Hospital's 340 licensed acute care beds. Department records show that the ACDU license was relinquished on March 30, 2009, which fulfilled the approval under CN #1394. Note, this approval did not relocate the beds to the main PSPH campus, it merely added this site and the associate beds to the license.

In November 2014, PSPH discontinued inpatient admissions at the ACDU site on College Way in Lacey. Department files show that there were meetings and discussions between Certificate of Need Staff and Providence Health & Services regarding the implications of closing the 50-bed ACDU, however, as of the writing of this evaluation, the 50 ACDU beds remain on St. Peter Hospital's license. It is noted, however, that the 50 beds are limited to chemical dependent services and cannot be used for any other type of services without prior Certificate of Need review and approval. [source: CN #1397 condition]

During the review of this project, Capital Medical Center submitted public comment expressing concerns with the timeline for implementation of phase two of the project identified by Providence. [source: August 21, 2018, public comment, pp4-5] Those comments are restated below.

Public Comment

"PSPH's ability to operationalize the beds in phase 2 in the timeline outlined is suspect.

In footnote 3 on page 5 of its Application, PSPH states that Olympia Behavioral Health, its JV with Universal, received an "intent to issue a Certificate of Need" and that the issuance of the actual CN is contingent on approval of a conditional use permit. The footnote also states that the new hospital will be 85 beds; of which 20 come from PSPH. According to the Application, "once Olympia Behavioral Health opens its hospital. PSPH will close its psychiatric unit and reduce the hospital's licensed bed capacity by 20 beds". On page 13 of the Application, PSPH notes that the new psychiatric hospital has to open ***BEFORE*** *the existing services located on the 2nd and 3rd floors of the Emilie Gamelin Pavilion can be relocated so that the remodel of the space to house the new beds can commence.*

PSPH suggests that the new psychiatric hospital will open in about 10 months. Yet, according to a conversation with the City of Lacey Community and Economic Development Department on August 20, 2018, no CUP application has been filed for the sites listed by the JV in their CN application. In addition, CRS records show that the project has yet to formally start the review process. A screenshot of the psychiatric projects that are under review by CRS is included as Attachment 2.

The Olympia Behavioral Health CN application noted that it would take 12 months from the start of construction to opening. Considering that construction has not yet commenced, the calculation used in this Application of 10 months is not realistic. It appears that the opening of the psychiatric hospital is at least two years away (2020).

This project may in fact, follow the very elongated timeline that the same JV partners have experienced in Spokane. The record shows that in Spokane, Providence and Universal Health (the JV) were one of three applicants proposing a new psychiatric hospital in Spokane County. The JV was the successful

[5] DOH license # HALC.FS.00000006.

applicant due partly to the projected short timeline proposed by the JV. The CN was approved on February 6, 2016 and the CN decision stated that "Providence/UHS anticipates the psychiatric hospital would become operational by January 1, 2017." There were no appeals or known delays, yet as of August 2018—the hospital has yet to open. A Spokesman Review article published in April of 2017 and included as Attachment 3 reported on groundbreaking and noted that the hospital would open sometime in the fall of 2018—almost 2 years later than anticipated. This delay occurred despite the fact that the land was owned by Providence and already zoned for health care use. In comparison, the conditional use permit for the Olympia Behavioral Health hospital requires a public hearing held by the City of Lacey.2

Without a clear or probable timeline, the financials are speculative at best, and cannot be relied upon for purposes of determining the financial feasibility of the Application."

In the conclusion section of its public comment, Capital Medical Center provided suggestions for conditions if the project is approved. Specific to the timeline, Capital Medical Center suggested the following condition. [source: August 21, 2018, public comment]

"That the second phase of the project, as described in the Application, must commence after the opening of the new behavioral health hospital and within the timeframes depicted in the application (July, 2019) or that Phase 2 becomes null and void."

Rebuttal Comment

Providence submitted rebuttal comment related to Capital Medical Center's concern regarding the timeline for implementation of phase two. The rebuttal comments are restated below. [source: Providence Health & Services-Washington rebuttal comments, pp5-8]

"Project Description and Implementation Timing

CMC's criticisms of Providence's ability to operationalize the 52 requested acute care beds are wrong. Providence operates (through ownership or affiliation) 14 health care facilities in the State of Washington, representing more than 4,000 licensed beds. Providence has undertaken and successfully executed multiple hospital-based projects to bring much needed capacity and health care services to our communities. Given the track record in this state and elsewhere, Providence has significant experience expanding hospitals and projecting and managing the phasing and execution of large construction projects.

CMC's criticism includes its suggestion that the Department apply a condition to approval of the PSPH CN application that would rescind the approval of 48 beds of the 52-bed request if construction on phase 2 (48 beds) of the project does not begin in July 2019. This suggestion is misplaced and unreasonable for three reasons and should be rejected:

- *First, on some large hospital-based projects, Providence models the project in phases, as it reduces unnecessary disruption of services and allows beds to be operationalized as need increases - this is much more efficient.*
- *Second, PSPH's acute bed project and the proposed Olympia Behavioral Health psychiatric hospital in Lacey* ***are distinct and separate projects.***
- *Third, CMC misunderstands the Department's approval and monitoring process: the Department requires a successful applicant to specify the commencement date of the project and then commence the project consistent with Department rules. Additionally, after the Department approves a project, it uses quarterly progress reports to track project completion, consistent with*

the application, as approved by the Department. Such progress reports are where the applicant notifies the Department of any completion issues.

There is simply no need for a CN approval condition as CMC suggests. PSPH has stated it will commence the project after CN approval and add the balance of beds, based on a phased approach, which is clearly more efficient from an operations and Planning Area need perspective, as well as less disruptive to inpatient care.

PSPH is currently licensed to operate 368 total beds. Through the CN process, PSPH requests the addition of 52 acute care beds. In the PSPH acute bed application, we state the proposed expansion of the 52 acute care beds will occur in two phases. The first phase will occur immediately following receipt of the Certificate of Need and will consist of the conversion of four (4) existing observation beds to acute medical/surgical beds on the 4th floor of the main tower. This first phase represents the commencement of the project and is expected to occur early in December of 2018 (or upon CN approval of the project). We expect the four beds to be licensed and operational by December 2018.

The second phase is expected to begin in July 2019 with an anticipated completion date of July 2021. The second phase will include a remodel of the 2nd and 3rd floors of the Emilie Gamelin Pavilion, which will comprise the additional 48 beds (with 24 beds per floor) that have been requested. In the Application, we note that in order to make way for the proposed 48 acute medical/surgical beds, a number of other services currently located on the 2nd and 3rd floors of Emilie Gamelin Pavilion will require relocation to other parts of the hospital campus and/or offsite locations. The current services located on the 2nd and 3rd floors of the Emilie Gamelin Pavilion include: 22-bed observation unit; physical, occupational and speech therapies for neurology; orthopedic outpatient services; lymphedema; pediatric PT/OT/Speech; and a hydrotherapy pool.

- ***Capital Medical Center's letter states: "In footnote 3 on page 5 of its Application, PSPH states that Olympia Behavioral Health, its JV with Universal, received an 'intent to issue a Certificate of Need' and that the issuance of the actual CN is contingent on approval of a conditional use permit. The footnote also states that the new hospital will be 85 beds; of which 20 come from PSPH. According to the Application, 'once Olympia Behavioral Health opens its hospital. PSPH will close its psychiatric unit and reduce the hospital's licensed bed capacity by 20 beds'. On page 13 of the Application, PSPH notes that the new psychiatric hospital has to open BEFORE the existing services located on the 2nd and 3rd floors of the Emilie Gamelin Pavilion can be relocated so that the remodel of the space to house the new beds can commence."***

*CMC's comments about Providence's ability to add the 48 beds in Phase 2 are simply wrong and uninformed. CMC incorrectly states that "the new psychiatric hospital has to be open **BEFORE** the existing services located on the 2nd and 3rd floors of the Emilie Gamelin Pavilion can be relocated so that the remodel of the space to house the beds can commence." Nowhere in our Application do we state the new psychiatric hospital has to be open before we can relocate services on the 2nd and 3rd floors. In our Application, we have stated where we anticipate the additional beds will be located and the timeline for these bed additions. That is what is required of any applicant.*

CMC's suggestion that the planned Olympia Behavioral Health psychiatric hospital has to be open to permit the transfer of the existing 20 bed psychiatric unit at PSPH in order to make way for the 22 observation beds in the Emilie Gamelin Pavilion is incorrect. At the time of writing the Application, Providence was working with its best available knowledge. As with any planning of large projects, flexibility is built into the build-out in order to accommodate any needed changes that may arise. Our

project timing and the phased approach reflect our best estimates at the time of submission of the Application. It should be noted that nothing precludes PSPH in Phase 2 from keeping the 22 observation beds on the 2nd floor and remodeling the 3rd floor of the Emilie Gamelin during the June 2019 to July 2020 period. After that, the 22 observation beds could be relocated to the recently constructed 3rd floor while the 2nd floor is being built out during the July 2020 to July 2021 period. Either way, Providence is committed to commencing the project on time and completing it as required. The timeline provided in the Application reflects our best estimates of implementation - it is clear, realistic, and not speculative."

Department's Evaluation of Implementation Timing

As Providence states in their rebuttal, there is no mention in the application or screening response that the implementation of this project is contingent on the timing of the psychiatric hospital project. The spaces identified in the project for the 48-bed phase two are not currently used for inpatient beds of any kind. The timing of the psychiatric project does not impact this timing of this proposal and will not be considered any further in this evaluation.

APPLICABILITY OF CERTIFICATE OF NEED LAW

Providence's application is subject to review as the change in bed capacity of a health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

EVALUATION CRITERIA

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

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

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

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

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

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

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

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

(i) Nationally recognized standards from professional organizations;

(ii) Standards developed by professional organizations in Washington State;

(iii) Federal Medicare and Medicaid certification requirements;

(iv) State licensing requirements;

(v) Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to a proposed undertaking; and

(vi) The written findings and recommendations of individuals, groups, or organizations with recognized expertise related to a proposed undertaking, with whom the department consults during the review of an application."

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

TYPE OF REVIEW

This project was reviewed under the regular timeline outlined in WAC 246-310-160, which is summarized below.

APPLICATION CHRONOLOGY

Action	Providence Health & Services
Letter of Intent Submitted	October 27, 2017
Application Submitted	April 27, 2018
Department's pre-review activities	
• DOH 1st Screening Letter	May 31, 2018
• Applicant's Responses Received	June 18, 2018
• DOH 2nd Screening Letter[6]	N/A
• Applicant's Responses Received	N/A
Beginning of Review	July 7, 2018
End of Public Comment/No Public Hearing Conducted	
• Public comments accepted through end of public comment	August 21, 2018
Rebuttal Comments Received	September 4, 2018
Department's Anticipated Decision Date	October 19, 2018
Pivotal Unresolved Issue Declared	April 12, 2019
Pivotal Unresolved Issue Info Submitted	May 3, 2019
Pivotal Unresolved Issue Public Comment Deadline	May 10, 2019
Pivotal Unresolved Issue Rebuttal Deadline	May 17, 2019
Department's Updated Decision Date with PUI	June 3, 2019
Department's Actual Decision Date	June 6, 2019

AFFECTED PERSONS

Washington Administrative Code 246-310-010(2) defines "affected person" as:
"…an "interested person" who:

(a) Is located or resides in the applicant's health service area;
(b) Testified at a public hearing or submitted written evidence; and
(c) Requested in writing to be informed of the department's decision."

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

(a) The applicant;

[6] Under WAC 246-310-090(2)(a), the department reserves the right to screen an application a second time if necessary. Due to the scope of the project, the department elected to screen the application a second time to ensure it was complete. Following the 15-working day screening period, the department found no further deficiencies in the application and began the review process.

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

During the review of this project, three persons or health care providers sought interested person status. A brief description of each is below.

MultiCare Health System

MultiCare Health System is a not-for-profit health care organization that owns and operates five hospitals in King and Pierce counties. All five hospitals provide a variety of healthcare services to residents of King and Pierce counties and surrounding communities. MultiCare Health System also owns and operates a variety of healthcare clinics located in King, Kitsap, Pierce, Snohomish, and Thurston counties. [source: MultiCare Health System website] MultiCare Health System did not provide written or oral comments on this project. MultiCare Health System does not meet the affected person qualifications identified above.

Capital Medical Center

Capital Medical Center is a 107-bed acute care hospital located in Olympia, within Thurston County. Services provided at Capital Medical Center include those typically associated with an acute care hospital, such as emergency services, obstetrics, cardiac care, intensive critical care, and diagnostic services. Capital Medical Center submitted a request for interested and affected person status for this application. Given that the hospital is located in Thurston County, it qualifies as an interested person. Capital Medical Center provided public comments on this application, as a result, Capital Medical Center meets the definition of an affected person as defined above.

SEIU 1199NW

A representative from SEIU (**S**ervices **E**mployees **I**nternational **U**nion) 1199NW requested interested person status. SEIU 1199NW is a statewide union of nurses and healthcare workers. According to its website, SEIU 1199NW represents more than 30,000 nurses and healthcare workers across Washington State. [source: SEIU 1199NW website] Though SEIU 1199NW represents employees at St. Peter Hospital, it is not located within the applicant's health service area. SEIU 1199NW meets the definition of an 'interested person.' As an interested person, SEIU 1199NW could provide public comments on the application but did not. As a result, SEIU 1199NW does not qualify as an "affected person." Since SEIU 1199NW does not meet the definition of an affected person, it could not provide rebuttal comments.

SOURCE INFORMATION REVIEWED

- Providence St. Peter Hospital's Certificate of Need application received April 27, 2018
- Providence St. Peter Hospital's screening responses received June 18, 2018
- Public comments received by the close of business on August 21, 2018
- Rebuttal documents received by the close of business on September 4, 2018

- Department of Health's Hospital and Patient Data Systems' Comprehensive Hospital Abstract Reporting System data for years 2008 through 2017
- OFM Population Projections – medium series for 2017
- Hospital/Finance and Charity Care (HFCC) Financial Review
- Department of Health Integrated Licensing and Regulatory System database [ILRS]
- Licensing and/or survey data provided by the Department of Health's Office of Health Systems and Oversight
- Licensing data provided by the Medical Quality Assurance Commission, Nursing Quality Assurance Commission, and Health Systems Quality Assurance Office of Customer Service
- Department of Health's Emergency Medical Services and Trauma designation dated December 2018
- Providence Health & Services' website at www.providence.org
- Providence St. Peter Hospital's website at www.providence.org/st-peter-hospital
- Joint Commission website at www.qualitycheck.org
- Certificate of Need historical files

CONCLUSIONS

For the reasons stated in this evaluation, the application submitted by Providence Health & Services – Washington proposing to add 52 medical/surgical beds to Providence St Peter Hospital in Olympia, within Thurston County is consistent with the applicable criteria of the Certificate of Need Program, provided Providence Health & Services – Washington agrees to the following in its entirety.

Project Description:

This certificate approves the addition of 52 general medical/surgical acute care beds to Providence St Peter Hospital located in Olympia. The project will be completed in two phases. Below is the number of beds by phase, as well as a configuration of acute care beds at completion of this project.

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1	4	Immediately following approval	4th Floor – Main Tower
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2. Providence Health & Services – Washington will provide charity care in compliance with its charity care policy for Providence St Peter Hospital. Providence Health & Services – Washington will use reasonable efforts to provide charity care consistent with the regional average or the amount identified in the application – whichever is higher. The regional charity care average from 2015-2017 was 1.03% of gross revenue and 3.27% of adjusted revenue. Providence Health & Services – Washington will maintain records of charity care applications received and the dollar amount of charity care discounts granted. The department requires that these records be available upon request.

3. Providence Health & Services – Washington will finance the project using cash reserves as stated in the application

4. Providence Health & Services – Washington agrees that the hospital will maintain Medicare and Medicaid certification, regardless of facility ownership.

Approved Costs:

The approved capital expenditure for this project is $34,484,554

CRITERIA DETERMINATIONS

A. Need (WAC 246-310-210)

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

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

WAC 246-310 does not contain an acute care bed 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.[7]

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

Providence Health & Services - Washington

This project proposes to add 52 acute care beds to Providence St Peter Hospital located in Olympia, within Thurston County. Providence provided an acute care bed methodology based on historical CHARS[8] data for years 2008 through 2017. Below are the assumptions and factors used in the numeric methodology. [source: Application, Exhibit 5, Exhibit 15]

- Hospital Planning Area – "Hospital Planning Area 24 – SWWA 10"[9]
- CHARS Data – Historical years 2008 through 2017
- Projected Population – Based on Claritas 2017 for SWWA 10 ZIP codes; Office of Financial Management medium series data for statewide. For each data source, historical and projected intercensal and postcensal estimates were calculated.
- Planning Horizon – Providence provided data through 2031, identifying a 7-year planning horizon following the base year. The base year is 2017; year seven is 2024.
- Excluded MDCs[10] and DRGs[11]
  - MDC 19 – patients, patient days, and DRGs for psychiatric
  - DRG385-391/789-795 – patients, patient days, and DRGs for neonates
  - DRG 462/945-946 – patients, patient days, and DRGs for rehabilitation
- Weighted Occupancy – Calculated consistent with the State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. Providence's methodology calculated a weighted occupancy of 68.61%.
- Existing Acute Care Bed Capacity – Two acute care hospitals operate in the Thurston County planning area.

[7] The acute care bed methodology in the 1987 SHP divides Washington State into four separate Health Service Areas (HSAs) that are established by geographic regions appropriate for effective health planning. Thurston County is located in HSA #2, which includes ten counties: Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, Wahkiakum

[8] CHARS=Comprehensive Hospital Abstract Reporting System

[9] Exhibit 5 of the application identifies the ZIP codes that make up this planning area – all ZIP codes identified are within Thurston County.

[10] MDC=Major Diagnostic Category

[11] DRG=Diagnosis Related Group

In addition, Providence provided the following information on emergency visits, current and projected hospital occupancy, population growth and in-migration to the planning area from surrounding areas [source: Application pp -24-28]

"Emergency/Trauma:
PSPH has been designated by the Department of Health as a Level III trauma center. Providence St. Peter Hospital is the largest trauma center in the five-county area, which includes Thurston, Lewis, Mason, Grays Harbor and Pacific counties. Our Level III emergency center provided 65,901 visits in 2017, as shown in Table 13. Given that more than 72% of PSPH's inpatient admissions come from the Emergency Department (Table 14), as Emergency Department volumes increase, so do admissions.

Applicant's Tables

Table 13. Emergency Department Visit Statistics, 2014-2017[12]

Hospital	2014	2015	2016	2017
Providence St. Peter Hospital	69,376	71,595	68,901	65,901

Source: PSPH
Excludes: neonates, rehab, chemical dependency (includes psych)

Table 14. PSPH Admits from the Emergency Department, 2014-2017

	2014	2015	2016	2017
Total Inpatient Admits	17,865	18,639	18,414	19,152
Admits from Emergency Department (ED)	10,771	11,264	12,269	13,915
% of Total Inpatient Admits from ED	63.1%	65.1%	66.6%	72.7%

Source: PSPH
Excludes: neonates, rehab, chemical dependency (includes psych)

Footnote 12 above from the image above states:
"The decline of the Emergency Room visits between 2015 and 2017 can be attributed to several factors. Due to the lack of beds at PSPH, the Emergency Department began experiencing an increase in boarding patients in the ED, which resulted in an increase in LWBS (left without being seen) percent, as patients experienced longer waiting times. In addition, in 2015, SeaMar opened its doors to their walk-in clinic on Lilly Road, minutes away from the PSHP Emergency Room. Finally, in December 2016, Providence also opened an Immediate Care clinic, allowing patients to seek an alternative to the Emergency Department."

Occupancy Rate

PSPH operated at 78.9% occupancy in 2016 and 83.7% occupancy in 2017 (see Table 15). The occupancy rates in Table 15 exclude neonate, inpatient psychiatric, and inpatient rehabilitation services. Both occupancy rates exceed the optimal hospital occupancy standard of 75% that is used when applying the Bed Need Forecasting Method. This trend is expected to continue.

Table 15 demonstrates PSPH's occupancy rate has increased substantially in recent years, and PSPH thus faces significant demand pressures on its available beds. Because more than 72% of its admissions come from the Emergency Department, PSPH often has to hold patients in the Department until an acute care bed becomes available. Adding acute care beds will allow PSPH to move patients from the Emergency Department into the optimal site of care in a timely manner. This will result in improved care for the patient and will help reduce the overall cost of care.

Applicant's Table

Table 15. PSPH Occupancy Rate, 2013-2017

	2013	2014	2015	2016	2017
Patient Days	83,649	74,157	74,856	82,084	87,034
ADC	229.2	203.2	205.1	224.9	238.4
Number of Acute Beds (50 bed chemical dependency center closed during 2014)	335	335	285	285	285
Occupancy	68.4%	60.6%	72.0%	78.9%	83.7%

*Excludes Neonates (DRGs 789-795), Rehab (DRGs 945 and 946), and Psych (MDC 19)

**Excludes Psychiatric Unit Utilization

Source: CHARS 2013-2017

Growing Population

From 2000-2015, the SWWA 10 Planning Area resident population grew 1.7% annually, such that in 2015, there were 252,905 residents in the Planning Area (Table 16). The Planning Area is estimated to have increased to 258,620 residents in 2017.

The population growth is driven primarily by growth in the number of residents age 65 years and older. As shown in Table 16, the number of residents age 65 years and older increased, on average, 4.5% per year from 2010-2015, and is forecasted to grow 4.3% per year during 2015-2020 and 4.2% per year during 2020-2025. This high rate of growth in the number of older residents is very important because older residents demand much greater levels of inpatient care. In turn, this translates into much greater demand for inpatient care in the Planning Area. As discussed further below, residents age 65 years and older from the SWWA 10 Planning Area have an inpatient use rate of patient days that is more than four times that of residents whose ages range from 0 to 64 years old.

Applicant's Table

Table 16. SWWA 10 Planning Area Population Statistics, 2000-2025

						Average Annual Growth			
	2000	2010	2015	2020	2025	2000-2010	2010-2015	2015-2020	2020-2025
Ages 0-64	*174,173*	*206,966*	*213,949*	*219,818*	*225,883*	*1.7%*	*0.7%*	*0.5%*	*0.5%*
Ages 65+	*22,646*	*31,118*	*38,956*	*48,282*	*59,680*	*3.2%*	*4.5%*	*4.3%*	*4.2%*
Total	**196,819**	**238,084**	**252,905**	**268,100**	**285,563**	**1.9%**	**1.2%**	**1.2%**	***1.3%***

Source: Claritas 2015

Planning Area Resident Utilization and In-Migration to PSPH

Residents from both inside and outside the Planning Area have increasingly relied on PSPH for inpatient care. Table 17 shows the previous five-year patient day volumes at PSPH for acute care, segmented by geographic designation. In order to adjust for the fact that PSPH previously had a 50-bed chemical dependency center that closed in 2014, MDC 20 (chemical dependency) patient days were excluded throughout the study period (i.e. 2013-2017) in Table 17.

The Table shows that, in each of the past five years, more than 30% of PSPH's patient days have been attributable to patients who reside ***outside*** *the Planning Area. Thus, PSPH serves the acute care needs not just of Planning Area residents, but also a significant number of residents from the surrounding region.*

Applicant's Table

Table 17. PSPH, Patient Days, by Patient Origin, 2013-2017

	2013	2014	2015	2016	2017	Average Annual Growth
PA Residents to PSPH	45,215	46,174	48,582	54,615	58,426	6.4%
In-migration to PSPH	25,068	24,045	25,791	26,875	28,050	2.8%
Total Acute Days at PSPH	**70,283**	**70,219**	**74,373**	**81,490**	**86,476**	**5.2%**
PA Residents to PSPH (% of Total)	64.3%	65.8%	65.3%	67.0%	67.6%	
In-migration to PSPH (% of Total)	35.7%	34.2%	34.7%	33.0%	32.4%	

*Excludes Neonates (DRGs 789-795), Rehab (DRGs 945 and 946), Psych (MDC 19), and Chemical Dependency/Substance Abuse (MDC 20)
**Excludes Psychiatric Unit Utilization
Source: CHARS 2012-2016
PA = Planning Area

Providence based its methodology on the available beds in the planning area and counted 395 beds. The 395 beds represent available medical/surgical beds between the two active hospitals in the planning area. The following bed types were excluded: NICU bassinets at all levels, rehabilitation beds, and psychiatric beds.

Table 3 below shows the results of Providence's numeric methodology for years 2017 through 2024 [source: Application Exhibit 15]

Table 3
Providence Acute Care Bed Mythology
Projection Years 2017-2024

	2017	2018	2019	2020	2021	2022	2023	2024
Gross Bed Need	400	411	423	435	447	459	472	485
Minus Existing Capacity	395	395	395	395	395	395	395	395
Net Need (surplus)	5	16	28	40	52	64	77	90

Table 1 above shows need in excess of the 52 requested beds in the projection year.

In addition to numeric need, the applicant must also demonstrate that other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need. Providence provided the following statement:

"The bed need forecast presented in Table 18 clearly demonstrates there was an unmet need of five (5) beds in 2017, growing at a rate of 11-12 beds annually until 2024, the target year for the 7-year planning horizon under the Bed Need Forecasting Model. PSPH is one of only two acute care hospitals in this Planning Area. Thus, without additional acute care beds, PSPH will be unable to continue providing necessary acute care access to Planning Area residents. By definition, the proposed project will not result in an unnecessary duplication of services. Further, as noted earlier, PSPH also serves as a regional tertiary referral center for cardiac, cancer, neuroscience, orthopedic, and Level II nursery services.." [source: Application p41]

Public Comment

The department received public comment from Capital Medical Center that expresses concerns about the need for additional acute care beds in the planning area. [source: August 21, 2018, public comment, pp3-4] The comments are restated below.

"PSPH overstates its internal need for additional beds.

The Application contains inconsistencies, errors and omissions that likely result in PSPH overstating its internal need for beds. These errors, inconsistencies and omissions also handicap affected persons in providing public comment because it is nearly impossible to "tie" or reconcile assumptions and data sources. Because of the problems, the projected patient days in the record cannot be relied upon and hence, cannot be used for purposes of demonstrating financial feasibility.

Specific inconsistencies, errors and omissions include:

- *Data in several tables (for example, but not limited to, Tables 3, 4, 15, 17) are purportedly from CHARS, but CMC cannot independently replicate the numbers. Of concern, the footnotes in each table suggest different exclusions. For example, PSPH's historical patient days in Table 17 do not match its historical patient days in Tables 3 or 4.*
- *Table 9 projects future patient days. However, it includes more than just acute (medical surgical) days. It also appears to continue the days associated with the current psychiatric unit out through 2023 (a unit that PSPH indicates will close by 2019).*
- *Page 30 of the Application includes an accurate description of the impact that the change from ICD9 to ICD10 has had on accounting for acute rehabilitation discharges and days. According to page 30, PSPH "DRGs 945 and 946 can no longer be used as the only factor to exclude rehab days from the model. By ignoring this change, the model will inaccurately assign patient days to acute care utilization and corresponding use rates, thereby artificially*

inflating net bed need." PSPH then suggests it excluded all patient days, regardless of DRG, from all Washington State rehab units and St. Lukes. However, PSPH did not state how it made the exclusions. Of significant concern, it appears from the footnotes in Tables 15 and 17, that only DRGs 945 and 946 were excluded. This overstates the Planning Area's acute patient days.

- *On Page 29, PSPH indicates that it used both OFM and Claritas population data. PSPH reiterated this fact on page 34. PSPH does not explain how or why it would use two different data sources (see footnote one to Table 18). This is of significant concern as it could inflate bed need.*

These issues call into question the extent of the need for additional acute care beds in the Planning Area and, even more importantly, PSPH's estimates of projected internal volume. Collectively, these issues raise questions regarding the reliability of the proposed patient days, which translate into concerns regarding the accuracy of the pro formas. The Department cannot rely on PSPH's internal projections in analyzing this CN application, and therefore the Application should be denied."

In the conclusion section of its public comment, Capital Medical Center provided suggestions for conditions if the project is approved. Specific to this sub-criterion, Capital Medical Center suggested the following three conditions. [source: August 21, 2018, public comment]

- *Any new acute care beds should be transferred from PSPH's "banked" licensed capacity and not be NEW beds. PSPH should not be allowed to secure new beds while its license includes 50 phantom beds.*
- *PSPH must make a long-term commitment to continue to provide its current scope of services. In its Application, PSPH made representations that it intends to continue to provide for the healthcare needs of the growing community and region.4 A review of the PSPH website reflects the suite of services offered by PSPH to members of the community.5 If the Department awards the CN to PSPH, the Department should impose, monitor, and enforce conditions that require PSPH to maintain the current scope of services offered at PSPH to ensure that PSPH continues to provide such services within the Planning Area for a period of at least 10 years.*
- *PSPH must continue to participate in the Medicare and Medicaid programs. In its Application, PSPH made representations that it is Medicare certified and that it participates in the Medicare and Medicaid programs.6 Enrollees in these health care programs include the most financially vulnerable and elderly members of the community. PSPH has not expressed a commitment to continue caring for Medicare and Medicaid patient in its Application. Considering the large number of beds requested and PSPH's market share, PSPH should be required to maintain its participation in Medicare and Medicaid. If the Department awards the CN to PSPH, the Department should impose, monitor, and enforce conditions that require PSPH, on a long-term basis, to continue participation in the Medicare and Medicaid programs, and to care for Medicare and Medicaid patients at a rate that is consistent with the payer mix in the Planning Area.*

<u>Rebuttal Comment</u>

Providence Health & Services-Washington provided the following rebuttal to comments submitted by Capital Medical Center that focus on the data used for the numeric methodology and need for the additional acute care beds. [source: Providence rebuttal comments, pp11-16]

"In its public comments, CMC asserts that PSPH produced several "inconsistencies, errors, and omissions" in its application. Upon re-examination of our application text, we did identify some

discrepancies between the data tables and footers regarding the exclusion criteria applied to CHARS statistics. We have corrected those data tables to correctly reflect what was included or excluded in a particular table. These corrections are provided below. However, there are several other claims made by CMC that are simply due to its own misunderstanding of the CHARS database, the Department's numeric need methodology for acute care beds, and the context of the specific discussion in the application to which the table was referring. These issues will be discussed below.

- ***Capital Medical Center's letter states: "Data in several tables (for example, but not limited to, Tables 3, 4, 15, 17) are purportedly from CHARS, but CMC cannot independently replicate the numbers. Of concern, the footnotes in each table suggest different exclusions. For example, PSPH's historical patient days in Table 17 do not match its historical patient days in Tables 3 or 4."***

Different exclusions conducted in our CHARS analysis were made to produce data tables specific to the particular discussion in the application. As mentioned above, upon re-examination of our application text, we found some minor discrepancies between the data tables and footers to some tables regarding the exclusion criteria applied to CHARS data. This may have led to CMC's inability to replicate some of the data tables.

Please see the revised application tables below with the corrected footer labels. It should be noted that no changes have been made to the figures presented in the revised tables below, only selected footers to the tables have been revised. It also should be noted that all of PSPH's rehabilitation unit utilization was excluded in all tables that detailed acute care utilization, not just rehabilitation DRGs 945-946.

Corrected Application Tables

Revised Table 4. Providence St. Peter Hospital, Total Inpatient Patient Days (Exclusions)[17]

	2013	2014	2015	2016	2017
Patient Days	83,649	74,157	74,856	82,084	87,034
Annual Growth		-11.3%	0.9%	9.7%	6.0%

*Excludes Neonates (DRGs 789-795), Psych (MDC 19) and Rehab (DRGs 945 and 946).
**Excludes Psychiatric and Rehabilitation Unit Utilization.
Source: CHARS 2013-2017.

Added the footer "Excludes Psychiatric and Rehabilitation Unit Utilization."

Applicant's Tables

Revised Table 9. PSPH Total Patient Day Forecasts, 2018-2023[18]

	2018	2019	2020	2021	2022	2023
Total Patient Days	104,412	105,788	107,163	108,290	109,576	110,862

*No exclusions.
Source: PSPH, 2018.

Relabeled the title to state "Total Patient Days."
For clarity, added a footer to state "No Exclusions."

Applicant's Table

Revised Table 15. Providence St. Peter Hospital. Occupancy Rate, 2013-2017[19]

	2013	2014	2015	2016	2017
Patient Days	83,649	74,157	74,856	82,084	87,034
ADC	229.2	203.2	205.1	224.9	238.4
Number of Acute Beds (50 bed chemical dependency center closed during 2014)	335	335	285	285	285
Occupancy	68.4%	60.6%	72.0%	78.9%	83.7%

*Excludes Neonates (DRGs 789-795), Rehab (DRGs 945 and 946), and Psych (MDC 19).
**Excludes Psychiatric and Rehabilitation Unit Utilization.
Source: CHARS 2013-2017.

Corrected the footer in the original table to state: "Excludes Psychiatric and Rehabilitation Unit Utilization."

Applicant's Table

Revised Table 17. Providence St. Peter Hospital, Patient Days, by Patient Origin, 2013-2017.[20]

	2013	2014	2015	2016	2017	Average Annual Growth
PA Residents to PSPH	45,215	46,174	48,582	54,615	58,426	6.4%
In-migration to PSPH	25,068	24,045	25,791	26,875	28,050	2.8%
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PA Residents to PSPH (% of Total)	64.3%	65.8%	65.3%	67.0%	67.6%	
In-migration to PSPH (% of Total)	35.7%	34.2%	34.7%	33.0%	32.4%	

*Excludes Neonates (DRGs 789-795), Rehab (DRGs 945 and 946), Psych (MDC 19), and Chemical Dependency/Substance Abuse (MDC 20).
**Excludes Psychiatric and Rehabilitation Unit Utilization.
Source: CHARS 2013-2017.
PA=Planning Area

Corrected the footer to state: "Excludes Psychiatric and Rehabilitation Unit Utilization."

Applicant's Table

Revised Table 23. Providence St. Peter Hospital, Market Share of Planning Area Resident Utilization, 2017[21]

SWWA 10 Planning Area Resident Utilization		Planning Area Residents at PSPH		PSPH Market Share of Planning Area	
Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
18,776	88,567	12,485	58,892	66.5%	66.5%

*Excludes Neonates (DRGs 789-795), Psych (MDC 19), Rehab (DRGs 945 and 946), and all WA state rehabilitation provider utilization (hospital IDs with fourth character "R" and St. Luke's Rehabilitation Institute)
**Excludes Psychiatric and Rehabilitation Unit Utilization
***Minor differences between "*Planning Area Residents at PSPH*" patient days above compared to "*Providence St. Peter Hospital, Patient Days, by Patient Origin, 2013-2017*" (Table 17) because Table 23 does not exclude MDC 20 (chemical dependency)
Source: CHARS 2017

Corrected the footer to state: "Excludes Neonates (DRGs 789-795), Psych (MDC 19), Rehab (DRGs 945 and 946), and all WA state rehabilitation provider utilization (hospital IDs with fourth character "R" and St. Luke's Rehabilitation Institute)."
Corrected the footer to state: "Excludes Psychiatric and Rehabilitation Unit Utilization."

Other Data Issues
There are a number of issues regarding data where the CMC assertions are incorrect. For instance, CMC states that apparently it was unable to independently replicate the numbers shown in Table 3 of the CN Application [PSPH Total Inpatient Days (No Exclusions)]. This is surprising since the figures in Table 3 can easily be cross-referenced and confirmed with the CHARS reports that are readily available and accessible. We stated Table 3 included all inpatient days, which is very clear. This can easily be confirmed, as stated above. Analysis of CHARS public reports include patient days, by hospital; one simply has to look up PSPH (Hospital ID "159") and confirm the TOT AL row in the CHARS report for 2017, for example, equals the figure included in Table 3. Therefore, CMC either does not understand how to interpret CHARS reports or it must have incorrectly compiled the CHARS data. Either way, its criticism regarding Table 3 is wrong.

There are other examples where CMC made inaccurate claims, regard less of whether the footers were properly labeled. A clear example of CMC's disregard of supporting text provided in our application is illustrated with its that "PSPH's historical patient days in Table 17 do not match its historical patient days in Tables 3 or 4." 24 What CMC failed to consider is the discussion surrounding Table 17 that specifically mentions "Table 17 shows the previous five-year patient day volumes at PSPH for acute care, segmented by geographic designation. In order to adjust for the fact that PSPH previously had a 50-bed chemical dependency center that closed in 2014, MDC 20 (chemical dependency) patient days were excluded throughout the study period (i.e. 2013-2017) in Table 17." 25 Again, application data tables use exclusion criteria that are most appropriate for the application discussion it is used to support. In the case of Table 17, its purpose is to show historical in-migration patterns for acute care at PSPH. However, a complicating factor is the fact that PSPH had previously operated a 50-bed chemical dependency center that closed in 2014; this factor would have affected 2013 and 2014 figures in Table 17 if only acute care days (i.e. non-neonate/psychiatric/rehab) had been excluded because MDC 20 would not have been excluded. By not excluding MDC 20, this would have shown a significant drop in 2014 in-migration, which would have been due to the closure of the chemical dependency center and not due to any fundamental shift in patients' general utilization of PSPH for acute care. Thus, Table 17 also excludes MDC 20 so a more accurate examination of historical in-migration of the current scope of acute care services provided at PSPH can be made.

- ***Capital Medical Center's letter states: "Table 9 projects future patient days. However, it includes more than just acute (medical surgical) days. It also appears to continue the days associated with the current psychiatric unit out through 2023 (a unit that PSPH indicates will close by 2019). "***

A revised Table 9 is provided below. Table 9 patient days do not have any exclusions. We have relabeled Table 9 to reflect the fact it includes all PSPH patient days. In that regard, it does include psychiatric unit patient days through the forecast, since at the time this application was filed, and through the current period, there is still some uncertainty regarding the DOH approval and its "intent to issue" a CN for Olympia Behavioral Health. In the interest of conservatism, the forecast did not exclude psychiatric patient days.

However, what CMC ignores is that acute days are the drivers of "With Project" forecasts for utilization, occupancy of acute care beds, and financial performance with the project. In terms of our request for additional acute care beds, the relevant forecast is for medical/surgical patient days, which we provided in our Revised Exhibit 29 With Project, included in our June 18, 2018 screening responses.

Applicant's Table

Revised Table 9. PSPH Total Patient Day Forecasts, 2018-2023[18]

	2018	2019	2020	2021	2022	2023
Total Patient Days	104,412	105,788	107,163	108,290	109,576	110,862

*No exclusions.
Source: PSPH, 2018.

- ***Capital Medical Center's letter states: "Page 30 of the Application includes an accurate description of the impact that the change from ICD9 to ICD10 has had on accounting for acute rehabilitation discharges and days. According to page 30, PSPH 'DRGs 945 and 946 can no longer be used as the only factor to exclude rehab days from the model. By ignoring this change, the model will inaccurately assign patient days to acute care utilization and corresponding use rates, thereby artificially inflating net bed need.' PSPH then suggests it excluded all patient days, regardless of DRG, from all Washington State rehab units and St. Lukes. However, PSPH did not state how it made the exclusions. Of significant concern, it appears from the footnotes in Tables 15 and 17, that only DRGs 945 and 946 were excluded. This overstates the Planning Area's acute patient days.***

Our analytic approach to exclude all rehabilitation hospital providers' utilization was to exclude all cases in CHARS associated with a hospital number with a fourth character "R", which is CHARS's nomenclature for classifying a hospital rehabilitation unit, as well as St. Luke's Rehabilitation lnstitute's hospital ID ("157"). For reference, we did state in our application:

> *'To correct for this reallocation of days from DRGs 945 and 946, beginning in Q4 2015, we have excluded all patient day figures, regardless of DRG, from all Washington State rehabilitation units and St. Luke's Rehabilitation Institute, from the acute care bed need model.'*

Our analytic methodology described above is a straightforward operationalization of what was said in our application based on readily-available information available in the CHARS File Layout and Data Dictionary (Excel) files provided on the Department's webpage for CHARS. For the purposes of the need model, note that in addition to removing all rehabilitation hospital providers' utilization, we also removed all cases in CHARS associated with DRGs 945 and 946 regardless of whether they were provided in a designated hospital rehabilitation unit or St. Luke's Rehabilitation Institute. Therefore, all rehabilitation patient days were excluded from our analysis of Planning Area acute patient days and other sections of the need analysis.

Regarding CMC's concern over Tables 15 and 17, we have corrected the footers to those tables, as discussed above. These tables did properly exclude all rehabilitation patient days; there was no "overstatement" of Planning Area patient days.

- ***Capital Medical Center's letter states: "On Page 29, PSPH indicates that it used both OFM and Claritas population data. PSPH reiterated this fact on page 34. PSPH does not explain how or why it would use two different data sources (see footnote one to Table 18). This is of significant concern as it could inflate bed need."***

CMC's comment indicates a lack of understanding about the complete numeric need methodology for acute care beds. It also demonstrates CMC staff does not understand Planning Area definitions.

The numeric need methodology relies on population estimates at the planning area, health service area, and statewide level. PSPH's planning area is the SWWA 10 planning area, which is defined at the zip code level - it is not Thurston County. The Department requires an applicant to use Claritas population data for analysis of zip codes. But again, the planning area is not the only unit of analysis within the need model. For analysis of statewide population data, the model relies on Washington State's Office of Financial Management (OFM) estimates and projections. This is the standard approach to modeling acute care need. For instance, in the Department's May 23, 2017 evaluation of Providence Regional Medical Center Everett's acute care application, the Department specifically mentions its use of both Claritas and OFM data sources used in the population estimates for the numeric need methodology:

> *'Projected Population - Based on Claritas 2016 for Central Snohomish; Office of Financial Management medium series data for statewide. For each data source, historical and projected intercensal and postcensal estimates were calculated. '*

Therefore, there is no contradiction or inconsistency from using multiple population data sources, as required, to meet the specific population data requirements of the need methodology. Here, too, CMC is wrong."

Providence Health & Services-Washington also provided the following rebuttal to comments focusing on the topic of new beds vs existing licensed beds and the suggested conditions submitted by Capital Medical Center. [source: Providence rebuttal comments, pp8-10]

*"**Capital Medical Center's letter states: "Any new acute care beds should be transferred from PSPH's 'banked' licensed capacity and not be NEW beds. PSPH should not be allowed to secure new beds while its license includes 50 phantom beds"***

CMC's suggestion that the 50 licensed chemical dependency beds should be converted to acute care beds is wrong and misinformed.

In Table 5 of the Application, PSPH has identified correctly its current number of licensed beds by type, which includes 50 beds designated for Chemical Dependency/Alcohol Treatment. The 50 beds have been included in the hospital acute care license for PSPH since 2009. The beds have remained continuously licensed, with PSPH renewing its hospital acute care license every three years and paying the required licensing fees on an annual basis.

As background, PSPH received CN #1394 in 2009, which approved the consolidation of 50 acute care beds that were previously licensed as part of a separate chemical dependency hospital into the PSPH acute care hospital license.6 When the CN was approved, the PSPH licensed acute care bed capacity increased from 340 beds to 390 beds. 7 CN #1394 was approved with one condition: "These 50 beds are limited to the provision of chemical dependent services as described in the application.

To be used for any other type of acute care service, prior CN approval is required." At all times, PSPH has fulfilled the condition.

In 2014, PSPH made a decision to close its inpatient residential treatment program at its Chemical Dependency Center ("CDC") on College Street in Lacey. However, PSPH has continued to provide outpatient chemical dependency services at the CDC, as well as inpatient chemical dependency services at its main campus. Following the closure of the inpatient residential treatment program at the CDC, PSPH still met the licensing requirements for the physical plant and access to moveable equipment.

Every three years, PSPH renews its hospital acute care license, with the current license not scheduled to expire until December 31, 2019. In addition, on an annual basis, PSPH continues to pay the licensing fees to maintain the hospital licensure for these beds.8 Across the State of Washington, many hospitals - like PSPH - pay licensing fees to maintain authorized bed capacity for a greater number of beds than those that are 24-hour assigned and set-up (acute care). The fees allow hospitals to maintain the licensure of the beds, which provides flexibility to grow or reduce services based on market needs and demand for services.

Finally, in order to preserve all options for addressing current and future bed needs, PSPH has continuously licensed and maintained the 50 chemical dependency / alcohol treatment beds within its hospital acute care license. By doing so, PSPH has maintained an important level of flexibility with its beds and could elect at some point to re-open an inpatient residential treatment center.

Capital Medical Center's letter states: "the Department should impose, monitor, and enforce conditions that require PSPH to maintain the current scope of services offered at PSPH to ensure that PSPH continues to provide such services within the Planning Area for a period of at least 10 years," and that "the Department should impose, monitor, and enforce conditions that require PSPH, on a long-term basis, to continue participation in the Medicare and Medicaid programs, and to care for Medicare and Medicaid patients at a rate that is consistent with the payer mix in the Planning Area."

CMC's requested conditions are irrelevant, inappropriate, and disingenuous: the two proposed conditions are neither necessary nor justified. With respect to the types of services PSPH is currently providing and intends to provide in the future, PSPH clearly states in its Application that the only service that is planned for elimination is the hydrotherapy pool in the Emilie Gamelin Pavilion. All other services will be maintained, with the only impact to services being the volume of services provided (not the type of services), with the expectation that the volume of services will increase as beds are added to the community. PSPH is not proposing any changes in the types of services offered. Thus, CMC's proposed condition is irrelevant, unnecessary, and inappropriate.

With respect to CMC's proposed Medicare and Medicaid condition, it is clearly noted in the Application that PSPH anticipates that it will maintain the same payer mix as it reported in 2017. Moreover, PSPH's deep and enduring commitment to the poor and vulnerable in our community will not change, and is not at issue. As stated in the Application, the PSPH and Providence Centralia Hospital combined 3-year charity care figure is 1.32% of total patient revenue, slightly higher than the regional 3-year average of 1.3%. In comparison, CMC provided just 0.27% in charity care over the same period.13 Further, in 2017, PSPH provided $36.1 million in community benefit, a further tangible and impactful demonstration of our commitment to the community, especially the poor and vulnerable. Providence is committed to serving its community and the larger region, as it has since

1887. The Application and the screening responses do not contain any suggestion that PSPH's payer mix, or its commitment to providing care to Medicare and Medicaid patients and other low-income, undeserved, or disadvantaged individuals and groups will change. Thus, again, CMC's proposed condition is irrelevant, unnecessary, and inappropriate. The Department should reject CMC's requests."

Department Evaluation

Below are the assumptions and factors used in the department's acute care bed need methodology. The methodology is included in this evaluation as Appendix A.

- Hospital Planning Area – Thurston County
- CHARS Data – Historical years 2008 through 2017
- Projected Population –Based on Office of Financial Management medium series data for Thurston County and statewide. Historical and projected intercensal and postcensal estimates were calculated.
- Excluded MDCs[12] and DRGs[13]
  - MDC 19 – patients, patient days, and DRGs for psychiatric
  - DRG385-391/789-795 – patients, patient days, and DRGs for neonates
  - DRG 462/945-946 – patients, patient days, and DRGs for rehabilitation
- Weighted Occupancy – Calculated consistent with the State Health Plan as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. The department's methodology calculated a weighted occupancy of 68.64%.
- Existing Acute Care Bed Capacity – Two acute care hospitals operates in the Thurston County planning area.

Below is a summary of the steps in the department's numeric need methodology.

Steps 1 through 4 develop trend information on historical hospital utilization.

In steps 1 through 4, the department focused on historical data for years 2008 through 2017 to determine the statewide and health service area [HSA] use trends for acute care services. Thurston County is within HSA #2. The department computed a trend line for statewide and HSA utilization of inpatient acute care services. The HSA and state use trend line projected an increase in acute care use: 0.4278 and 0.8595, respectively. The SHP requires use of either the statewide or HSA trend line "*whichever has the slowest change."* The HSA trend line, with the slighter increase, showed the slowest change and is considered more statistically reliable. The department applied the data derived from those calculations to the projection years in the following steps.

Steps 5 through 9 calculate baseline, non-psychiatric bed need forecasts.

For these steps, the department calculates base-year use rates, broken down by population ages 0-64 and ages 65 and older, determining the rates at which different populations receive inpatient non-psychiatric care. This includes calculating in-migration to Thurston County (for Washington and out-of-state residents) and out-migration (to other Washington State hospitals and Oregon hospitals). This results in a use rate for the hospital in Thurston County. The department then multiplies this use rate by the slope acquired in Step 4 to project how this use rate may change during the projection period.

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

Table 4 below shows the use rates, broken down by age group that Providence and the department applied to the projected population for the projection year:

Table 4
Department Numeric Need Methodology
Use Rates by Age Cohort

	0-64	65+
Department	217.31/1,000 population	994.13/1,000 population
Providence	213.62/1,000 population	1,009.30/1,000 population

When the use rates are applied to the projected population, the result is the projected number of patient days for the planning area. The numeric methodology is designed to project bed need in a specified "target year." It is the practice of the department to evaluate need for a given project through at least seven years from the last full year of available CHARS data. Using 2017 CHARS data, seven years is 2024; ten years is 2027.

Steps 10 through 12 are intended to determine the total baseline hospital bed need forecasts, including need for short-stay psychiatric services.

In step 10, the department projected the number of acute care beds needed in the planning area, subtracted the existing capacity, resulting in a net need for acute care beds.

The department and Providence largely agreed on the bed count for Thurston County, with the exception of three beds at Capital Medical Center (CMC). Though CMC has historically been licensed for 110 beds, the last two license updates and the 2017 end of year financial reports submitted to the department indicate that only 107 beds are licensed. Therefore, the department counts CMC as 107 rather than 110.

The year-end set up beds for CMC is shown below:

12	# of Beds Available	Beds	# of Beds Available	Beds
	Intensive Care	10	Skilled Nursing	0
	Semi -Intensive Care	20	Swing Beds	0
	Acute - Medical / Surg	55	Chemical Dependenc	0
	Acute - Pediatrics	0	Other (Excl Nursery)	0
	Acute - Obstetrical	22	Total Beds Available	107
	Acute - Rehabilitation	0	(Excluding Nursery)	
	Psychiatric	0	Total Beds Licensed	107
			Nursery - Bassinets	22

Source: CMC 2017 year-end financial report

There is one other notable discrepancy between the department's methodology and Providence's methodology. Providence relied on a planning area defined as Hospital Planning Area 24 – SWWA 10. Providence provided the definition of this planning area which only includes Thurston County ZIP codes. A simpler way of looking at the planning for this region is simply to use Thurston County as a whole. When possible, the department uses a single population data source rather than multiple. The statewide acute care bed methodology was developed using population data exclusively from

the Office of Financial Management (OFM). OFM produces population estimates at the county level, but not at the ZIP code level. The department's use of OFM across the entire methodology increases the consistency of the projections. The population using Claritas 2017 data and OFM 2017 data for the base and projection years are shown below.

Table 5
Population Source Difference

	OFM	Claritas	Difference
2017	278,179	266,640	11,539
2024	312,072	290,748	21,324

The complete reasons for the differences between the OFM and Claritas projections are not known, however it should be noted that Providence omitted one ZIP code in Thurston County that does have population associated with it – 98579. When this ZIP code is included, the populations for 2017 and 2024 are 280,602 and 305,952, respectively. This is much closer to the OFM projections. Another source for the discrepancy could include different expectations for in and out migration, as well as the fact that Claritas projects at the ZIP code level whereas OFM captures the entire geography of the county. In any case, the difference in population between data sources, while present, does not impact whether or not there is numeric need in Thurston County.

Table 6 below shows the department's methodology calculations for years 2018 through 2024. This table also shows the impact to the planning area as the beds are added by phase.

Table 6
Department of Health Methodology
Projection Years 2017 through 2023

	2018	2019	2020	2021	2022	2023	2024
Gross Number of Beds Needed	431	442	465	476	487	498	509
Minus Existing Capacity	392	392	392	392	392	392	392
Ned Bed Need/(Surplus)	**39**	**50**	**73**	**84**	**95**	**106**	**117**
Bed Additions	0	4	0	48	0	0	0
Net Bed Need/(Surplus) with project[14]	**39**	**45**	**69**	**6**	**16**	**27**	**37**

Step 11 projects need for short-stay psychiatric beds. Step 12 is the adjustment phase where any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the application of the methodology to over or understate the need for acute care beds. This application did not request short-stay psychiatric beds, nor are there any circumstances known to the department (or suggested by the applicant) to suggest that adjustments are necessary to any prior steps. Therefore, neither Providence nor the department completed steps 11 or 12. Neither of these steps will be discussed any further.

The primary differences between the result of the department's methodology and the methodology provided by Providence are the source material and, to a lesser extent, the count of beds in the planning area. Ultimately, both models show need in excess of the request made by Providence for St Peter Hospital.

[14] The occupancy standard shifts as a result of this project, which is why these numbers do not sum.

Based on the department's need methodology alone, need for additional acute care beds in Thurston County is demonstrated.

The public comment submitted by CMC suggested that the data in the tables within the application is not replicable and therefore not reliable. In rebuttal, Providence clarified which data points were included or excluded in each of the tables. For the purposes of numeric need, however, the department evaluated the numeric need methodology in Exhibit 15 – the tables referenced by Providence and CMC are summaries sourced from this exhibit.

In addition to the numeric need methodology, the department must determine whether other services or facilities of the type proposed are not or will not be sufficiently available and accessible to meet that need.

It should be noted that CMC did not challenge whether there was need in the planning area, nor did they state that other healthcare resources in the planning area would be sufficient to meet that need.

CMC identified that Providence has 50 licensed beds which are currently unused. As noted under the Project Description section of this evaluation, Providence does have authorization to operate 50 beds at the College Street location. These beds are exclusively dedicated to alcohol and chemical dependency services. In rebuttal Providence identified that these beds have been continuously licensed under the PSPH license. Because these beds are licensed at a different site and are exclusively dedicated to alcohol and chemical dependency services, these beds are not considered suitable for exchange.

Absent documentation that there is insufficient numeric need in the planning area or that the existing healthcare system could support the upcoming numeric need, the department concludes that the planning area does not have sufficient beds available and accessible to the community. **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.

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

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

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

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

Charity care shows a willingness of a provider to provide services to individuals who do not have private insurance, do not qualify for Medicare, do not qualify for Medicaid, or are under insured.[15] With the passage of the Affordable Care Act in March 2010, the amount of charity care is expected to decrease, but not disappear.

Providence Health & Services - Washington

Providence provided copies of the following policies currently in used at SPH. [source: Application Exhibit 18 and June 18, 2018, screening response, Exhibits 31 and 32]

- Admission/Patient Rights and Responsibilities Policy-Approved June 2017
- Non-Discrimination Policy – Updated April 2017
- Charity Care Policy-Updated January 2016

SPH is currently Medicare and Medicaid certified. Providence provided its current source of revenues by payer for PSPH and stated that the additional 52 beds would not change the payer mix. [source: Application, p16 and p5] Current and projected hospital-wide payer mix is shown below.

Revenue Source	Current and Projected
Medicare	55.0%
Medicaid	16.5%
Commercial	24.0%
Other (includes other Government, L & I and self-pay)	4.5%
Total	**100.0%**

In addition to the policies and payer mix information, Providence provided the following information related to uncompensated care provided by PSPH specifically. [source: Application, p38]

"PSPH is part of Providence, whose mission is to provide compassionate care to all people in need. This includes a special concern for those who are poor and vulnerable. With more than 130 years of history providing services to those in need, PSPH turns no one away.

Given our Mission to care for those who are poor and vulnerable, PSPH cares for large populations of charity care and Medicaid patients. In 2017, PSPH offered $5.7 million in free and discounted care for those in need. In addition to providing a high level of free and discounted medical care, PSPH provided more than an additional $30 million in unfunded cost of government-sponsored medical care; community health, grants and donations; education and research programs and subsidized services. In total, for 2017, PSPH provided more than $36 million in community benefit.

With Medicaid expansion and health insurance exchanges, PSPH's charity care spending reflects the success of more people gaining health insurance coverage. We are using community benefit investments to create healthier communities beyond just the need for free and discounted care. Not only does this improve access to care, but, through programs and donations, PSPH's community benefit programs connect families with preventive care to keep them healthy, fill gaps in community services, and provide opportunities that bring hope in difficult times.

The breakdown of PSPH's community benefit contributions in 2017 is provided in Table 21.

[15] WAC 246-453-010(4)

Applicant's Table 21 Recreated PSPH Community Benefit, 2017

Service	***Amount***
Unfunded portion of Government-sponsored medical care	*$21.2 million*
Fee and Discounted Medical Care	*$5.7 million*
Community health, grants and donations	*$0.3 million*
Education and research programs	*$5.4 million*
Subsidized services	*$3.5 million*
Total	***$36.1 million***

Public Comment
None

Rebuttal Comment
None

Department Evaluation

Providence has been providing healthcare services to the residents of Washington State through its hospitals, nursing homes, assisted living facilities, ambulatory surgical facilities (ASFs), in-home service agencies, and medical clinics for many years. Healthcare services are stated to be available to low-income, racial and ethnic minorities, handicapped and other underserved groups. [source: Providence website]

The Admission Policy describes the process PSPH uses to admit a patient and outlines rights and responsibilities for both PSPH and the patient. Included with the Admission Policy is the Patient Rights and Responsibilities Policy. This policy includes the following non-discrimination language. *"Consistent with our Mission and core values and with applicable state and federal law, Providence respects and upholds the rights and responsibilities of all individuals receiving care and services at Providence St. Peter Hospital. Patients are made aware of their rights and responsibilities prior to receiving hospital care or services."*

The Non-Discrimination Policy includes the following language.
"Consistent with Providence's Mission and Core Values, it is the policy of Providence to not discriminate against, exclude, or treat differently any individuals accessing any Providence Health Program or Activity on any basis prohibited by local, state or federal laws, including but not limited to on the basis of race, color, national origin, age, Disability, Handicap, or sex, as those terms are defined under federal law and rules. Where applicable, federal statutory protections for religious freedom and conscience are applied. It is also Providence's policy to provide free aids and language assistance services to individuals with a Disability, Handicap, or Limited English Proficiency who are accessing a Providence Health Programs or Activity. Such services may include providing Qualified Bilingual/Multilingual Staff, Qualified Interpreters, and Qualified Translators free of charge."

PSPH currently provides services to both Medicare and Medicaid patients. Providence does not anticipate any changes in Medicare or Medicaid percentages resulting in approval of this project.

PSPH's current Medicare revenues are approximately 55% of total revenues and Medicaid revenues are currently 16%. Commercial and other revenues are expected to remain largely consistent at approximately 24% and 5%, respectively. Financial data provided in the application also shows both Medicare and Medicaid revenues.

The Financial Assistance Policy (Charity Care) provided in the application has been reviewed and approved by the Department of Health's Hospital Financial/Charity Care Program (HFCCP). The policy outlines the process one would use to obtain financial assistance or charity care. The policy was approved in January 2016. This is the same policy posted to the department's website for PSPH. The pro forma financial documents provided in the application include a charity care 'line item' as a deduction of revenue

Charity Care Percentage Requirement

For charity care reporting purposes, Washington State is divided into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Providence proposes to add 52 acute care beds to PSPH located in Thurston County within the Southwest Region. Currently there are 14 hospitals operating within the region. Of the 14 hospitals, all reported charity care data for the years reviewed.

Table 7 below compares the three-year historical average of charity care provided by the hospitals currently operating in the Southwest Region and PSPH's historical charity care percentages for years 2015-2017. The table also compares the projected percentage of charity care. [source: Screening Response Exhibit 29 and HFCCP 2015-2017 charity care summaries]

Table 7
Charity Care Percentage Comparisons

	Percentage of Total Revenue	Percentage of Adjusted Revenue
Southwest Region Historical 3-Year Average	1.03%	3.27%
Thurston County	0.90%	2.52%
PSPH Historical 3-Year Average	1.07%	3.67%
PSPH Center Projected Average	1.05%	--

As noted in Table 5 above, the three-year historical average shows PSPH has been providing charity care above both the total and adjusted regional averages. For this project, Providence projects that PSPH would provide charity care at approximately the regional average for total revenues and above the average for adjusted revenues. At the time PSPH submitted their application, 2017 data was not yet available; and their projection exceeded the regional average at that time. PSPH provided charity care at 1.20% of total revenues in 2017.

Providence has been providing health care services at PSPH for many years. Charity care is health care provided through the hospital at no cost or reduced cost to low income patients. Charity care is a state-mandated and partially state-funded program that allows uninsured or underinsured people to receive inpatient and outpatient care at a reduced cost. Only people who meet certain income and asset criteria are eligible to receive charity care. Information provided in the application indicates that Providence offers a variety of community outreach programs throughout the areas they serve. Outreach programs help offset costs for healthcare services in the communities, but it is not charity care and cannot be counted toward the percentage of charity care provided by a hospital under Certificate of Need rules.

The focus of this sub-criterion is charity care percentages specific to PSPH. In past hospital CN applications, the department has been attaching a charity care condition to the approvals, based, in

part, on the fluctuation of charity care percentages since the passage of the Affordable Care Act in March 2010.

If this project is approved, the department concludes that Providence must agree to the charity care condition stated below.

> Providence St Peter Hospital will provide charity care in compliance with its charity care policies reviewed and approved by the Department of Health, or any subsequent policies reviewed and approved by the Department of Health. Providence St Peter Hospital will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Southwest Region. Currently, this amount is 1.03% gross revenue and 3.27% of adjusted revenue. Providence St Peter Hospital will maintain records of charity care applications received and the dollar amount of charity care discounts granted. The department requires these records to be available upon request.

Providence must also agree to a condition requiring continued participation in the Medicare and Medicaid programs. Based on the information provided in the application and with Providence's agreement to the conditions, the department concludes t**his sub-criterion is met.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providence Health & Services - Washington

Providence relied on a proprietary study supplied by KSA, a management and strategy consulting firm. Providence identified the following data sources used by KSA to project their internal volumes, summarized below. [source: Screening Response pp2-3]

- *US Census Bureau population and demographic data*
- *CHARS data*
- *Nielsen data, a global measurement and data analytics company*
- *Truven Health Analytics data, a health care data and analytics company*
- *Providence internal data and internal stakeholder reviews*
- *Proprietary KSA information used to evaluate health care reform and payor trends, future market demand drivers, and service line trends in the health care industry and planning area.*

The result of KSA's study supplied the following assumptions for Providence's assumptions. [source: Application pp42-43]

- *The 2018 projected figures are driven by PSPH's rolling forecast.*
- *The 2019 figures are driven by PSPH's 2019 budget.*

- *Total discharges and total patient days for 2019 and 2020 increase 1.3% per each year from 2018 and, for 2021 increase 0.64%. After 2021, the annual rates increase between 1.04% and 1.13% annually. These annual rates of increase are based on a study by Kurt Salmon & Associates performed in 2017.*
- *Medical/surgical discharges and medical/surgical patient days for 2019 and 2020 increase 1.3% per each year from 2018 and, for 2021, increase 0.64%. After 2021, the annual rates increase by ~1.0% thereafter. These annual rates of increase are based on a study by Kurt Salmon & Associates performed in 2017.*
- *Length of stay increases slightly over 2018 to 2019 (by 0.018%) and remains around 0.05% thereafter.*
- *Occupancy rate increases to 83.5% in 2019 and then falls to 72.5% in 2020 with steady increases though 2026, when occupancy reaches 77.5%.*

Using the assumptions stated above, Providence projected the number of discharges, patient days, average daily census, and occupancy with the 52 bed increase. The projections shown in Table 8 below beginning with calendar year 2019. [source: Screening, Exhibit 29]

Table 8
Utilization Projections
Med/Surg Only

Year	Discharges	Patient Days	ADC	No. of Beds	Occupancy
2019	17,816	88,045	241.22	290	82.4%
2020	18,047	89,189	244.35	290	83.5%
2021	18,220	90,085	246.81	338	72.5%
2022	18,417	91,140	249.70	338	73.2%
2023	18,615	92,196	252.59	338	74.1%

The assumptions Providence used to project revenue, expenses, and net income for the projection years are below. [source: Application pp51-53]

- *The gross and net revenues are based on actual inpatient, observation, and extended outpatient cases (excluding Rehab, Family Birth Center, and Psych).*
- *Incremental revenues were calculated on a per case basis, based on actual reimbursement from 2017 cases, inpatient, observation, and extended outpatient cases (excluding Rehab, Family Birth Center, and Psych).*
- *Payer mix for both cases and gross revenues was held constant at 2017 rates.*
- *Deductions from revenues were calculated based on actuals.*
- *Charity care is assumed constant at 1.02% of gross revenues, slightly higher than the PSPH figure for 2016. PSPH reported charity care at 0.95% of gross revenue in 2016 and, for conservatism, we modeled our forecast at 1.02% despite experiencing declining charity care rates over the past 3 years.[1] Please see Table 22 for charity care statistics.*
- *FTEs (by account classification, by year), Salaries & Wages, and Benefits were modeled for forecast incremental case volumes based on actual inpatient, observation, and extended outpatient cases (excluding Rehab, Family Birth Center, and Psych). It is assumed an FTE works 2,080 hours per year.*
- *Fixed staffing expenses were added for the two inpatient units in the Emilie Gamelin Pavilion when it opens in 2021. This includes: two RN minimum staffing, 24/7 Health Unit*

Coordinator, and two managers. This fixed staffing model is carried forward for the units until volume growth warrants additional variable staffing costs.

- *Non-productive hours are calculated by multiplying productive hours by 1.10; the non-productive factor is thus 10% of productive hours, which is consistent with actual run rate.*
- *Benefits as a percentage of wages and salaries are estimated at 9.5%. Retirement, health care, and workers comp are recorded at the system level (not locally) so they are excluded from the benefit percentage.*
- *Expenses were modeled for the forecast incremental case volumes based on actual inpatient, observation, and extended outpatient cases (excluding Rehab, Family Birth Center, and Psych).*
    - *Supplies were calculated on a per case basis as a percentage of net revenues from 2017 actuals.*
    - *Purchased services were calculated on a per case basis based on 2017 actuals.*
    - *Pharmacy and drugs were calculated on a per case basis based on net revenues from 2017 actuals.*
- *Annual depreciation expenses included approximately $34.485 million project costs as well as a $5 million annual routine capital expenditure depreciation amount.*
- *Washington State sales tax is set at 7.9%*

Based on the assumptions above, Providence provided the following revenue and expense statement for PSPH in their screening response. The statement showed years 2014 through 2026. Projected years 2019 through 2022 are shown below. [source: screening response, Exhibit 29]

Table 9
Revenues and Expenses
Years 2019 through 2023

	2019	2020	2021	2022	2023
Net Revenue	$527,361,812	$546,262,975	$567,664,765	$591,321,266	$616,164,221
Total Expenses	$384,070,082	$402,991,594	$425,885,228	$449,402,152	$473,350,572
Net Profit/(Loss)	**$143,291,730**	**$143,271,381**	**$141,779,537**	**$141,919,114**	**$142,813,649**

The 'Net Revenue' line item is gross inpatient and outpatient hospital revenue, plus any non-operating revenue. The 'Total Expenses' line item includes all expenses related to hospital operations, including all staff salaries/wages.

Public Comment

During the review of this project, Capital Medical Center provided comments expressing concerns related to this sub-criterion. [source: August 21, 2018, public comments, pp5-7] The comments are restated below.

"Providence's pro forma assumptions are inconsistent with its actual operations.
Providence's lack of consistency and the lack of explanation of its financial assumptions, coupled with the likely overstatement of volume mean that the Department does not have the information it needs to determine the financial feasibility of this project.

While the revenues in PSPH's pro formas largely align with their actual 2017 year-end reports provided to the Department, the pro formas include a ***significant under reporting of actual expenses in comparison to the 2017 year-end reports****.3 In 2017, PSPH reported to the Department an*

operating loss of nearly $10 million, yet the statement of revenue and expenses included as Exhibit 29 of its screening response shows a positive operating income of $134.6 million in the very same year (2017). Further, the pro formas for this Application, show a positive operating income in each of the projection years of at least $141 million. However, PSPH apparently excluded any consideration of system or corporate overhead from its Application, while showing it in its year end filings to the Department in line item "other direct expenses". Including allocation of System overhead is commonplace in CN applications (see for example, the Trios hospital CN application) and is essential for the Department to effectively evaluate financial feasibility.

Table 1 provides a comparison of the financials from the Application and the Department's year end reports.

Capital Medical Center's Recreated Table 1
Comparison of Providence St. Peter Hospital Historical Financials,
Screening Response, and Department of Health Year End Reports, 2015-2017

	2015 DOH Year End Financials	PSPH Screening Response (Exhibit 29)-2015	Difference	2016 DOH Year End Financials	PSPH Screening Response (Exhibit 29)-2016	Difference	2017 DOH Year End Financials	PSPH Screening Response (Exhibit 29)-2017	Difference
Total Operating Revenue	467,007,007	467,007,007	0	470,428,558	470,428,558	0	493,097,928	493,125,350	27,422
Total Operating Expenses	442,675,619	324,308,368	118,367,251	462,193,643	330,431,449	131,762,194	502,903,845	358,555,473	44,348,372
Operating Income (Loss)	24,331,388	142,698,639	118,367,251	8,234,915	139,997,110	131,762,195	(9,805,917)	134,569,877	144,375,794

Source: Department of Health Year Reports for PSPH, 2015-2017 and PSPH Screening Response, Exhibit 29

Among the Providence system, the PSPH CN financial variance from its DOH Year End reports is unique. For example, Providence Regional Medical Center-Everett's the historical financial information provided in its 2016 acute bed expansion application matched, almost exactly, its Department Year End Reports.

The adjustment/exclusion of Providence Health & Services corporate overhead is a serious omission with more than a ***$100,000,000 impact*** *on the financial feasibility of this project. The services provided by the parent organization are substantial, and without them PSPH would be required to purchase them from another source or provide them internally. PSPH has therefore understated operating expenses and drastically overstated its income.*

Clearly, the financials submitted with the Application, are not consistent with how PSPH reports to the Department of Health in its year-end reports and the Department cannot rely on the financial information submitted with this Application. Based on the lack of information provided by PSPH, this project is not viable and should be denied for failing to meet the financial feasibility requirements of WAC 246-310-220.

PSPH's Application fails to satisfy the Department requirements for a CN. The removal of the Corporate overhead allocation is deeply concerning, because it paints a picture of a financially successful organization that deserves additional beds to service the community. On the contrary, the financial statements provided to the Department of Health in 2017 show an operating loss of $10 million. CMC requests denial of this CN."

Rebuttal Comment

In response to the public comments above, Providence Health & Services-Washington provided the following rebuttal comments. [source: Providence rebuttal comments, pp17-19]

"We have stated above that our historical utilization figures were correct. On pages 41-43 of the PSPH Application, and included in Tables 25 and 26 of the Application, we explained in detail the forecast methodology, including all assumptions, which were used "Without the Project" and "With the Project", respectively. We will not repeat that discussion here. These forecasts are reasonable and do correctly project expected performance with the project.

- ***Capital Medical Center's letter states: "Providence's proforma assumptions are inconsistent with its actual operations" and "the proformas include a significant under reporting of actual expenses in comparison to the 2017 year-end reports."***

While preparing the pro forma forecast for the Application, PSPH did not fully account for some indirect, overhead expenses related to shared services from the system level. In developing the pro forma, PSPH modeled the operating performance of the hospital. This included all operating expenses (i .e. expenses that are controlled at the hospital level and reflected in the hospital budget). In that regard, some shared services, managed under a different budget, were not included. This is a reasonable approach to evaluate project impacts on hospital-specific financial performance.

In the interest of transparency, and to respond to CMC's concern, we have revised our financial statements with and without the project to include indirect allocated costs for shared services. Such allocated costs are included in the line item "Other Expenses" in our revised financial statements. This inclusion does not affect financial performance, specifically our ability to demonstrate the project's conformance to the Financial Feasibility Criterion (1) ("the immediate and long-range capital and operating costs of the project can be met'). Please see revised Exhibits 9 and 10. We have included all tables in these Exhibits, even those where there was no impact from adding cost allocations. Exhibit 9 includes proforma and cost center statements of revenue and expenses with the project and revised Exhibit 10 includes proforma and cost center statements of revenue and expenses without the project.

In terms of the methodology used to project Other Expenses, where system allocated costs are included, the following steps and assumptions have been used:

1. *Budget 2018 system allocations at the functional level (HR, Finance, IT, Revenue Cycle, etc.) were identified.*
2. *Those functional areas that would grow along with the volume growth were then identified. For example, system executives/finance/etc. would not be expected to increase with PSPH volumes, but IT/Revenue Cycle/Human Resources/etc. would.*
3. *Those functional areas expected to increase were tied to FTEs, NSR ("net system revenue"), or Operating Expense, as recommended by System finance staff, and were increased.*
4. *For those functional areas expected to increase in cost, there was further stratification of those areas expected to grow at the same percentage rate as volume, such as benefit costs, or at a rate of increase that would be 50% of volume, such as IT or HR, where there is overhead and more fixed staffing. This approach was used to increase these components of the allocations over the forecast, with and without the project, consistent with volume growth within the financial models, with and without the project.*

In addition, because the proformas have been updated, we have revised Tables 7 and 8 from the Application. Table 7 and Table 8 are the only tables in the Application impacted by this update.

Applicant's Tables

Revised Table 7. PSPH Facility-Wide Operating Expenses - With Project

Year	Total Operating Expense (000)
2019	$504,259
2020	$509,241
2021	$517,453
2022	$524,568
2023	$530,897
2024	$537,268

Source: PSPH

Revised Table 8. PSPH Facility-Wide Operating Expenses - Without Project

Year	Total Operating Expense (000)
2019	$504,259
2020	$509,241
2021	$512,825
2022	$515,009
2023	$517,236
2024	$519,507

Source: PSPH

Other Revisions to Financial Models

In review of the financial models, it was determined that certain elements of revenues and expenses, on a per statistic basis, had been inflated over the forecast. Such inflation has been completely removed. Please see revised Exhibits 9 and 10.

Other Expenses, where allocated costs are included, also includes a very small amount (roughly 5% of Other Expenses) of miscellaneous other expenses, defined to include expenses where another specific account classification does not exist. This might include, for example, service recovery expenses, such as a case where someone loses a hearing aid in the hospital and the cost for its replacement by PSPH staff is entered into Other Expense, or miscodings may be included in Other Expense. As noted above, such costs are a very small portion of Other Expenses; the majority of Other Expenses are system allocated expenses."

Department Evaluation

To evaluate this sub-criterion, the department first reviewed the assumptions used by Providence to determine the projected number of admissions, patient days, and occupancy of the hospital with the

additional 52 beds. Since PSPH would continue to operate during the bed addition project, Providence provided its patient days and discharge projections beginning with year 2018 through year 2026. When compared to historical data [years 2014 through 2017] obtained from the Department of Health's Hospital and Patient Data Systems' Hospital Census and Charges Report, the volume projections are reasonable. The department can reasonably substantiate Providence's volume assumptions. After reviewing Providence's admission and patient day assumptions for PSPH, the department concludes they are reasonable.

Providence based its revenue and expenses for PSPH on the assumptions referenced above. In their comments, Capital Medical Center correctly pointed out that Providence's historical financial information and projections appeared to be inconsistent with actual figures provided to the Department of Health in their year-end financial reports. These reports are submitted annually and are publically available on the Washington State Department of Health website.

Providence provided rebuttal to CMC's public comments. Rebuttal is an opportunity for the applicant or affected person to refute comments made during that phase of the review but not make wholesale changes in the reviewable materials to correct errors or omissions. The department's letter to Providence outlining the rebuttal process informs the applicant and affected persons that "*rebuttal comments are limited to the documents enclosed."* The "documents enclosed" included only CMC's comments on the project.

The expected process for rebuttal is for an applicant to direct the department to where information can be found within the application or screening responses. In this case, the correct information did not exist in either of those documents. Providence acknowledged the deficiencies. Providence did not they refute the accuracy of CMC's statements related to this specific issue. Instead Providence submitted new, significantly revised pro forma financial statements. Changes included:

- Removal of inflation from the financial projections
- changes in
    - "other expenses" to include corporate allocations of over $100 million
    - gross revenue,
    - deductions,
    - charity care, and
    - numerous expenses.

It was unclear whether the updated figures provided in rebuttal are related to the removal of inflation or some other adjustments. Providence volunteered this information unprompted. Capital Medical Center did not identify these areas of concern in their public comment, with the exception of corporate allocations.

The revised financial projections provided in rebuttal go beyond the scope of rebuttal – rather than pointing out data in the application or screening response to correct statements made during public comment, the information submitted was, in fact, a supplement to the screening response submitted in June 2018. Providence had the opportunity to request that this updated information be considered an amendment to the application. A fee would be required in this case. An amendment is required whenever significant changes are made to an application outside of a direct response to screening.[16] Applicants can amend the application up until the end of the public comment period, which includes

[16] WAC 246-310-100

rebuttal.[17][18] An amendment to a pending CN application effectively "restarts" the review, with new opportunity to screen the application and a full new public comment and rebuttal period.

RCW 70.38.115(6) directs the program to specify what information is required for certificate of need applications. Consistent with this, CN applications specifically direct the applicant to exclude inflation from financial models. If Providence was following the application guidelines within the application, inflation would not have been included.

All assumptions used to prepare the pro forma financial statements are to be disclosed within the application. Providence did not include inflation in their list of financial assumptions in the application. The new financial statements from rebuttal don't disclose the complete assumptions that were used to prepare them.

The pro forma revenue and expense statements provided by Providence would assist the department in evaluating the financial viability of the proposed project. However, the revision to the pro forma financial revenue and expense statements could not be considered without significant deviation from historical practice. Certificate of Need is a public process – the department cannot rely on new information submitted in rebuttal, because the community and affected persons would not be afforded the opportunity to comment.

Even if the department had the ability to consider the new financial information submitted by Providence in rebuttal without deviating from historical practice significantly, the department still did not have complete financial assumptions to determine the project's financial feasibility. Had Providence timely submitted an amendment to the application (including the revised financial assumptions from rebuttal), the department would have had several screening questions on the financial assumptions. Following beginning of review, interested and affected persons would be afforded an opportunity to comment on these revisions.

Some examples of the revisions in rebuttal are highlighted below. For reader ease, one year – 2022 – has been highlighted. The discrepancies in this year are representative of the discrepancies throughout projection period.

Table 10
Year 2022 Pro Forma Discrepancies

	Total Gross Revenues	**Salaries and Wages**	**"Other" Expenses**
Screening Response	$2,528,660,766	$235,882,447	$8,748,881
Rebuttal	$2,181,875,335	$191,015,650	$156,209,117
Difference	**$346,785,431**	**$44,866,797**	**($147,460,236)**

As shown above, these differences are significant, in the magnitude of hundreds of millions of dollars. Though some are explained partially (e.g. inflation, corporate allocations), the complete reasons for these differences are unknown.

[17] The last day to submit rebuttal comments in this review was September 4, 2018
[18] WAC 246-310-100(5) identifies when an application can be amended under a regular review.

It is important to note that the *project's* financial feasibility is under review in this application – not the financial feasibility of the organization.[19]

Without reliable revenue and expense assumptions, the department was unable to conclude that the revenue and expense statements were reliable. Rather than issuing a denial, the department instead elected to declare a pivotal unresolved issue (PUI) to seek clarity on this issue. This is permitted under WAC 246-310-090(1)(a)(iii) and allows the department to reopen the record to request new information. This new information has its own new public comment and rebuttal period, which allows the department to consider new information in a fair and transparent manner.

Pivotal Unresolved Issue – Providence Health & Services – Washington

In response to the PUI, Providence confirmed that the pro forma provided in rebuttal was accurate and reflective of actual operations, provided a comprehensive revised list of assumptions, confirmed there were no changes to volume assumptions, and clarified the role inflation played in the original pro forma.

The revised, complete revenue and expense assumptions are captured below. [source: PUI Response pdf3]

Revenues

1. *The gross and net revenues are based on actual inpatient, observation, and extended outpatient cases (excluding Rehab, Family Birth Center, and Psych).*
2. *Incremental revenues were calculated on a per case basis, based on actual reimbursement from 2017 cases, inpatient, observation, and extended outpatient cases (excluding Rehab, Family Birth Center, and Psych).*
3. *Payer mix for both cases and gross revenues was held constant at 2017 rates.*
4. *Deductions from revenues were calculated based on actuals.*
5. *Charity care is assumed constant at 1.05% of gross revenues, slightly higher than the PSPH figure for 2016.*
6. *Bad debt is assumed constant at 0.15% of gross revenues.*
7. *All revenues are non-inflated dollars.*

Expenses

1. *FTEs (by account classification, by year), Salaries & Wages, and Benefits were modeled for forecast incremental case volumes based on actual inpatient, observation, and extended outpatient cases (excluding Rehab, Family Birth Center, and Psych). It is assumed an FTE works 2,080 hours per year.*
2. *Fixed staffing expenses were added for the two inpatient units in the Emilie Gamelin Pavilion when it opens in 2021. This includes: two RN minimum staffing, 24/7 Health Unit Coordinator, and two managers. This fixed staffing model is carried forward for the units until volume growth warrants additional variable staffing costs.*
3. *Non-productive hours are calculated by multiplying productive hours by 1.1 0; the non-productive factor is thus 10% of productive hours, which is consistent with actual run rate.*

[19] RCW 70.38.152(2)(c) indicates that "the financial feasibility and probable impact **of the proposal** on the cost and charges for providing health services in the community to be served." Informs the evaluation of financial feasibility [emphasis added]

4. *Benefits as a percentage of wages and salaries are estimated at 9.5%. Retirement, health care, and workers comp are recorded at the system level (not locally) so they are excluded from the benefit percentage.*
5. *Expenses were modeled for the forecast incremental case volumes based on actual inpatient, observation, and extended outpatient cases (excluding Rehab, Family Birth Center, and Psych).*
    a. *Supplies were calculated on a per case basis on 2017 actuals.*
    b. *Purchased services were calculated on a per case basis based on 2017 actuals.*
    c. *Pharmacy and drugs were calculated on a per case basis on 2017 actuals.*
6. *Annual depreciation expenses included approximately $34.485 million project costs as well as approximately $2.5 million annual routine capital expenditure depreciation amount*
7. *"Other Expenses" includes 1) system allocated costs and 2) other miscellaneous expenses*
    a. *System allocated costs include, but are not limited to, human resources, finance, information services, revenue cycle, supply chain, etc.*
    b. *Other miscellaneous expenses include, but are not limited to, minor equipment (printers, software, etc.), leases, rentals, dues and membership fees, subscriptions, etc.*
8. *Washington State sales tax is set at 7.9%.*
9. *All expenses are non-inflated dollars.*

Providence also provided details regarding how system allocations are accounted for at the facility level, below:

"In the Providence Rebuttal, we updated the pro forma financial statements to include system allocated costs for shared services. The system allocated costs include the costs associated with non-revenue generating departments and/or centralized functions at the corporate system-level that are allocated to our regions and hospitals. These functions include Human Resources, Finance, Information Services, Revenue Cycle, and others.

The system allocated costs are included in the line item "Other Expenses" in our revised financial statements. This inclusion does not affect the project's financial performance, specifically the project's satisfaction of financial feasibility criterion (1): "the immediate and long-range capital and operating costs of the project can be met."

In terms of the methodology used to project Other Expenses, where system allocated costs are included in the revised pro forma statements, the following assumptions have been used (Note: These assumptions were previously identified in Providence's Rebuttal):

1. *Budget 2018 system allocations at the functional level (HR, Finance, IT, Revenue Cycle, etc.) were identified.*
2. *Those functional areas that would grow along with the volume growth were then identified. For example, system executives/finance/etc. would not be expected to increase with PSPH volumes, but IT/Revenue Cycle/Human Resources/etc.44*
3. *Those functional areas expected to increase were tied to FTEs, NSR ("net system revenue"), or Operating Expense, as recommended by System finance staff, and were increased.*
4. *For those functional areas expected to increase in cost, there was further stratification of those areas expected to grow at the same percentage rate as volume, such as benefit costs, or at a rate of increase that would be 50% of volume, such as IT or HR, where there is overhead and more fixed staffing. This approach was used to increase these components of*

the allocations over the forecast, with and without the project, consistent with volume growth within the financial models, with and without the project

It is important to recognize that the determination of system allocated costs by cost category does not involve the application of a single standard methodology or formula. Instead, the allocation of indirect costs is based upon various methodologies and formulas that are suited to the specific type of cost category that is involved. The assumptions set forth above represent the basic financial principles that have been used to allocate system costs in Providence's pro forma financial statements."

Pivotal Unresolved Issue – Public Comments

Capital Medical Center is the only entity that provided comments on the PUI:

"The information submitted by PSPH in its May 3 PUI response demonstrates that significant changes were made in rebuttal. The Program's PUI letter indicating that the purpose of the PUI is to assist the department in fully understanding which information is accurate and applicable to the project is misplaced. The fact is that ***new information cannot be provided in rebuttal,*** *and if provided cannot be considered. The only remedy is for PSPH to either withdraw its current application or wait for denial and then begin the process anew with a new application correcting the deficiencies.*

The Program has a long and consistent history regarding the proper scope of rebuttal. According to the Program, rebuttal is for the applicant and any affected party to respond to public comment, and while clarification is permissible, the submittal of new information is not. Capital has identified a significant number of decisions in which the Program has, consistent with the statement above, made decisions denying applicants based on impermissible scope of rebuttal.

The most recent is a CN decision issued on May 3, 2019, related to a Thurston County dialysis matter. Here, three parties were under concurrent review. One of the parties, Fresenius Medical (FMC) was denied on the basis of untimely rebuttal. An excerpt from that decision is below:

> *FMC provided a detailed description of the assumptions used for projecting revenue, expenses, and net income of proposed Deschutes facility with 12 stations. In public comment DaVita called into question whether the FTE projections were reliable, based on the small incremental FTE increase year by year. In rebuttal, FMC asserted that these projections were reasonable and based on acceptable staffing ratios.*
>
> ***However, FMC went on to update their FTE projections and provide updated financial projections.***
>
> ***When the department receives public comment in opposition to a project, there is an expected process for rebuttal. In rebuttal, the department expects an applicant directs to identify where information can be found within the application or screening responses in order to refute claims made in public comment In this case, the correct information did not exist in either of those documents. FMC first stated that DaVita's comments were unfounded, but then went on to update the projections anyway.*** *Changes included:*
>
> - *A change in the FTE projections*
> - *Pro Forma updates including*
>   - *FTE compensation and benefits*
>   - *Housekeeping and utilities*

It is unclear why FMC updated their projections after reasserting they were reasonable.

The department's letter to all applicants outlines the rebuttal process and informs the applicants and affected persons that "rebuttal comments are limited to the documents enclosed." *The "documents enclosed" included only public comments on the projects submitted by Puget Sound Kidney Centers and DaVita. Of particular concern, FMC volunteered a change to projected housekeeping and utility costs in the rebuttal proforma. Neither DaVita nor PSKC identified this as an area of concern in their public comment*

The revised financial projections provided in rebuttal go beyond the scope of rebuttal. All assumptions used to prepare the pro forma financial statements are to be disclosed within the application.....

The pro forma revenue and expense statements provided by FMC would assist the department in evaluating the financial viability of the proposed project. However, ***the revision to the proforma financial revenue and expense statements could not be considered without significant deviation from historical practice. Certificate of Need is a public process - the department cannot rely on new information submitted in rebuttal, because the community and affected persons would not be afforded the opportunity to comment***

Source: 2018 Cycle 1 Non-Special Circumstance Evaluation Dated May 3, 2019 for four CN applications proposing to add dialysis station capacity in Thurston County: Fresenius Medical Care {new 12 station facility), Fresenius Medical Care {7 station expansion), DaVita, Inc.{new 19 station facility) and Puget Sound Kidney Centers {new 19 station facility), p. 41-42. Bold added for emphasis

In conclusion, PSPH erred in a number of ways. First, it did not disclose its underlying assumptions regarding cost allocations in its initial filing and 2) by providing new pro formas in rebuttal. Because the rebuttal information cannot be considered, the record does not contain the information the Program needs to make a positive finding regarding WAC 246-310-220.

The Program should not compound the PSPH deficiency errors and compromise the record further by altering its consistent practice and somehow thinking that it is its burden in ex- parte to sort through the various pro formas included. The only pro forma that can be considered is the one included with the application filing, and even PSPH acknowledges its omissions and errors.

Pivotal Unresolved Issue – Rebuttal

Providence's rebuttal to Capital Medical Centers' comments is restated below:

"During the course of reviewing the certificate of need application by Providence Health & Services - Washington d/b/a Providence St. Peter Hospital ("Providence") to add 52 acute care beds to its current licensed capacity, the Certificate of Need Program ("CN Program") of the Department of Health issued a letter dated April 9, 2019, declaring the existence of a pivotal unresolved issue ("PUI") and requesting Providence to submit additional information. The PUI declaration relates only to a single financial feasibility CN review criterion, specifically WAC 246-310-220(1). Providence submitted its response to the CN Program's request for information on May 3, 2019.

The CN Program gave the public "an opportunity to comment on [the) additional information" submitted by Providence in response to the CN Program's PUI document request. 1 The CN Program

was clear that any such public comments should be only "on [the] PUI documentation" submitted by Providence.2 It is important to recognize that Capital Medical Center's May 8 letter contains no substantive comment on Providence's PUI documentation. Instead, Capital argues that the CN Program should not consider Providence's rebuttal comments submitted on September 4, 2018, and repeats some of the arguments it made in its public comments last summer. We will respond to each of Capital's two points.

With respect to Providence's rebuttal comments, Capital is wrong about both the law and departmental policy.

On April 9, 2019, the CN Program declared a PUI with respect to Providence's application. As a matter of law, a PUI declaration reopens a CN application record so that the CN Program may obtain "additional information from the person submitting the application." Absent a PUI, an application record closes with the submittal of rebuttal comments. However, a PUI declaration creates "[a)n exception to this rule" and "submission of further information by an applicant" is permitted. Here, the CN Program declared a PUI specifically to obtain additional information regarding Providence's financial projections. The CN Program has the authority to accept new information after the record closes by declaring a PUI, and has exercised that authority here.

Capital's entire argument that Providence's "new information" in rebuttal may not be considered is moot in light of the CN Program's PUI declaration. As a matter of law, the PUI declaration allows the CN Program to accept and consider this information.

Although the PUI declaration resolves the issue in any event, we also would note that Providence's September 4 rebuttal comments were consistent with departmental policy regarding the proper scope of rebuttal. The policy is that rebuttal comments should be limited to responding to public comments and should not be used to add new information to the record that is not responsive to public comments. It is not that "new information cannot be provided in rebuttal," as Capital puts it, even if the new information is responsive to public comments. By Capital's logic, if a competitor submits public comments, for example, asserting that an application should be denied because the applicant is under investigation, the applicant would be precluded from demonstrating, in rebuttal, that the investigation was completed with no adverse findings, because this would be "new information" and "new information cannot be provided in rebuttal." This would be absurd. All of Providence's September 4, 2018, rebuttal comments were responsive to public comments, and therefore within the proper scope of rebuttal, and Capital does not even attempt to claim otherwise.

Furthermore, Capital's reliance on a recent kidney dialysis decision is misplaced. Kidney dialysis applications are subject to a highly-competitive, twice-yearly concurrent review process governed by a distinct set of regulations. If a dialysis applicant is permitted to change certain aspects of its application in rebuttal, this could unfairly prejudice the other applicants in the concurrent review process. In the specific dialysis decision referenced by Capital, the denied applicant, Fresenius, had recently had its staffing projections challenged by a competitor in an August 13-15, 2018, adjudicative hearing relating to CN applications in Grant County and Grays Harbor County. The presiding officer in that consolidated case ultimately denied Fresenius's applications based on the staffing issue. ° Following that hearing, Fresenius attempted to change its staffing projections for its Thurston County application, the one at issue in the evaluation cited by Capital, which was in a concurrent review with the same competitor that successfully challenged Fresenius's staffing projections in Grant County and Grays Harbor County.11 Moreover, Fresenius also made changes to aspects of its financial projections that neither of the competing applicants even "identified ...as

an area of concern in their public comment" - i. e., it provided new information that was not responsive to public comments, and therefore was outside the scope of proper rebuttal. Neither the kidney dialysis concurrent review process, nor this decision arising out of it, have any bearing on Providence's application at issue here. Providence simply seeks to meet a need for additional acute care beds. There is no concurrent review, and no competing applicant whose interests need to be protected. Here, the CN Program's objective simply should be to make the correct decision as to whether Providence's project should be approved, based on the most complete and accurate information the CN Program can obtain. The CN Program's declaration of a PUI to obtain additional information serves this objective.

With respect to Capital's earlier comments, Providence already has fully responded.
Capital's May 8 letter does not contain any substantive comments on the PUI responses submitted by Providence to the CN Program on May 3. Instead, Capital simply quotes from the public comments it submitted last summer. The issues raised in Capital's public comments have now been addressed twice: first, in Providence's September 4 rebuttal comments and, second, in Providence's May 3 responses to the CN Program's PUI declaration and request for information. We will not repeat those responses in this document. All of the issues raised by Capital last year have now been thoroughly addressed and resolved. Capital has raised no new substantive issues in its May 8 letter.

As part of the PUI process, Capital has been given an opportunity to submit substantive comments on Providence's PUI responses. Rather than availing itself of that opportunity, Capital has raised procedural objections. As discussed above, those objections are not valid. Moreover, the objections have in any event been rendered moot by the CN Program's declaration of a PUI, which authorizes it to request and accept additional information from Providence as part of the PUI process. The information provided by Providence fully responds to the CN Program's PUI request for information and, in addition, once again fully addresses the public comments made by Capital last summer and repeated in its May 8 letter.

Conclusion
As discussed above, the arguments raised by Capital in its public comments to the PUI response by Providence have no merit. To summarize our response on the first point: Capital's argument about whether "new information" may be provided in rebuttal is moot in light of the CN Program's PUI declaration, which permits the CN Program to accept and consider new information. But even if a PUI had not been declared, Providence's rebuttal comments were consistent with the scope of proper rebuttal, as all the information Providence provided in rebuttal was in response to public comments. Moreover, Capital's reliance on the recent dialysis decision is misplaced, since none of the concerns present in that process (e.g. concurrent review, prejudice to competing applicants, unique issues relating to dialysis projects, etc.) are present here. Finally, Capital's argument is not only wrong as a matter of law and policy, it is pure gamesmanship, entirely unmoored from the public health considerations that are supposed to drive departmental decision-making.

No objections have been raised by Capital or any other member of the public with respect to the substantive information submitted by Providence in response to the CN Program's request for additional information. Therefore, Providence respectfully requests the CN Program to complete its review of Providence's CN application and to issue a CN to Providence to add 52 acute care beds to its hospital license.

Pivotal Unresolved Issue – Department's Evaluation

This section is limited to the financial information provided in response to the PUI – the volume assumptions were already substantiated.

Providence based its revenue and expenses for PSPH on the assumptions referenced above. Providence also used its current operations [at the time the application was being prepared] as a base-line for the revenue and expenses projected for PSPH as a whole, with limited adjustments for psychiatric services, rehabilitation services, and the family birth center. A review of PSPH's fiscal year historical data reported to the Department of Health shows that Providence operated PSPH at a profit for fiscal years 2014 through 2017. [source: DOH Hospital and Patient Data Systems' Hospital Census and Charges Report-year 2014-2017]

Capital Medical Center provided comments regarding the pivotal unresolved issue and whether it was appropriate to incorporate Providence's revised pro forma in this review. Providence accurately captured the difference between a PUI in the context of a regular, non-competitive review and in a concurrent review. In summary, the department weighs a number of factors in its decision to declare a PUI or to deny a project.

Among the considerations for declaring a PUI includes whether another provider is able to fill community need. The dialysis example cited by CMC is an instance in which there were four competing applications. Though one of the applicants inappropriately rebutted public comment and was subsequently denied for their proposals, there was an applicant who passed all of the applicable review criteria. There was no need to declare a PUI and delay the decision even further.

In contrast, the project submitted by PSPH has demonstrated numeric need, but there were numerous issues with the financial feasibility documentation. Unlike the dialysis project referenced above, there is no other provider with an application prepared to meet community need. While the department is not required to declare a PUI under any circumstance, it is a tool used to reopen the record in order to resolve an issue that is pivotal to the outcome of a project. The financial information the department was able to consider without reopening the record was pivotal to the outcome of the project. Thus, any information submitted appropriately within the PUI has been properly added to the record.

As Providence noted in their rebuttal, CMC's public comments did not call into question any of the revised assumptions or subsequent pro forma. Therefore the department will review the revised assumptions

To assist in the evaluation of this sub-criterion, the Department of Health's Hospital/Finance and Charity Care Program (HFCCP) reviewed the pro forma financial statements submitted by Providence for PSPH. To determine whether Providence would meet its immediate and long range capital costs, HFCCP reviewed the 2017 historical balance sheet for both Providence Health & Services and PSPH. The information shown in Table 1 below is for St Peter Hospital and for Providence Health & Services WA as a whole. [source: HFCCP analysis, p2, Excel source sheet]

Table 11
Balance Sheets

PSP FY 2017 Actual			
Assets		Liabilities	
Current	105,796,564	Current	25,846,028
Board Designated	43,204,194	Long Term Debt	50,981,452
Property/Plant/Equipment	116,656,353	Other	
Other	40,368,349	Equity	229,197,980
Total	306,025,460	Total	306,025,460
Fiscal Year End Financial and Utilization Report to WA ST Dept. of Health			
Providence Health & Services FY 2017			
Assets		Liabilities	
Current	5,507,000,000	Current	4,221,000,000
Board Designated	9,986,000,000	Long Term Debt	6,485,000,000
Property/Plant/Equipment	10,955,000,000	Other	2,193,000,000
Other	1,197,000,000	Equity	14,746,000,000
Total	27,645,000,000	Total	27,645,000,000

For hospital projects, HFCCP provides a financial ratio analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios typically analyzed are **1)** long-term debt to equity; **2)** current assets to current liabilities; **3)** assets financed by liabilities; **4)** total operating expense to total operating revenue; and **5)** debt service coverage. Historical and projected balance sheet data is used in the analysis. Providence's 2017 balance sheet and PSPH's 2017 balance sheets were both used to review applicable ratios and pro forma financial information.

Table 12 compares statewide data for historical year 2017, Providence and PSPH historical year 2017, and projected years through 2024. [source: HFCCP analysis, p3, Excel source sheet]

Table 12
Current and Projected Debt Ratios
Providence and Providence St Peter Hospital

PSP Actual 2017					2022	2023	2024
Ratio Category	Trend	State 2017	PH & S 2017	PSP Actual 2017	CONy4	CONy5	CONy6
Long Term Debt to Equity	B	0.443	0.440	0.222	N/A	N/A	N/A
Current Assets/Current Liabilities	A	3.326	1.305	4.093	N/A	N/A	N/A
Assets Funded by Liabilities	B	0.372	0.387	0.251	N/A	N/A	N/A
Operating Expense/Operating Revenue	B	0.980	1.000	1.020	0.760	0.768	0.777
Debt Service Coverage	A	4.753	26.756	15.940	75.146	75.569	75.890
Long Term Debt to Equity	Long Term Debt/Equity						
Current Assets/Current Liabilities	Current Assets/Current Liabilities						
Assets Funded by Liabilities	Current Liabilities+Long term Debt/Assets						
Operating Expense/Operating Revenue	Operating Expense/Operating Revenue						
Debt Service Coverage	Net Profit+Depr and Interest Exp/Current Mat. LTD and Interest Exp						*

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

After reviewing the financial ratios above, staff from HFCCP provided the following statements. [source: HFCCP analysis, p3]

"CON year 3, (third year following addition of the beds) fiscal year end ratios for PSP are within acceptable range of the 2017 State average. The hospital is breaking even in each year of the projections. Review of the financial and utilization information show that the immediate and long-range capital expenditure as well as the 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.

Providence Health & Services - Washington

The capital expenditure associated with the addition of 52 acute care beds is $34,484,554. The table below summarizes costs by category. [source: Application, p4]

Table 13
Providence St Peter Hospital
Estimated Capital Expenditure Breakdown

Item	Cost	Percentage
Construction	$23,573,466	68.36%
Moveable Equipment	$833,223	2.42%
Fixed Equipment	$2,472,157	7.17%
Architect/Engineering fees	$2,595,571	7.53%
Consulting Fees	$211,596	0.61%
Supervision/Inspection	$712,372	2.07%
Cost of Financing*	$1,128,405	3.27%
WA Sales tax	$2,393,509	6.94%
Other	$564,255	1.64%
Total	**$34,484,554**	**100.00%**

**The amount listed in Table 27, line item m, is an internal representation of capital interest during the construction period, not a traditional cost of financing as used by the Department. It is a type of internal opportunity cost for the capital that would have been earning a return if it had not been allocated toward the project costs. The amount is calculated by applying a monthly interest percentage to the capital amount, beginning three months after construction and continuing to apply the interest percentage as capital is drawn down until the completion of construction.* [source: Screening response p4]

Providence provided a letter from Sellen Construction Company attesting that the costs identified above are reasonable. [source: Application, Exhibit 20]

Since PSPH is currently operational, no start-up costs are required. [source: Application, p49]

Public Comment
None

Rebuttal Comment
None

Department Evaluation

Providence provided a letter from a contractor, attesting that the construction estimate within the application is reasonable. Providence confirmed that PSPH would continue full operations during construction and the addition of 52 beds. As a result, no start-up costs are required.

In its financial review, the HFCCP provided the following information and review regarding the rates proposed by Providence for PSPH: "*PSPH's rates are similar to the Washington statewide averages.*" [source: HFCCP Program analysis p4]

Table 14
HFCCP Rate Analysis

Prov. St. Peter	2018	2019	2020	2021	2022	2023	2024
Rate per Various Items		**CONyr1**	**CONyr2**	**CONyr3**	**CONyr4**	**CONyr5**	**CONyr6**
Admissions	23,239	23,541	23,847	24,094	24,366	24,639	24,911
Patient Days	104,412	105,788	107,163	108,290	109,576	110,862	112,148
Gross Revenue	2,036,360,914	2,067,783,927	2,099,472,646	2,138,874,420	2,181,875,335	2,225,171,731	2,268,769,518
Deductions From Revenue	1,541,368,945	1,565,570,021	1,589,977,744	1,620,933,804	1,654,478,911	1,688,254,114	1,722,264,013
Net Patient Billing	494,991,969	502,213,906	509,494,902	517,940,616	527,396,424	536,917,617	546,505,505
Other Operating Revenue	7,906,258	7,906,258	7,906,258	7,924,183	7,945,806	7,967,440	7,989,084
Net Operating Revenue	502,898,227	510,120,164	517,401,160	525,864,799	535,342,230	544,885,057	554,494,589
Operating Expense	499,679,800	504,258,609	509,241,470	517,452,790	524,567,629	530,896,807	537,268,149
Operating Profit	3,218,427	5,861,555	8,159,690	8,412,009	10,774,601	13,988,250	17,226,440
Other Revenue	-	-	-	-	-	-	-
Net Profit	3,218,427	5,861,555	8,159,690	8,412,009	10,774,601	13,988,250	17,226,440
Operating Revenue per Admission	$ 21,300	$ 21,334	$ 21,365	$ 21,497	$ 21,645	$ 21,791	$ 21,938
Operating Expense per Admission	$ 21,502	$ 21,420	$ 21,355	$ 21,476	$ 21,529	$ 21,547	$ 21,568
Net Profit per Admission	$ 138	$ 249	$ 342	$ 349	$ 442	$ 568	$ 692
Operating Revenue per Patient Day	$ 4,741	$ 4,747	$ 4,754	$ 4,783	$ 4,813	$ 4,843	$ 4,873
Operating Expense per Patient Day	$ 4,786	$ 4,767	$ 4,752	$ 4,778	$ 4,787	$ 4,789	$ 4,791
Net Profit per Patient Day	$ 31	$ 55	$ 76	$ 78	$ 98	$ 126	$ 154
Operating Revenue per Adj Admissions	$ 14,134	$ 14,124	$ 14,113	$ 14,091	$ 14,092	$ 14,093	$ 14,094
Operating Expense per Adj Admissions	$ 14,268	$ 14,182	$ 14,106	$ 14,078	$ 14,017	$ 13,935	$ 13,856
Net Profit per Adj Admissions	$ 92	$ 165	$ 226	$ 229	$ 288	$ 367	$ 444
Operating Revenue per Adj Pat Days	$ 3,146	$ 3,143	$ 3,141	$ 3,135	$ 3,134	$ 3,132	$ 3,131
Operating Expense per Adj Pat Days	$ 3,176	$ 3,156	$ 3,139	$ 3,132	$ 3,117	$ 3,097	$ 3,078
Net Profit per Adj Pat Days	$ 20	$ 37	$ 50	$ 51	$ 64	$ 82	$ 99

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

Based on the above information, the department concludes that PSPH's expansion would probably not have an unreasonable impact on the costs and charges for healthcare services in Thurston County and surrounding communities. **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.

Providence Health & Services - Washington

The total estimated capital expenditure associated with the additional 52 acute care beds is $34,484,554. Of that amount, approximately 70% is related to construction; 10% is related to equipment, and the remaining 20% is for sales tax and fees (consulting, architect, and engineering). [source: Application, p46]

Providence intends to fund the project using Providence St Joseph Health reserves and provided a letter of financial commitment for the project. There are no start-up costs associated with this project. [source: Application, Exhibit 21, 22]

Public Comment

None

Rebuttal Comment

None

Department Evaluation

After reviewing the balance sheet, the HFCCP provided the following statements. [source: HFCCP analysis, p4]

"The CN project capital expenditure is $34,484,554. Providence Health & Services will use its existing reserves. This investment represents 0.1% of total assets, and only .3% of Board Designated Assets of the parent organization as of 2017.

The financing methods used are appropriate business practice."

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

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

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

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

WAC 246-310 does not contain specific WAC 246-310-230(1) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what specific staffing patterns or numbers of FTEs [full time equivalents] 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.

Providence Health & Services - Washington

PSPH currently operates 285 acute care beds. Table 15 provides a breakdown of current and projected FTEs [full time equivalents]. [source: Screening Response, Exhibit 29]

Table 15
Current and Proposed FTEs

	2018	2019	2020	2021	2022	2023
Management Physicians	1.66	1.68	1.69	1.71	1.73	1.75
RNs	760.03	771.13	782.44	799.11	809.00	822.83
Physicians	4.46	4.53	4.60	4.67	4.73	4.80
Non Physician Medical	5.71	5.80	5.89	5.97	6.06	6.15
Other/Support	1,132.92	1,144.17	1,155.65	1,170.29	1,184.08	1,194.25
Nonproductive Hours	225.52	227.76	230.04	232.56	235.25	237.99
Agency	6.35	6.44	6.54	6.63	6.72	6.81
Total	**2,136.65**	**2,161.51**	**2,186.85**	**2,220.94**	**2,247.57**	**2,274.58**
Increase/(Decrease)		**24.86**	**25.34**	**34.09**	**26.63**	**27.01**

In addition to the table above, Providence provided the following statements related to this sub-criterion. [source: Application, p56]

"We do not anticipate any staffing challenges. PSPH has an excellent reputation and history of being able to retain and recruit appropriate personnel. PSPH offers a competitive wage scale, a generous benefit package, and a professionally rewarding work setting.

Providence has multiple resources available to assist with the identification and recruitment of appropriate and qualified personnel:

- *Experienced recruitment teams locally and within Providence to recruit qualified manpower;*
- *Strong success in recruiting for critical-to-fill positions with recruiters that offer support on a national level as well as local level;*
- *Career listings on the Providence Web site and job postings on multiple search engines and listing sites (e.g., Indeed, Career Builders, Monster, NW Jobs).*
- *Educational programs with local colleges and universities, as well as the University of Providence Bachelor of Science in Nursing program (operated by Providence).*

Each of these factors has contributed to the ability to maintain a highly qualified employee and management base."

Public Comment
None

Rebuttal Comment
None

Department Evaluation

PSPH is currently licensed for 285 general acute care beds. With an additional 52 beds, the increase in staff coincides with the increase in admissions and patient days for the hospital.

For this project, Providence intends to use the strategies for recruitment and retention of staff it has successfully used in the past. The strategies identified by Providence are consistent with those of other applicants reviewed and approved by the department.

Information provided in the application demonstrates that PSPH is a well-established provider of healthcare services Thurston County and surrounding areas. Information provided in the application demonstrates that Providence has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

There was no public comment related to this sub-criterion. Based on the above information, the department concludes that Providence demonstrated adequate staffing at PSPH 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(2) 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 relationships, ancillary and support services should be for a project of this type and size. Therefore, using its experience and expertise the department assessed the materials contained in the application.

Providence Health & Services - Washington

Providence provided the following statements related to this sub-criterion. [source: Application, p58 and June 18, 2018, screening response, p4]

"PSPH is an existing acute care hospital providing high quality patient services, which includes appropriate ancillary and support services. PSPH has expanded ancillary services that ensure efficiency and access to state-of-the-art diagnostic and therapeutic services to serve all patients in the best possible manner. The existing ancillary and support services will support the additional bed capacity."

"PSPH utilizes a combination of internal and external arrangements to address the ancillary and support services needed by the hospital. All but one service is provided via an existing internal arrangement. PSPH has the ability to increase its internal support services, as needed. PSPH also has one existing external arrangement related to linen services. Since PSPH already contracts for linen services, the hospital will adjust its linen services, as needed, after CN Application # 18-34 is approved and the additional beds become available. Linen expenses have been included within "purchased services" in the proforma. No new contracts or new services will be required for the additional 52 beds."

Public Comment
None

Rebuttal Comment
None

Department Evaluation
PSPH has been in operation for many years. All ancillary and support services are already in place. With the addition of 52 more acute care beds, Providence expects some ancillary and support needs may increase, but that existing arrangements are sufficient to account for this increase.

Based on the information reviewed in the application, the department concludes that there is reasonable assurance that Providence will continue to maintain the necessary relationships with ancillary and support services with the addition of 52 beds. **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.

Providence Health & Services - Washington
Providence provided the following statements related to this sub-criterion. [source: Application, pp59-60]

"PSPH has no history of criminal convictions related to ownership / operation of a health care facility, licensure revocations or other sanctions described in WAC 246-310-230(5)(a). (Note: the above WAC has been re-codified as WAC 246-310-230.) Patient care at PSPH is and will continue to be provided in conformance with all applicable federal and state requirements."

"PSPH is licensed by the State of Washington Department of Health, is Medicare certified, and is accredited by The Joint Commission. PSPH also participates in a variety of other accreditation, licensure and certification reviews by external agencies (please see a list of current licensures and accreditations on page 8 under section I.E: Facility licensure/accreditation status)."

Public Comment
None

Rebuttal Comment
None

Department Evaluation
As part of this review, the department must conclude that the proposed services provided by an applicant would be provided in a manner that ensures safe and adequate care to the public.[20] To accomplish this task, the department reviewed the quality of care compliance history for the healthcare facilities owned, operated, or managed by Providence or its subsidiaries.

Providence Health & Services is part of Providence St Joseph Health which is one of the largest not-for-profit healthcare systems in the United States. Providence operates several healthcare facilities and services nationwide through a number of subsidiaries. Its Washington facilities are operated under the Providence Health & Services subsidiary. [sources: Application, Exhibit 3.]

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

Washington State Survey Data

The eight Providence hospitals currently operating include Providence Holy Family Hospital, Providence St Joseph's Hospital, Providence Mount Carmel Hospital, Providence Centralia Hospital, Providence Sacred Heart Medical Center and Children's Hospital, Providence St Mary Medical Center, Providence St Peter Hospital, and Providence Regional Medical Center Everett. Swedish Health Services and Western Health Connect also operate under the Providence umbrella – their Washington State hospitals include Swedish Edmonds, Swedish First Hill, Swedish Issaquah, Swedish Cherry Hill, and Kadlec Regional Medical Center.

All of the hospitals listed above are accredited. The Providence hospitals and Kadlec Regional Medical Center are accredited by the Joint Commission. The Swedish hospitals are accredited by Det Norske Veritas (DNV). [source: Joint Commission website, DNV website, ILRS]

The department also reviewed the survey deficiency history for years 2016 through 2018 for all Providence hospitals located in Washington State. Of the eight Washington State hospitals, three had deficiencies in one of the three years. All deficiencies were corrected with no outstanding compliance issues.[21]

In addition to the hospitals above, department also reviewed the compliance history for the two ambulatory surgical facilities and 13 in-home service agency licenses, including home health, hospice and a hospice care center. All of these facilities are operational. Using its own internal database, the survey data showed that more than 40 surveys have been conducted and completed by Washington State surveyors since year 2016. All surveys resulted in no significant non-compliance issues. [source: ILRS survey data and Department of Health Investigations and Inspections Office]

Providence has not yet hired staff for this surgery center, including a medical director. Since the medical director will be an employee of Providence (not the surgery center), no medical director contract was provided. If this project is approved, the department would attach a condition requiring Providence to submit a listing of key staff for the surgery center. Key staff includes all credentialed or licensed management staff, including the director of nursing, and medical director.

Other States

In addition to a review of all Washington State facilities owned and operated by Providence, the department also examined a sample of Providence/St Joseph Health facilities nationwide. According to information in the application and its website, Providence operates healthcare facilities across the western United States. The department randomly selected Providence and Providence-affiliated facilities in Montana, California, and Texas to review for their compliance with state and federal standards, shown below:

[21] The three hospitals were Holy Family Hospital in Spokane County, Providence Regional Medical Center-Everett in Snohomish County, and Providence St. Peter in Thurston County.

Department's Table 9
Providence and Affiliated Facilities Outside of Washington

Facility Name	State	Joint Commission?	State Enforcement Action since 2016?
Providence			
Providence Little Company of Mary Medical Center San Pedro	CA	yes	yes[22]
Providence Little Company of Mary Medical Center Torrance	CA	yes	no
Providence Saint John's Health Center	CA	yes	yes[23]
Providence Saint Joseph Medical Center	CA	yes	no
Providence Tarzana Medical Center	CA	yes	no
Providence Affiliate – St Joseph Health			
Petaluma Valley Hospital	CA	yes	no
Hoag Hospital Newport Beach	CA	no – DNV	no
Covenant Health Plainview	TX	no	no

As shown above, out-of-state Providence facilities have demonstrated compliance with applicable state and federal regulations. No evidence on any of the state licensing websites indicated that any of the above facilities have ever been closed or decertified from participation in Medicare or Medicated as a result of compliance issues. Furthermore the penalties identified above were resolved through minor administrative fines.

Based on the above information and agreement to the conditions identified in this evaluation, the department concludes that Providence demonstrated reasonable assurance that Providence would continue to operate in compliance with state and federal requirements if this project is approved. **This sub criterion is met.**

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

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

Providence Health & Services - Washington

Providence provided the following statements related to this review criterion. [source: Application, pp58-59]

"PSPH has developed long-term collaborative relationships with other providers to expand program offerings and ensure access and continuity of appropriate care for residents of Thurston County and

[22] One administrative enforcement action related to an ulcer acquired after admission and failure to report timely. No other violations found. Fine paid in full.
[23] One administrative enforcement action related to reporting "retention of a foreign object in a patient." No other violations found. Fine paid in full.

the other surrounding communities served by PSPH. PSPH coordinates patient access to other Providence entities as well as community providers to ensure continuity of care during hospital discharge to other levels of care as well as when other facilities need to transfer patients to PSPH for more advanced care. Those providers include hospitals, hospice, home care, long-term care facilities, psychiatric care, assisted living and other providers.

We will continue to evolve our relationship with hospitals, nursing homes, and other providers as we finalize our operational plans in the next 6 to 10 months. Our processes and relationships are reviewed annually to maintain strong inclusive relationships and processes for the care continuum."

Public Comment
None

Rebuttal Comment
None

Department Evaluation
Information in the application demonstrates that as a current provider, PSPH has the infrastructure in place to expand. Additionally, Providence provided information within the application to demonstrate it intends to continue existing relationships and establish new relationships as necessary.

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

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

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

D. Cost Containment (WAC 246-310-240)
Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that Providence **met** the applicable cost containment criteria in WAC 246-310-240.

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.
To determine if a proposed project is the best alternative, in terms of cost, efficiency, or effectiveness, the department takes a multi-step approach. First the department determines if the application has met the other criteria of WAC 246-310-210 thru 230. If the project has failed to meet one or more of these criteria then the project cannot be considered to be the best alternative in terms of cost, efficiency, or effectiveness as a result the application would fail this sub-criterion.

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

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

Providence Health & Services - Washington

Step One

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

Step Two

Before submitting this application, Providence considered four total options. The options are below. [source: Application, pdf65]

"PSPH considered several alternatives to the request to add 52 acute care beds including: 1) full remodel on both 2nd and 3rd floors of Emilie Gamelin Pavilion (the proposed project); (2) the partial remodel of the 3rd floor and full remodel of the 2nd floor of the Emilie Gamelin Pavilion; (3) build a new tower to accommodate acute medical / surgical beds, including an option to increase the number of beds; or (4) do nothing. The decision-making criteria included access to health care services; quality of care; cost and operating efficiency; staffing impacts; and legal restrictions. PSPH selected option one as the appropriate choice for bed expansion."

Below are Providence's rationales for rejecting options 2-4. [source: Application pdf66-67]

Option 2:

- "*The partial remodel would leave a number of double bed configurations and would potentially leave some space facing code compliance concerns that would add to costs if fully rectified."*

Option 3:

- "*It is not practical or cost effective to build a new tower when existing space is available at lower costs."*

Option 4:

- *"PSPH would not be able to meet the community demand for inpatient care after 2018 pursuing this alternative."*

Step Three

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

Public Comments

None

Rebuttal Comments
None

Department Evaluation
Information provided in the Providence application supporting documentation demonstrate that the additional acute care beds are needed at PSPH. Providence discussed the occupancy constraints and appropriately concluded that a "do nothing" option was not the best option.

Providence provided information in the application that supports rejection building an additional tower or a different type of remodel. Though both options could be appropriate, they are not as operationally efficient as the proposed project.

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

The department concludes that the project as submitted by Providence is the best available option for the planning area and surrounding communities. **This sub-criterion is met.**

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

Providence Health & Services - Washington
"Providence ensures that all construction projects meet the Washington State Building Code and the Washington Energy Code. In addition, the energy conservation program ensures all construction projects are evaluated for alternative electrical and mechanical systems incorporating energy use reduction technology. Providence endeavors to exceed energy codes where it is affordable to do so in the interest of reducing ongoing operating costs.t." [source: Application, pdf69]

Public Comments
None

Rebuttal Comments
None

Department Evaluation
As part of its analysis, HFCCP provided the following statements regarding the construction costs, scope, and method. [source: HFCCP analysis, p5]

"The costs of the project are the cost for construction, planning and process. PSP's projections are below.

Table 17
Capital Expenditure per Unit

Prov. St. Peter	
Total Capital	$ 34,484,554
Beds/Stations/Other (Unit)	52
Total Capital per Unit	$ 663,164.50

The costs shown are within past construction costs reviewed by this office. Also construction cost can vary quite a bit due to type of construction, quality of material, custom vs. standard design, building site and other factors. PSP is using existing space and will design the facility to the latest energy and hospital standards.

Staff is satisfied the applicant plans are appropriate."

Based on the information provided in the application and the analysis from HFCCP, the department concludes **this sub-criterion is met.**

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

Providence Health & Services - Washington
Within the complete revenue and expense assumptions provided with the PUI, Providence identified that all revenues deductions, and expenses are based on actuals from 2017. [source: PUI Response, pdf3-4]

Public Comments
None

Rebuttal Comments
None

Department Evaluation
As part of its analysis, HFCCP provided the following statements related to this sub-criterion. [source: HFCCP analysis, p5]

"Staff is satisfied that adding 52 acute care beds servicing a bed need area which has projected bed need and where the population is growing in number should not have an unreasonable impact of the costs and charges to the public of providing services by other persons.

Staff is satisfied the project is appropriate."

The department concludes **this sub-criterion is met.**

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

Providence Health & Services - Washington
"*PSPH continually looks for ways to improve patient care, operational efficiency and patient throughput. PSPH has implemented several initiatives during the last several years in order to create additional capacity and ensure patients are served in the right care setting at the right time*

without expanding licensed acute care beds. These improvements had a positive impact by opening up capacity temporarily. However, the demand for services continues to increase, and these initiatives are no longer enough to allow PSPH to fulfill the demand for inpatient services.

Examples of initiatives implemented at PSPH during the past several years include the following:

- *PSPH has opened a Clinical Observation unit to care for patients who observation status.*
- *Implemented routine discontinuation of telemetry (heart monitoring) based on specific evidence based criteria to decrease cost of care and increase availability of telemetry monitoring.*
- *Implemented virtual technology to monitor patients who need close observation and have freed up certified nursing staff from 1:1 observation.*
- *Implemented technology that displays real-time orders from our electronic medical record (EMR) to notify staff of a patient admission and discharge.*
- *Created a discharge lounge for patients waiting for transportation at discharge; this allows us to open beds for admissions.*
- *Deployed environment of care and transporter staff to floors during peak discharge times in order to decrease room turnover time.*
- *Implemented "don't be late for your discharge date" education and communication for patients and families regarding discharge expectations and earlier preparation with discharge instructions.*
- *Implemented a transfer center staffed by clinicians for patient placement in the correct bed in a timely manner.*
- *Placed discharge planners / case managers in the emergency room to work with people who frequently come to the ED for inappropriate reasons; the goal is to connect these individuals to appropriate services and avoid unnecessary admissions to acute care.*
- *Opened the Providence Community Care Center, a social service hub to meet the needs of the vulnerable in the community.*
- *PSPH pays for a medical director and a nurse practitioner to care for patients at Mother Joseph Care Center; the goal is to reduce unnecessary admissions to acute care and provide onsite medical treatment.*
- *Hired a full-time psychiatrist to work in the ED to provide care for behavioral health needs for our patients and to create a plan of care and send to an appropriate care setting when possible.*
- *Transfer appropriate patients from the ED to Providence Centralia hospital for acute care.*
- *Level loading elective surgery and procedural cases.*
- *Education campaign on options for care in appropriate settings (e.g. virtual visits, immediate care, primary care and ED).*
- *Partnering with shelters for temporary respite care options."*

[source: Application, pdf67-68]

Public Comments
None

Rebuttal Comments
None

Department Evaluation

This project has the potential to improve delivery of acute care services to the residents of Thurston County and surrounding communities with the addition of 52 acute care beds to PSPH. The department is satisfied the project is appropriate and needed. **This sub-criterion is met.**

Appendix A

Thurston County Acute Care Bed Need
Step 1

2008 to 2017 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	10-YEAR TOTAL
HSA #2	302,501	309,790	309,937	309,010	311,032	311,619	312,666	320,941	335,301	351,317	**3,174,114**
STATEWIDE TOTAL	2,069,175	2,065,777	2,055,241	2,068,011	2,054,931	2,067,274	2,116,496	2,210,893	2,274,457	2,387,290	**21,369,545**

Thurston County Acute Care Bed Need
Step 2

2008 to 2017 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	10-YEAR TOTAL
HSA #2	302,501	309,790	309,937	309,010	311,032	311,619	312,666	320,941	335,301	351,317	3,174,114
STATEWIDE TOTAL	2,069,175	2,065,777	2,055,241	2,068,011	2,054,931	2,067,274	2,116,496	2,210,893	2,274,457	2,387,290	21,369,545

2007 TO 2016 HSA TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	10-YEAR TOTAL
HSA #2	2,284	2,181	1,713	2,085	1,235	1,194	2,164	2,553	3,263	3,605	**22,277**
STATEWIDE TOTAL	17,292	16,685	17,392	17,964	16,983	20,118	22,239	29,898	29,562	31,607	**219,740**

HSA #2 Psych Hospitals include Rainier Springs in Vancouver (operational in 2018, no data yet), 2 Thurston County psych hospitals - not yet operational

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2008 to 2017 HSA TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	10-YEAR TOTAL
HSA #2	300,217	307,609	308,224	306,925	309,797	310,425	310,502	318,388	332,038	347,712	**3,151,837**
STATEWIDE TOTAL	2,051,883	2,049,092	2,037,849	2,050,047	2,037,948	2,047,156	2,094,257	2,180,995	2,244,895	2,355,683	**21,149,805**

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Thurston County Acute Care Bed Need
Step 3

2008 to 2017 HSA TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	10-YEAR TOTAL
HSA #2	300,217	307,609	308,224	306,925	309,797	310,425	310,502	318,388	332,038	347,712	**3,151,837**
STATEWIDE TOTAL	2,051,883	2,049,092	2,037,849	2,050,047	2,037,948	2,047,156	2,094,257	2,180,995	2,244,895	2,355,683	**21,149,805**

TOTAL POPULATIONS

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	10-YEAR TOTAL
HSA #2	1,013,014	1,029,092	1,045,270	1,054,836	1,064,402	1,073,968	1,083,534	1,093,100	1,111,098	1,129,096	**10,697,410**
STATEWIDE TOTAL	6,558,454	6,641,495	6,724,540	6,791,914	6,859,288	6,926,662	6,994,036	7,061,410	7,176,813	7,292,215	**69,026,826**

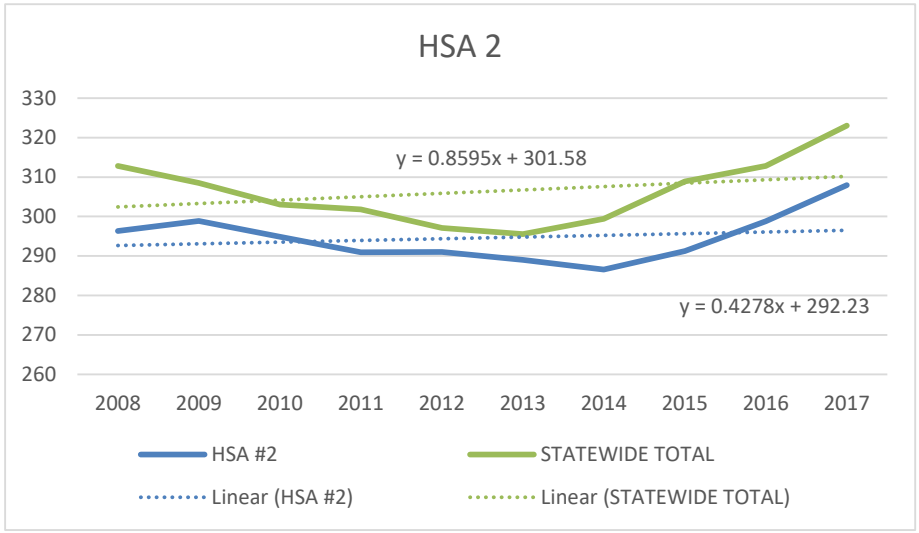
RESIDENT USE RATE PER 1,000

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	10-YEAR TOTAL
HSA #2	296.3602	298.913	294.875	290.9694	291.0526	289.0449	286.5641	291.2707	298.8377	307.9561	2945.84377
STATEWIDE TOTAL	312.8608	308.5287	303.0466	301.8364	297.1078	295.5473	299.4347	308.8611	312.7983	323.0408	3063.06257

Thurston County Acute Care Bed Need
Step 4

RESIDENT USE RATE PER 1,000

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	TREND LINE
HSA #2	296.3602	298.913	294.875	290.9694	291.0526	289.0449	286.5641	291.2707	298.8377	307.9561	0.4278
STATEWIDE TOTAL	312.8608	308.5287	303.0466	301.8364	297.1078	295.5473	299.4347	308.8611	312.7983	323.0408	0.8595



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Thurston County Acute Care Bed Need
Steps 5 & 6

STEP #5
2017

HOSPITAL PATIENT DAYS

	Total Patient Days in Thurston Hospitals	-	Out of State (OOS) Resident Patient Days in Thurston Hospitals	=	Total Patient Days in Thurston Hospitals, Minus OOS	%
0-64	48,189		482		47,707	1.00%
65+	55,092		497		54,595	0.90%
TOTAL	**103,281**		**979**		**102,302**	0.95%

	Total Patient Days in Washington State Hospitals Minus Thurston	-	Out of State (OOS) Resident Patient Days in Washington State Hospitals Minus Thurston	=	Total Patient Days in Washington State Hospitals, Minus OOS, Minus Thurston	%
0-64	1,231,281		65,987		1,165,294	5.36%
65+	1,052,728		44,223		1,008,505	4.20%
TOTAL	**2,284,009**		**110,210**		**2,173,799**	4.83%

	Total Thurston Resident Patient Days in Thurston Hospitals	+	Total Thurston Resident Patient Days in Other Washington State Hospitals	=	Total Thurston Resident Patient Days	+	Thurston Resident Patient Days Provided in Oregon	=	Total Thurston Resident Patient Days - All Settings
0-64	32,044		17,313		49,357		0		49,357
65+	37,998		8,067		46,065		0		46,065
TOTAL	**70,042**		**25,380**		**95,422**		**0**		**95,422**

	Total Other Washington State Resident Patient Days in Thurston Hospitals	+	Total Other Washington State Resident Patient Days in Other Washington State Hospitals	=	Total Other Washington State Resident Patient Days	+	Other Washington State Resident Patient Days Provided in Oregon	=	Total Other Washington State Resident Patient Days - All Settings
0-64	15,663		1,147,981		1,163,644		55,390		1,219,034
65+	16,597		1,000,438		1,017,035		20,699		1,037,734
TOTAL	**32,260**		**2,148,419**		**2,180,679**		**76,089**		**2,256,768**

Thurston County Acute Care Bed Need
Steps 5 & 6

MARKET SHARES

PERCENTAGES OF PATIENT DAYS

THURSTON RESIDENT PATIENT DAYS

	In Thurston Hospitals	In Other Washington State Hospitals	In Oregon Hospitals
0-64	64.92%	35.08%	0.00%
65+	82.49%	17.51%	0.00%

OTHER WASHINGTON STATE RESIDENT PATIENT DAYS

	In Thurston Hospitals	In Other Washington State Hospitals	In Oregon Hospitals
0-64	1.28%	94.17%	4.54%
65+	1.60%	96.41%	1.99%

2017
POPULATION BY PLANNING AREA

	Thurston County	Other Washington State
0-64	227,131	5,936,815
65+	46,337	1,081,932
TOTAL	273,468	7,018,747

STEP #6
USE RATE BY PLANNING AREA

	Thurston County	Other Washington State
0-64	217.31	205.33
65+	994.13	959.15

Thurston County Acute Care Bed Need
Step 7A

USE RATE BY PLANNING AREA
2017
Thurston County

0-64	**217.31**
65+	**994.13**

PROJECTED POPULATION - THURSTON COUNTY

PROJECTION YEAR	**2024**
0-64	245,861
65+	60,588
TOTAL	306,449

PROJECTED USE RATE

PROJECTION YEAR	**2024**
USE RATES	
0-64 Using HSA #2 Trend	220.30
0-64 Using Statewide Trend	**223.32**
65+ Using HSA #2 Trend	997.12
65+ Using Statewide Trend	**1,000.15**

Thurston County Acute Care Bed Need
Step 8

PROJECTED USE RATE

PROJECTION YEAR	**2024**
USE RATES	
0-64	220.30
65+	997.12

PROJECTED POPULATION

PROJECTION YEAR	**2024**
0-64	245,861
65+	60,588
TOTAL	**306,449**

PROJECTED NUMBER OF PATIENT DAYS

PROJECTION YEAR	**2024**
0-64	54,163
65+	60,414
TOTAL	**114,577**

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Thurston County Acute Care Bed Need
Step 9

PROJECTED NUMBER OF PATIENT DAYS

PROJECTION YEAR	2024		
	THURSTON COUNTY RESIDENTS	ALL OTHER WASHINGTON STATE	TOTAL WASHINGTON STATE
0-64	54,163	1,435,222	1,489,385
65+	60,414	1,425,843	1,486,257
TOTAL	**114,577**	**2,861,065**	**2,975,642**

MARKET SHARE (% PATIENT DAYS FROM STEP 5)

THURSTON RESIDENT PATIENT DAYS

	In Thurston Hospitals	In Other Washington State Hospitals	In Oregon Hospitals
0-64	64.92%	35.08%	0.00%
65+	82.49%	17.51%	0.00%

OTHER WASHINGTON STATE RESIDENT PATIENT DAYS

	In Thurston Hospitals	In Other Washington State Hospitals	In Oregon Hospitals
0-64	1.28%	94.17%	4.54%
65+	1.60%	96.41%	1.99%

PROJECTED RESIDENT PATIENT DAYS BY LOCATION, WITH MARKET SHARE ASSIGNED

THURSTON RESIDENT PATIENT DAYS

	In Thurston Hospitals	In Other Washington State Hospitals	In Oregon Hospitals
0-64	35,164	18,999	0
65+	49,834	10,580	0
TOTAL	**84,998**	**29,579**	**0**

OTHER WASHINGTON STATE RESIDENT PATIENT DAYS

	In Thurston Hospitals	In Other Washington State Hospitals	In Oregon Hospitals
0-64	18,441	1,351,568	65,213
65+	22,804	1,374,599	28,440
TOTAL	**41,245**	**2,726,167**	**93,653**

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Thurston County Acute Care Bed Need
Step 9

NUMBER OF PATIENT DAYS PROJECTED IN CENTRAL PIERCE HOSPITALS

0-64	53,605
65+	72,638
TOTAL	**126,243**

NUMBER OF PATIENT DAYS PROJECTED IN ALL OTHER WASHINGTON STATE HOSPITALS

2,755,746

NUMBER OF WASHINGTON STATE PATIENT DAYS PROJECTED IN OREGON HOSPITALS

93,653

PERCENTAGE OF OUT OF STATE RESIDENT PATIENT DAYS IN WASHINGTON STATE HOSPITALS

THURSTON

0-64	1.00%
65+	0.90%

ALL OTHER WASHINGTON STATE

0-64	5.36%
65+	4.20%

PROJECTED NUMBER OF PATIENT DAYS IN PROJECTION YEAR, PLUS OUT OF STATE RESIDENTS

PROJECTION YEAR **2024**

PATIENT DAYS IN CENTRAL PIERCE IN PROJECTION YEAR

		Ratio - Projected Patient Days in Planning Area Hospitals over Planning Area Resident Patient Days
0-64	54,141	0.999593992
65+	73,293	1.213192163
TOTAL	**127,435**	

Thurston County Acute Care Bed Need
Step 10A

THURSTON PLANNING AREA	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
POPULATION 0-64	227,131	228,222	229,312	241,500	242,590	243,680	244,771	245,861	253,337	254,427	255,517
0-64 USE RATE	217.31	217.73	218.16	218.59	219.02	219.44	219.87	220.30	220.73	221.16	221.58
POPULATION 65+	46,337	48,276	50,215	52,832	54,771	56,710	58,649	60,588	63,170	65,109	67,048
65+ USE RATE	994.13	994.56	994.98	995.41	995.84	996.27	996.70	997.12	997.55	997.98	998.41
TOTAL POPULATION	273,468	276,498	279,527	294,332	297,361	300,390	303,420	306,449	316,507	319,536	322,565
TOTAL THURSTON RESIDENT DAYS	95,422	97,705	99,990	105,379	107,675	109,973	112,274	114,577	118,934	121,246	123,560
TOTAL DAYS IN THURSTON HOSPITALS	105,223	107,921	110,622	116,569	119,281	121,996	124,714	127,435	132,346	135,075	137,808
AVAILABLE BEDS PER MOST RECENT DATA AVAILABLE - EITHER ACUTE CARE SURVEY OR YEAR-END FINANCIAL REPORT											
Providence St Peter Hospital	285	285	285	285	285	285	285	285	285	285	285
Capital Medical Center	107	107	107	107	107	107	107	107	107	107	107
TOTAL	**392**	**392**	**392**	**392**	**392**	**392**	**392**	**392**	**392**	**392**	**392**
Market Share By Hospital											
Providence St Peter Hospital	72.70%	72.70%	72.70%	72.70%	72.70%	72.70%	72.70%	72.70%	72.70%	72.70%	72.70%
Capital Medical Center	27.30%	27.30%	27.30%	27.30%	27.30%	27.30%	27.30%	27.30%	27.30%	27.30%	27.30%
Occupancy Standard by Hospital											
Providence St Peter Hospital	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%
Capital Medical Center	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%
WEIGHTED OCCUPANCY STANDARD	68.64%	68.64%	68.64%	68.64%	68.64%	68.64%	68.64%	68.64%	68.64%	68.64%	68.64%
GROSS BED NEED	**420.02**	**430.79**	**441.57**	**465.31**	**476.14**	**486.97**	**497.82**	**508.68**	**528.29**	**539.18**	**550.09**
NET BED NEED/(SURPLUS)	**28.02**	**38.79**	**49.57**	**73.31**	**84.14**	**94.97**	**105.82**	**116.68**	**136.29**	**147.18**	**158.09**

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Thurston County Acute Care Bed Need
Step 10B

THURSTON PLANNING AREA	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
POPULATION 0-64	227,131	228,222	229,312	241,500	242,590	243,680	244,771	245,861	253,337	254,427	255,517
0-64 USE RATE	217.31	217.73	218.16	218.59	219.02	219.44	219.87	220.30	220.73	221.16	221.58
POPULATION 65+	46,337	48,276	50,215	52,832	54,771	56,710	58,649	60,588	63,170	65,109	67,048
65+ USE RATE	994.13	994.56	994.98	995.41	995.84	996.27	996.70	997.12	997.55	997.98	998.41
TOTAL POPULATION	273,468	276,498	279,527	294,332	297,361	300,390	303,420	306,449	316,507	319,536	322,565
TOTAL CENTRAL PIERCE RESIDENT DAYS	95,422	97,705	99,990	105,379	107,675	109,973	112,274	114,577	118,934	121,246	123,560
TOTAL DAYS IN CENTRAL PIERCE HOSPITALS	105,223	107,921	110,622	116,569	119,281	121,996	124,714	127,435	132,346	135,075	137,808
AVAILABLE BEDS											
Providence St Peter Hospital	285	285	289	289	337	337	337	337	337	337	337
Capital Medical Center	107	107	107	107	107	107	107	107	107	107	107
TOTAL	**392**	**392**	**396**	**396**	**444**	**444**	**444**	**444**	**444**	**444**	**444**
Market Share by Hospital											
Providence St Peter Hospital	72.70%	72.70%	72.98%	72.98%	75.90%	75.90%	75.90%	75.90%	75.90%	75.90%	75.90%
Capital Medical Center	27.30%	27.30%	27.02%	27.02%	24.10%	24.10%	24.10%	24.10%	24.10%	24.10%	24.10%
Occupancy Standard by Hospital											
Providence St Peter Hospital	70.00%	70.00%	70.00%	70.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
Capital Medical Center	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%
WEIGHTED OCCUPANCY STANDARD	68.64%	68.64%	68.65%	68.65%	72.59%	72.59%	72.59%	72.59%	72.59%	72.59%	72.59%
GROSS BED NEED	**420.02**	**430.79**	**441.48**	**465.22**	**450.20**	**460.44**	**470.70**	**480.97**	**499.50**	**509.81**	**520.12**
NET BED NEED/(SURPLUS)	**28.02**	**38.79**	**45.48**	**69.22**	**6.20**	**16.44**	**26.70**	**36.97**	**55.50**	**65.81**	**76.12**

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