EXECUTIVE SUMMARY

EVALUATIONS OF THE FOLLOWING THREE CERTIFICATE OF NEED APPLICATIONS PROPOSING TO ADD ACUTE CARE BED CAPACITY TO THE SOUTHEAST KING COUNTY PLANNING AREA:

- **AUBURN REGIONAL MEDICAL CENTER PROPOSING TO ADD 70 ACUTE CARE BEDS TO THE EXISTING HOSPITAL**
- **MULTICARE HEALTH SYSTEM PROPOSING TO ESTABLISH A 58 ACUTE CARE BED HOSPITAL IN COVINGTON**
- **VALLEY MEDICAL CENTER PROPOSING TO ADD 60 ACUTE CARE BEDS TO THE EXISTING HOSPITAL**

BRIEF PROJECT DESCRIPTIONS

Auburn Regional Medical Center

Auburn Regional Medical Center (Auburn) proposes to add 70 acute care beds to the existing hospital located at 202 North Division Street in Auburn, Washington. The new beds would be housed in a new 3-story tower built on the northeast corner of the current hospital campus. The new capacity would serve the residents of Southeast King County.

The capital expenditure associated with the total tower construction is $34,159,515. If this project is approved, Auburn anticipates that the beds would become operational by January 2014. Under this timeline, year 2015 would be the facility's first full calendar year of operation. [Auburn Application, p8 & 16]

MultiCare Health System

MultiCare Health System (MultiCare) proposes to add 58 acute care beds to the organization's Covington Medical Park located at 17700 Southeast 272nd Street in Covington, Washington. The new beds would be housed in a new 4-story tower space constructed at the Medical Park site. The new capacity would serve the residents of Southeast King County.

The capital expenditure associated with the total expansion is $174,700,000. Of this amount, $158,516,892 is attributed to the phased 4-story tower expansion of the medical park. If this project is approved, MultiCare anticipates that the beds would become operational in two phases. Completion of Phase 2 would include the remaining 24 of the 58 new acute care beds and will be operational by July 2015. Under this timeline, year 2016 would be the facility's first full calendar year of operation. [MultiCare Application, p16 & 26]

Valley Medical Center

Public Hospital District #1 of King County dba Valley Medical Center (Valley) proposes to add 60 acute care beds to the district's existing hospital located at 400 43rd Street in Renton, Washington. The new beds would be housed in vacated space within the hospital (30 acute care beds) and a newly constructed 6th floor (remaining 30 beds) of a new 7-story tower built on the current hospital campus. The new capacity would serve the residents of Southeast King County

The capital expenditure associated with the total expansion is $38,845,000[1]. Of this amount, $19,922,500 is attributed to the phased 60 bed expansion of the hospital. If this project is approved, Valley anticipates that the beds would become operational in two phases. Completion of the 6th floor of the tower for Phase 2 would include the remaining 30 acute care beds. Under this timeline, year 2014 would be the facility's first full calendar year of operation. [Valley Application, p4 &10; April 9, 2010 Supplemental Information, p3]

APPLICABILITY OF CERTIFICATE OF NEED LAW

Acute care bed additions are subject to Certificate of Need 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).

CONCLUSIONS

Auburn Regional Medical Center

For the reasons stated in this evaluation, the application submitted on behalf of Auburn Regional Medical Center proposing to add 70 acute care beds to the Southeast King planning area is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

MultiCare Health System

For the reasons stated in this evaluation and agreement to the following term, the application submitted on behalf of MultiCare Health System proposing to establish a 58-bed acute care hospital within the Southeast King planning area is consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is approved.

Approved Capital Costs: $158,516,892

Term:

MultiCare will provide to the department, for review and approval, an executed version of the Admission Policy to be used at the proposed hospital. The adopted policy must specifically address a patient's guaranteed admission without regard to items such as race, ethnicity, national origin, citizenship, age, sex, pre-existing condition, physical or mental status and be consistent with the proposed agreement provided in the application.

Valley Medical Center

For the reasons stated in this evaluation, the application submitted on behalf of Valley Medical Center proposing to add 60 acute care beds to the Southeast King planning area is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

[1] Upon analysis of the application and screening responses, the total costs were reviewed and computation errors corrected to increase the stated costs by $500,000.

EVALUATIONS OF THE FOLLOWING THREE CERTIFICATE OF NEED APPLICATIONS PROPOSING TO ADD ACUTE CARE BED CAPACITY TO THE SOUTHEAST KING COUNTY PLANNING AREA:

- **AUBURN REGIONAL MEDICAL CENTER PROPOSING TO ADD 70 ACUTE CARE BEDS TO THE EXISTING HOSPITAL**
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- **VALLEY MEDICAL CENTER PROPOSING TO ADD 60 ACUTE CARE BEDS TO THE EXISTING HOSPITAL**

PROJECT DESCRIPTIONS

Auburn Regional Medical Center

Auburn Regional Medical Center, Inc. (Auburn) is owned and operated by Universal Health Services Inc. Auburn, a for-profit hospital, is located at 202 N. Division Street in the city of Auburn within King County. Auburn is currently licensed for 162 beds, with 124 categorized as acute care, and holds a three year accreditation from the Joint Commission. Auburn currently provides geropsychiatric services in a 38 bed unit located within the hospital. [DOH Office of Health Care Survey; CN historical files]

With this application Auburn proposes to add 70 acute care beds to the existing hospital. The new beds would be housed in a new 3-story tower built on the northeast corner of the current hospital campus. At project completion the Auburn Regional Medical Center will have 232 licensed beds: 194 acute care and 38 geropsychiatric beds. The new beds would be added in two phases as described below [Auburn Application, p27 & 16]

Phase One

Auburn intends to complete construction of the tower in Phase 1, projected for July 2012. In addition to parking capacity and lobby space, the tower will initially house 54 of the new acute care beds distributed to new space developed for the Intensive care and Progressive/Intermediate care units. The resulting bed count at the end of Phase 1 will be 178 acute care beds.

Phase Two

This phase will involve completion of the medical/surgical unit on the new tower's new second floor and will house the remaining 16 new acute care beds. Phase two would begin construction in 2013. The resulting bed count at the end of Phase 2 in 2014 will be 194 acute care beds.

The capital expenditure associated with the total tower construction is $34,159,515. If this project is approved, Auburn anticipates that the last 16 beds would be available for services by January 2014. Under this timeline, year 2015 would be the facility's first full calendar year of operation.

Of the total costs under review, 63% is related to tower construction costs; 19% is related to additional equipment; and the remainder is allocated to taxes and fees. The totals are outlined below. [Auburn Application, p37]

Breakdown Of Capital Costs	Total	% of Total
Leasehold Improvements	$ 21,478,182	63%
Fixed & Moveable Equipment	$ 6,354,000	19%
Architect / Consulting Fees	$ 3,305,129	10%
Taxes & Review Fees	$ 3,022,203	9%
Total Estimated Capital Costs	**$ 34,159,514**	**100.00%**

MultiCare Health System

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

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

This application proposes to establish a 58 acute care bed hospital through an expansion of the existing Covington Medical Park. The new beds would be housed in new space at the Covington Medical Park which will include the construction of a 4-story tower. The 58 beds would be added in two phases as described below. [MultiCare Application, p15 & 24]

Phase One

MultiCare intends to begin construction in 2012. Phase 1 will involve construction of space to accommodate 34 of the new acute care beds and focus upon the completion of floors 1, 2, and 4. This new capacity is expected to be available for service by July 2014.

Phase Two

The remaining 24 beds will be made operational on the 3rd floor of the new construction. Phase 2 would be complete and operational by July 2015. The total number of acute care beds would total 58.

The capital expenditure associated with the total tower expansion is $174,700,000. Of this amount, $158,516,891 is attributed to the phased 58 bed expansion of the medical park. Of the total costs under review, 59% is related to land and construction; 14% is allocated to equipment; and the remainder distributed between taxes, fees, and financial costs. The totals are outlined below. [MultiCare Application, p53]

[2] Tacoma General Hospital and Allenmore Hospital are located at two separate sites; they are operated under the same hospital license of "Tacoma General/Allenmore Hospital."

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

Breakdown Of Capital Costs	Total	% of Total
Land & Construction	$ 92,737,597	59%
Leasehold Improvements	$ 1,680,000	1%
Fixed & Moveable Equipment	$ 21,846,709	14%
Architect / Consulting Fees	$ 17,233,143	11%
Financing Costs	$ 12,617,824	8%
Taxes & Review Fees	$ 12,401,618	8%
Total Estimated Capital Costs	**$158,516,891**	**100.00%**

Valley Medical Center

Public Hospital District #1 of King County dba Valley Medical Center (Valley) is established as the oldest and largest hospital district in Washington which encompasses the cities of Kent, Renton, and portions of Tukwila, Auburn, Black Diamond, Covington, Federal Way, Maple Valley, Newcastle and Seattle. Valley Medical Center is located at 400 43rd Street in Renton, Washington. Valley is currently licensed for 303 beds, with 283 categorized as acute care beds[4], and holds a three year accreditation from the Joint Commission. [DOH Office of Health Care Survey; CN historical files; VMC website]

Valley Medical Center (Valley) proposes to add 60 acute care beds to the district's hospital site. The initial 30 new beds would be housed in vacated space within the existing hospital. The 6th floor of a new 7-story tower built on the current hospital campus will house the remaining 30 beds. The new capacity would serve the residents of Southeast King County

If this project is approved, Valley anticipates that the beds would become operational in two phases. Phase 2 would be completed in 2013. Under this timeline, year 2014 would be the facility's first full calendar year of operation. [Valley Application, p4 &10; Valley April 9, 2010 Supplemental Information, p3]

Phase One

Valley intends to complete Phase 1 by January 2012 through re-habituating space available in NW A & B of the hospital with 30 new beds. This space will become available through the re-location of current programs to the lower floors of the newly constructed patient tower. The resulting bed count at the end of Phase 1 will be 313 acute care beds.

Phase Two

This phase will involve the completion of the new tower's 6th floor. Phase 2 would provide space for the remaining 30 new acute care beds and is scheduled to become available for services in 2013. The resulting bed count at the end of Phase 2 will be 343 acute care beds and a total licensed capacity of 363. [Valley Application, p4]

The capital expenditure associated with the total expansion is $38,845,000[5]. Of this amount, $19,922,500 is attributed to the phased 60 bed expansion of the hospital and $18,922,500 for the

[4] The remainder includes a 20 bed ICN level II and NICU level III nursery

[5] Upon analysis of the completed application, the total costs were reviewed and computation errors corrected to increase the stated costs by $500,000.

completion of a shelled-in 7th floor. If this project is approved, Valley anticipates that the last 30 beds would be available for services by 2013. Under this timeline, year 2014 would be the facility's first full calendar year of operation.

Of the total costs under review, 85% is related to construction with nominal amounts related to remodeling of the existing hospital space in NW A & B, additional equipment and related taxes and fees. The totals are outlined below. [Valley Application, p32; Valley April 9, 2010 Supplemental Information, p3]

Breakdown Of Capital Costs	Total	% of Total
Construction[6]	$ 16,974,500	85%
Leasehold Improvements	$ 250,000	1%
Fixed & Moveable Equipment	$ 1,654,000	8%
Architect / Consulting Fees	$ 450,000	2%
Taxes & Review Fees	$ 594,000	3%
Total Estimated Capital Costs	**$ 19,922,500**	**100.00%**

APPLICABILITY OF CERTIFICATE OF NEED LAW

Acute care bed additions are subject to Certificate of Need 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).

CRITERIA EVALUATION

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

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

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

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

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

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

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

[6] Includes costs for sunk costs in construction of 6th floor, construction necessary to complete 6th floor, and costs for the shelled-in 7th floor

"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."

APPLICATION CHRONOLOGY

Action	Auburn	MultiCare	Valley
Letter of Intent Submitted	December 31, 2009	November 20, 2009	December 22, 2009
Application Submitted	February 1, 2010	December 23, 2009	January 25, 2010
Department's pre-review Activities including screening and responses	December 24, 2009 through June 10, 2010		
Beginning of Review	June 11, 2010		
Public Hearing/End of Public Comment	August 5, 2010		
Rebuttal Comments Received	August 23, 2010		
Department's Anticipated Decision Date	October 7, 2010		
Department's Updated Decision Date	November 8, 2010		
Department's Actual Decision Date	December 20, 2010		

COMPARATIVE REVIEW AND AFFECTED PERSONS

The comparative review process promotes the expressed public policy goal of RCW 70.38 that the development or expansion of health care facilities is accomplished in a planned, orderly fashion and without unnecessary duplication. In the case of these projects submitted by Auburn, MultiCare, and Valley, the department will issue one single evaluation regarding whether all, any, or none of the projects should be issued a Certificate of Need.

In additional to the three applicants, one additional entity sought and received affected person status under WAC 246-310-010.

- Premera Blue Cross – A Health Insurance carrier within Western Washington.

SOURCE INFORMATION REVIEWED

- Auburn Regional Medical Center's Certificate of Need application submitted February 1, 2010
- MultiCare Health System's Certificate of Need application submitted December 23, 2009
- Auburn Regional Medical Center's supplemental information dated April 9, 2010
- MultiCare Health System's supplemental information dated April 9, 2010
- Valley Medical Center's supplemental information dated April 9, 2010
- MultiCare Health System's supplemental information dated June 11, 2010

- Valley Medical Center's supplemental information dated June 11, 2010
- Auburn Regional Medical Center's supplemental screening responses[7] received July 1, 2010
- Department of Health's Office of Hospital and Patient Data Systems (HPDS) financial feasibility and cost containment analysis for Auburn Regional Medical Center dated September 20, 2010
- Department of Health's Office of Hospital and Patient Data Systems (HPDS) financial feasibility and cost containment analysis for MultiCare Health System dated September 20, 2010
- Department of Health's Office of Hospital and Patient Data Systems (HPDS) financial feasibility and cost containment analysis for Valley Medical Center dated September 23, 2010
- Comprehensive Hospital Abstract Reporting System (CHARS) data and Charity Care Policy approvals obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Public comment received during the course of the review
- Documents and testimony submitted during the public hearing on April 6, 2010
- Acute care bed capacity surveys submitted by Auburn Regional Medical Center, Enumclaw Regional Hospital, and St. Francis Hospital.
- Auburn Regional Medical Center's rebuttal comments dated August 23, 2010
- MultiCare Health System's rebuttal comments dated August 23, 2010
- Valley Medical Center's rebuttal comments dated August 23, 2010
- Premera Blue Cross's rebuttal comments dated August 23, 2010
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Population estimates and forecasts obtained from the Claritas, Inc.
- Data obtained from the HPDS website
- Data obtained from the MultiCare Health System website
- Data obtained from the Valley Medical Center website
- Certificate of Need Historical files
- Department of Health's Investigation and Inspection's Office (IIO) files

CONCLUSIONS

Auburn Regional Medical Center

For the reasons stated in this evaluation, the application submitted on behalf of Auburn Regional Medical Center proposing to add 70 acute care beds to the Southeast King planning area is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

MultiCare Health System

For the reasons stated in this evaluation and agreement to the following term, the application submitted on behalf of MultiCare Health System proposing to establish a 58-bed acute care hospital within the Southeast King planning area is consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is approved.

Approved Capital Costs: $158,516,892

[7] WAC 246-310-090(2)(d)

Term:

MultiCare will provide to the department, for review and approval, an executed version of the Admission Policy to be used at the proposed hospital. The adopted policy must specifically address a patient's guaranteed admission without regard to items such as race, ethnicity, national origin, citizenship, age, sex, pre-existing condition, physical or mental status and be consistent with the proposed agreement provided in the application.

Valley Medical Center

For the reasons stated in this evaluation, the application submitted on behalf of Valley Medical Center proposing to add 60 acute care beds to the Southeast King planning area is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

A. Need (WAC 246-310-210)

Based on the source information reviewed, in relation to the need criteria in WAC 246-310-210, (1) and (2) the department determines that:

- Auburn Regional Medical Center's project has not met the need criteria
- MultiCare Health System's project has met the need criteria
- Valley Medical Center's project has not met the need criteria

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

The Department uses the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan to assist in its determination of need for acute care capacity. This forecasting method is designed to evaluate need for additional capacity in general, rather than identify need for a specific project. The Department prepared bed need forecasts to determine baseline need for acute care capacity. This set of projections is completed prior to determining whether the applicant should be approved to meet any projected need.

Summary of Auburn's Numeric Methodology

Auburn proposes to add 70 acute care beds to the hospitals capacity in multiple phases. Given that this proposal involves construction, Auburn intends to begin the construction project in January, 2011. The first 54 beds would be added in year 2012, resulting in 178 acute care beds at Auburn. The remaining 26 beds are anticipated to become available in 2014. Under this timeline, 2018 would be Auburn's third year of operation with 194 acute care beds, or a total compliment of 232 licensed beds. [Auburn Application, p16, CN Historical files]

Auburn provided two numeric methodologies for consideration in support of the requested beds. The method submitted as part of the original application relied upon discharge data of the facilities in steps 1 through 4 for the years between 1999 and 2008. The method submitted during screening of the application relied upon discharge data of the residents in steps 1 through 4 during the same timeframe. The screening version which applies the resident patient days will be used in the review of this bed request. [Auburn Application, Exhibit 7; Auburn July 1, 2010 Supplemental Addendum, Attachment 2]

Auburn followed each step of the methodology as prescribed and used the appropriate planning area patient days and population figures for HSA1 and the state. As a result, Auburn computed a surplus of beds through 2012. The first indication of need for additional beds emerges in 2013 (2 beds) and increases to equal a need for 36 planning area beds by 2015; insufficient to support the proposed 70 beds. A complete summary of the applicant's projections are shown in Table 1. [Auburn July 1, 2010 Supplemental Addendum, Attachment 2]

Table 1
Summary of the Auburn Need Methodology for Southeast King Planning Area

	2008	2009	2010	2011	2012	2013	2014	2015
Patient Days	118,762	122,660	126,709	131,111	135,718	139,133	143,399	147,441
Planning Area Beds	550	550	550	550	568	568	568	568
Adjusted Gross Need	486	502	519	537	556	570	588	604
Adjusted Net Need	-64	-48	-31	-13	-12	2	20	36

* Negative number indicates a surplus of beds. All numbers are rounded.

Summary of MultiCare's Numeric Methodology

MultiCare proposes to add 58 acute care beds in the expansion of the Covington Medical Park in multiple phases. Given that this proposal does involve construction, MultiCare intends to begin offering services in the initial 34 beds in 2012. The remaining 24 beds would be added by 2015, resulting in 58 acute care beds at completion. Under this timeline, 2018 would be MultiCare's third year of operation with 58 acute care beds. [MultiCare Application, pp23-26]

For its numeric demonstration of need for the additional beds, MultiCare produced two numeric methodologies. The method submitted as part of the original application relied upon discharge data of the residents in the planning area for the years between 1999 and 2008. The method submitted during rebuttal of the application added 2009 discharge data of the residents in the planning area and a timeframe of 2000-2009. Due to the timing of when the updated methodology was submitted, the original application version will be used in the review of this bed request. [MultiCare Application, Exhibit 12; MultiCare Rebuttal, Appendix 1]

MultiCare followed each step of the methodology as prescribed and used the appropriate planning area patient days and population figures for HSA1 and the state. MultiCare ultimately computed a need of planning area beds in each projection year due primarily to the reduced number of beds considered in the current supply. The need for additional beds is equal to 17 in 2010 and extends to a need for 98 additional beds by 2015. A complete summary of the MultiCare's projections are shown in Table 2. [MultiCare Application, Exhibit 12]

Table 2
Summary of the MultiCare Need Methodology for Southeast King Planning Area

	2008	2009	2010	2011	2012	2013	2014	2015
Patient Days	116,495	119,812	123,870	128,124	132,585	137,267	142,765	147,966
Planning Area Beds	474	474	492	492	510	510	510	510
Adjusted Gross Need	478	492	509	526	545	564	587	608
Adjusted Net Need	4	18	17	34	35	54	77	98

* Negative number indicates a surplus of beds. All numbers are rounded.

Summary of Valley's Numeric Methodology

Valley proposes to add 60 acute care beds to the hospital in two phases. Valley intends to begin offering services in the initial 30 beds in 2012. The remaining 30 beds would be added by 2014, resulting in 343 acute care beds at completion. Under this timeline, 2017 would be Valley's third year of operation with 343 acute care beds. [Valley Application, pp9-10]

For its numeric demonstration of need for the additional beds, Valley produced a numeric methodology which relied upon discharge data of the residents in the planning area for the years between 1999 and 2008. This version will be used in the review of this bed request. [Valley Application, Attachment 9]

Valley followed each step of the methodology as prescribed and used the appropriate planning area patient days and population figures for HSA1 and the state. As a result, Valley computed a surplus of beds through 2012. The first indication of need for additional beds emerges in 2013 (12 beds)

and increases to equal a need for 56 planning area beds by 2015; below the number necessary to support the proposed 60 beds. A complete summary of the Valley's projections are shown in Table 3. [Valley Application, Attachment 9]

Table 3
Summary of the Valley Need Methodology for Southeast King Planning Area

	2008	2009	2010	2011	2012	2013	2014	2015
Patient Days	116,495	119,812	123,870	128,124	132,585	137,267	142,785	147,966
Planning Area Beds	514	514	532	532	550	550	550	550
Adjusted Gross Need	476	490	507	524	543	562	585	606
Adjusted Net Need	-38	-24	-25	-8	-7	12	35	56

* Negative number indicates a surplus of beds. All numbers are rounded.

The Department's Determination of Numeric Need:

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

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

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

The completed methodology is presented as a series of steps in the appendix of this evaluation. The methodology presented here incorporates all adjustments that were made following preparation of the methodology. Where necessary, both adjusted and un-adjusted computations are provided. The methodology uses population and healthcare use statistics on several levels: statewide, Health Service Area (HSA)[8], and planning area. The planning area for this evaluation is

[8] The state is divided into four HSA's by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Snohomish, and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum counties. HSA 3 is composed of Benton,

the Southeast King planning area. The Southeast King planning area is described in Puget Sound Health Systems Agency documents from 1981 as the area in the southeast portion of King County[9].

When preparing acute care bed need projections, the department relies upon population forecasts published by OFM. OFM publishes a set of forecasts known as the "medium-series" county population projections, based on the 2000 census, updated November 2007[10]. However, OFM figures are not available for any area smaller than an entire county. Because OFM does not provide population estimates at the level necessary for inclusion of the necessary parts of King County, the department relied upon estimates and projections developed by Claritas, Inc. for the applicable zip code populations in the Southeast King planning area.

A seven-year horizon for forecasting acute care bed projections will be used in the evaluation of the Auburn and Valley applications, which is consistent with the recommendations within the state health plan that states, "For most purposes, bed projections should not be made for more than seven years into the future". By proposing to construct a new hospital, MultiCare's application may have up to a 15-year horizon applied, which is also consistent with most new hospital projects reviewed by the CN Program and state health plan recommendations[11]. Prior to the release of this evaluation, the department produced the 2009 hospital data used to compile the bed forecasts. As a result, the department will initially set the target year as 2016 for the existing Auburn and Valley facilities, which is seven years after the most recent available data (2009). Each of the applicant's has methodologies based upon the 2008 data available at the time of application. MultiCare, by proposing a new facility, can warrant a larger planning horizon and is detailed later in this evaluation.

This portion of the evaluation will describe, in summary, the calculations made at each step and the assumptions and adjustments made in that process. It will also include a review of any deviations related to the assumptions or adjustments made by the applicant's in their application of the methodology. The titles for each step are excerpted from the 1987 SHP.

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

For this step, attached as Step 1, the department obtained planning area resident utilization data for 2000 through 2009 from the Department of Health Office of Hospital and Patient Data Systems' CHARS (Comprehensive Hospital Abstract Reporting System) database. Total resident patient days were identified for the Southeast King Planning Area, HSA 1, and the State of Washington as a whole, excluding psychiatric patient days (Major Diagnostic Category, MDC-19) and neonatal bassinette patient days (Major Diagnostic Category, MDC-15), according to the county in which care was provided.

Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan, and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman counties.

[9] Described in 1981 Puget Sound Health Systems Agency documents as the area bounded by I-90, by the county line on the East and South, and by Puget Sound and I-5 to the West.

[10] The November 2007 series was the most current data set available during the production of the state acute care methodology following the release of the 2009 CHARS data and can be found at http://www.ofm.wa.gov/pop/estimates.asp and compiled internally by DOH

[11] State Health Plan, p. C-30, Section 4(a) & (b)

Auburn
Auburn followed this step as described above with slight variations in the totals reported.

MultiCare
MultiCare followed this step as described above with slight variations in the totals reported.

Valley
Valley followed this step as described above with slight variations in the totals reported.

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

Auburn
Auburn followed this step as described above with no patient days deducted.

MultiCare
MultiCare followed this step as described above with slight variations in the totals reported.

Valley
Valley followed this step as described above with slight variations in the totals reported.

Step 3: For each year, compute the statewide and HSA average use rates.
The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each HSA by that HSA's population and multiplied by 1,000. Population figures for this analysis were derived from historical population estimates for the Southeast King planning area were established using Claritas, Inc. data

Auburn
Auburn followed this step as described above with no deviations.

MultiCare
MultiCare followed this step as described above with no deviations.

Valley
Valley followed this step as described above with no deviations.

Step 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.
The department has computed trend lines for the State and HSA 1 based upon the trends in use rates from these ten years and has included them as Step 4. The resulting trend lines show an upward slope meaning use rates are increasing. Also, the overall state growth rate is less than the HSA1 rate. This conclusion is supported by increasing utilization reported by hospitals throughout

the state in recent years, and is indicative of a growing population. More significant than overall population growth is the fact that the state's population is growing older as the large number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations.

Auburn
Auburn followed this step as described above with no deviations. Due to differing source years applied in previous steps, the resulting slopes differ, but confirm that the state rate is more conservative than that of the HSA.

MultiCare
MultiCare followed this step as described above with no deviations. Due to differing source years applied in previous steps, the resulting slopes differ, but confirm that the state rate is more conservative than that of the HSA.

Valley
Valley followed this step as described above with no deviations. Due to differing source years applied in previous steps, the resulting slopes differ, but confirm that the state rate is more conservative than that of the HSA.

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live. (The psychiatric patient day data are used separately in the short-stay psychiatric hospital bed need forecasts.)
The previous four steps of the methodology utilizes data particular to the residents of the Southeast King planning area. In order to forecast the availability of services for the residents of a given region, patient days must also be identified for the facilities available within the planning area. Step 5 identifies referral patterns in and out of the Southeast King planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also used 2008 discharge data for Washington residents that receive health care in Oregon. This data is the most recent obtained from the Oregon Department of Human Services (the department is not aware of similar data for the State of Idaho).

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

Auburn
Auburn followed this step as described above with 2008 CHARS data.

MultiCare
MultiCare followed this step as described above with 2008 CHARS data.

Valley
Valley followed this step as described above with 2008 CHARS data.

Step 6: Compute each hospital planning area's use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+).
Step 6 illustrates the age-specific use rates for the year 2009 for the Southeast King planning area and for the rest of the state.

Auburn
Auburn followed this step as described above with no deviations. Computed 2008 use rates are slightly higher, but comparable, to those produced by the department for 2009.

MultiCare
MultiCare followed this step as described above with no deviations. Computed 2008 use rates are slightly higher, but comparable, to those produced by the department for 2009.

Valley
Valley followed this step as described above with no deviations. Computed 2008 use rates are slightly higher, but comparable, to those produced by the department for 2009.

Step 7A: Forecast each hospital planning area's use rates for the target year by "trend-adjusting" each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the appropriate health planning region's ten-year use rate trend, whichever trend would result in the smaller adjustment.
As discussed in Step 4, the department used the ten-year use rate trends for 2000-2009 to reflect the use patterns of Washington residents. The 2009 use rates determined in Step 6 were multiplied by the slopes of both the Health Service Area's ten-year use rate trend line and by the slope of the statewide ten-year use rate trend line for comparison purposes. The State has a lower projected rate (an annual increase of 1.5852) than the HSA1 trend rate of 1.6410. As directed in Step 7A, the department applied the State trend to project future use rates.

The methodology is designed to project bed need in a specified "target year." It is the practice of the department to evaluate need for an expansion project through seven years from the last full year of available CHARS data, or 2009 for purposes of this analysis. Therefore, the target year for the expansion projects will be 2016. For a new hospital, the practice of the department is to allow a projection period of 15 years, or 2024.

Auburn
Auburn also applied the 2008 State use rate and followed this step as described above with no deviations.

MultiCare
MultiCare also applied the 2008 State use rate and followed this step as described above with no deviations.

Valley
Valley also applied the 2008 State use rate and followed this step as described above with no deviations.

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.
Using the forecasted use rate for the target year 2016 and population projections, projected patient days for Southeast King planning area residents are illustrated in Step 8. As noted in Step 7, above, forecasts have been prepared for a series of years and are presented in summary in Step 10 as "Total Southeast King Res Days."

Auburn
Auburn applied this step based upon 2008 values and computed as described above with no deviations.

MultiCare
MultiCare followed this step based upon 2008 values and computed projections for 2010, 2015, and 2020.

Valley
Valley followed this step based upon 2008 values and computed projections for 2010, 2015, and 2020.

Step 9: Allocate the forecasted non-psychiatric patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.
Using the patient origin study developed for Step 5, Step 9 illustrates how the projected patient days for the Southeast King planning area and the remainder of the state were allocated from county of residence to the area where the care is projected to be delivered in the target year 2016. The results of these calculations are presented in Step 10 as "Total Days in Southeast King Hospitals."

Auburn
Auburn followed this step as described.

MultiCare
MultiCare followed this step as described.

Valley
Valley followed this step as described.

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

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

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

SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information was gathered through a capacity survey of the state hospitals, inclusive of the Southeast King County hospitals. For those hospitals that do not respond to the department's capacity survey, the information is obtained through the Department of Health's Office of Hospital and Patient Data Systems records.

For this project, there are four hospitals considered in the Southeast King planning area. Below are a summary of these facilities and the Department's determination of the capacity values used in the production of the acute care bed methodology. Three of the hospitals currently operating in the Southeast King planning area have completed and returned a survey for use in the establishment of the available bed capacity.

Auburn Regional Medical Center

Auburn is located at 202 N. Division Street in the city of Auburn within King County. Auburn is currently eligible for a licensed capacity of 162 beds[12]. Of these beds, 38 are reported as providing geropsychiatric services. Auburn will be recorded to have a total capacity of 124 acute care beds. [Auburn Utilization Survey, CN Application 09-17]

Enumclaw Regional Hospital

Enumclaw is critical access hospital located at 1450 Battersby Avenue in Enumclaw and is licensed for 38 beds. As a critical access hospital, Enumclaw can operate no more than 25 beds as acute care. Enumclaw has a licensed nursing home within its city limits. Therefore Enumclaw does not qualify for the exemption under RCW 70.38.105(4)(e). Enumclaw reports 25 of the beds are set up or assignable. Enumclaw will be recorded to have a total capacity of 25 beds. [Enumclaw Utilization Survey]

St. Francis Hospital

St. Francis Hospital is located at 34515 – 9th Avenue South in Federal Way, within King County. The hospital provides Medicare and Medicaid acute care services to residents of Southeast King and Northern Pierce counties and holds a three-year accreditation with the Joint Commission. Due

[12] Auburn Regional was approved for an additional 18 geropsychiatric beds and CN#1402 was issued in September, 2009

to recent program decisions[13], St. Francis Hospital will increase their acute care beds totals to 118 in 2009 and 136 in 2012. St. Francis will be recorded to have the appropriate number of beds in each forecast year. [St. Francis Utilization Survey; CN Historical Records]

Valley Medical Center

Public Hospital District #1 of King County dba Valley Medical Center (Valley) which encompasses the cities of Kent, Renton, and portions of Tukwila, Auburn, Black Diamond, Covington, Federal Way, Maple Valley, Newcastle and Seattle**.** Valley Medical Center is located at 400 43rd Street in Renton, Washington. Valley is licensed for 303 beds and operates a 20 bed ICN level II and NICU level III nursery. Valley will be recorded to have a total capacity of 283 acute care beds. [DOH Facility Records]

While the methodology states that short-stay psychiatric beds should be included in the above totals, the fact that all psychiatric patient days were excluded from the patient days analyzed elsewhere in the methodology makes their inclusion inconsistent with the patient days used to determine need. There are no psychiatric hospitals located in the Southeast King planning area. In summary, among the four hospitals operating in the Southeast King planning area, the Department has determined that there are 550 available licensed beds.

The totals represented by each applicant are displayed in Table 4. The differences lead to the department applying a differing capacity value of available beds in the methodology than either MultiCare or Valley. [Auburn Application, p49 & Exhibit 13; MultiCare Application, p26 & Exhibit 6]

Table 4
Southeast King Planning Area 2009 Acute Care Bed Capacity Totals

Hospital	Auburn Total	MultiCare Total	Valley Total	Department Total
Auburn Regional Medical Center	124	106	106	124
Enumclaw Regional Hospital	25	25	25	25
St. Francis Hospital	118	100	100	118
Valley Medical Center	283	243	283	283
Applied Methodology Capacity	**550**	**474**	**514**	**550**

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

As a result of this change, the Southeast King planning area's weighted occupancy has been determined to be 66.89% through 2012, decreasing nominally to 66.83 with St. Francis's bed increase in 2012. The weighted occupancy standard assumptions detailed above, is reflected in the line "Wtd Occ Std" in Step 10.

[13] CN10-05 released December 14, 2009

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

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

Auburn

Auburn also did not provide psychiatric forecasts within its methodology.

MultiCare

MultiCare also did not provide psychiatric forecasts within its methodology.

Valley

Valley also did not provide psychiatric forecasts within its methodology.

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

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

Auburn

Auburn followed this step as described above.

MultiCare

MultiCare followed this step as described above.

Valley

Valley followed this step as described above.

The results of the department's methodology are available in Appendix A as Steps 10A through 10E attached to this evaluation. Step 10A calculates the Southeast King planning area bed need without any of the proposed projects. [Appendix A]

Table 5
Department Methodology Summary
Step 10A – Without Proposed Projects

	2010	2011	2012	2013	2014	2015	2016
Planning Area # of beds	550	550	568	568	568	568	568
Adjusted Gross Need	506	524	542	560	579	597	615
Need/(Surplus) – Without Project (Step 10a)	(44)	(26)	(26)	(8)	11	29	47

* Negative number indicates a surplus of beds. All numbers are rounded.

As shown in Table 5, the surplus, though delayed with the St. Francis beds in 2012, turns to a need for beds by 2014. Step 10A indicates that without the addition of new beds to the planning area, the need would surpass supply by 2014. [Appendix A, Step 10a]

Auburn

Step 10B demonstrates the impact of Auburn adding 70 additional beds to the planning area in 2012 and 2014. A summary of those results are shown in Table 6.

Table 6
Step 10B – With Auburn Project – Summary

	2010	2011	2012	2013	2014	2015	2016
Planning Area # of beds	550	550	622	622	638	638	638
Adjusted Gross Need	506	524	543	562	580	599	617
Need/(Surplus) - With Project (Step 10b)	(44)	(26)	(78)	(60)	(58)	(39)	(21)

* Negative number indicates a surplus of beds. All numbers are rounded.

Step 10B illustrates the effect on the planning area if Auburn begins to add acute care beds to the planning area in year 2012. In that year, when considering the results in 10A, the net planning area surplus increases from 26 to 78 beds with the inclusion of the first 54 beds, and then maintains a surplus three years beyond completion of the phased implementation. [Appendix A, Step 10b]

MultiCare

Step 10C demonstrates the impact of MultiCare adding 58 additional beds to the planning area in multiple phases. Though the need forecast period for a new hospital is generally 15 years, the Table 7 below summarizes the years up to 2017, the forecast year necessary to show a need supporting 58 beds. A complete 15 year forecast is detailed in the attached methodology.

Table 7
Step 10C – With MultiCare Project through 2017

	2010	2011	2012	2013	2014	2015	2016	2017
Planning Area # of beds	550	550	568	568	602	626	626	626
Adjusted Gross Need	506	524	542	560	587	603	621	640
Need/(Surplus) - With Project (Step 10c)	(44)	(26)	(26)	(8)	(15)	(23)	(5)	14

* Negative number indicates a surplus of beds. All numbers are rounded.

Step 10C illustrates the effect on the planning area if MultiCare begins to add 34 of the 58 acute care beds to the planning area beginning in year 2014. The complete hospital addition would address the projected need in the planning area through 2016 and a need re-emerges in 2017. [Appendix A, Step 10c]

Valley

Step 10D demonstrates the impact of Valley adding 60 additional beds to the planning area in multiple phases. A summary of those results are shown in Table 8.

Table 8
Step 10D – With Valley Project – Summary

	2010	2011	2012	2013	2014	2015	2016
Planning Area # of beds	550	550	598	628	628	628	628
Adjusted Gross Need	506	524	521	536	553	571	588
Need/(Surplus) - With Project (Step 10b)	(44)	(26)	(77)	(92)	(75)	(57)	(40)

* Negative number indicates a surplus of beds. All numbers are rounded.

Step 10D illustrates the effect on the planning area if Valley begins to add acute care beds to the planning area in year 2012. In that year, the net planning area surplus increases to 77 beds with the inclusion of the first 30 beds in NW-A and NW-B, and then maintains a surplus five years beyond completion of the phased implementation of the remaining beds. [Appendix A, Step 10d]

During the review of these applications, the department received numerous letters of support and personal testimony regarding each project before and during the August 6, 2010 public hearing. The letters of support were submitted by residents of the planning area as well as elected representatives from the Washington State House of Representatives. In addition, local officials and a variety of physicians also provided comment supporting specific projects. A clear majority of the letters expressed concerns with access to available beds, travel times to the existing hospitals in the planning area, and the increased bed need due, in part, to population growth within the planning area's Eastern region. [Public comment provided during the review]

Auburn

Auburn responded to the public comment by concluding that the Auburn expansion proposal is superior to the others being reviewed by focusing upon a number of issues, including the validity of its forecasted patient days, access to a higher acuity of care at the Auburn facility, and what Auburn believes is a better cost alternative. Regarding its projections, Auburn applies an annual growth rate of 6.47% in their patient day forecasts when compared to an average growth rate for total patient days of 10.97% in the years 2003-2008. Auburn also contends that they will continue to provide higher acuity of care than that proposed by MultiCare and that their application accomplishes this through a lower cost per bed. [2003-2008 CHARS data; Auburn Rebuttal, pp7-9]

Further, Auburn contends that the MultiCare application should be denied outright. A summary of Auburn's conclusion reads, "[the] deficiencies or omissions are of such a significant and serious nature that they result in the Department being unable to determine the project's conformance to applicable review standards, rules and statute". [Auburn Rebuttal, p7 & 18]

Specifically regarding the MultiCare proposal, Auburn asserts that; 1) MultiCare is suggesting that they will provide tertiary pediatric services which require separate CN review; 2) Significant capital expenses have been omitted; and 3) No allocation for overhead is included. To support these positions, Auburn cites statements made in the MultiCare application which indicate that the proposed facility will offer pediatric sub-specialties and services, that "the major equipment noted

by [MultiCare] would cost at least six to seven times the $1.2 million that has been allocated", and that the integrated delivery and electronic health record system costs are not represented in the pro-forma financials. [Auburn Rebuttal, pp1-7]

In reviewing the issues raised, the department has found the following statements. Regarding the tertiary pediatric care, MultiCare states that Mary Bridge pediatric specialists will be involved with care for newborn babies of mothers who give birth at the proposed hospital. The additional statements cited by Auburn regarding the planned pediatric care provides no specific indication that care intended to be available at the proposed facility will rise to the standards defining ICN level II or NICU level III care. In fact, a review of the quote source includes references to available ICN level II and NICU level III services through the affiliated hospital of Good Samaritan in Puyallup and Mary Bridge in Tacoma. [MultiCare Application, p19; MultiCare Rebuttal, p17]

Regarding the reported capital expenditures, Auburn refers to a recent ruling[14] in which a hospital was proposing the transfer of used equipment to a proposed off-campus dialysis facility. According to the definition of capital costs for dialysis facilities[15], it was determined that these costs needed to be accounted for as the definition prescribes. In this application, the definition of capital costs is different[16]. Application materials indicate that this equipment is already purchased and the applicable definition of capital costs does not require the inclusion of the equipment costs as presented by Auburn. [Auburn Rebuttal, p3; MultiCare Rebuttal, p21]

In reference to the cost allocations to overhead, MultiCare points to their cost center projections identified in its application. The projections separate out support services and the associated costs in areas such as FTEs, professional fees, and other unspecified expenses. Upon review, these figures are compiled into the expense statement for the pro forma of the 58-bed scenario proposed. [MultiCare Application, p198; MultiCare Supplemental Information, Exhibit 19, MultiCare rebuttal, p21]

MultiCare

MultiCare also responded to number of public comments in establishing their applications strengths, itemized by each of the primary sections of a CoN evaluation. In the particular points, MultiCare contends that their application best satisfies the criteria set forth in rule. MultiCare specifically defends its financing plans, their care delivery model, and that they are the best available option for the residents of the planning area.

Additional rebuttal is provided specifically addressing comment that MultiCare determined to be key questions; 1) How many additional acute care beds are projected to be needed the planning area, and 2) Whether there is a large enough need projection to warrant approval of more than one of the proposed projects. MultiCare points to that fact each of the applications submitted need methodologies which project need for additional capacity in the forecast years. MultiCare also observes that, "there was substantial disagreement in the public comments regarding how many additional beds should be approved". MultiCare concludes that any concern regarding adding too

[14] Master Case #M2008-118469 re: Central Washington Hospital
[15] WAC 246-310-280(2)
[16] WAC 246-310-010(10)

many beds to the planning area makes their proposal the best alternative as it is the most conservative approach to address a forecasted need. [MultiCare Rebuttal, p4 & 9]

Valley

Amongst a number of topics responding to public testimony, including quality and availability of higher acuity care, Valley responded directly to comments regarding the effects of their capital expenditures on the hospital district. Valley restated what was presented in the application that, "the Valley project is funded by cash on hand and through funds generated by operations and any increase in the Valley Medical Center tax rate would require voter approval". [Valley Application, p34; Valley Rebuttal, p2]

Valley also expresses concern about MultiCare's application. Valley addressed topics related to MultiCare's reported capital expenditures, the occupancy rates and market share assumptions MultiCare applies in its need methodology, and assertions made related to hospital efficiencies and the lack of higher acuity services. Valley concludes that the MultiCare application is incomplete and has the potential to negatively affect the ability for the existing hospitals to care for the residents of the planning area. [Valley Rebuttal, p2]

Issues related to the MultiCare's capital expenditures were addressed above in the discussion about capital expenditure definitions prescribed in rule. Of the issues Valley cited in relation to MultiCare's forecasts, the department relied primarily upon the program's need methodology produced as part of this evaluation. Any inaccuracies within the MultiCare forecasts are not represented in the department's calculations.

As part of the review of the issues discussed by each applicant, the department considered the need methodology's forecast of total patient days generated by the residents of the planning area. These projections are adjusted up with a history of in-migration to the area, or down if there is a history of out-migration for care. Southeast King shows outmigration levels are highest for the 0-64 age cohort, indicating that the current hospitals capture approximately 60% of the Resident days generated. The projected days for the years following project completions in 2015 are reprinted below in Table 9. [Evaluation, Appendix A]

Table 9
Department Need Methodology Resident and Hospital Patient Days Projections

	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Total Southeast King **Resident** Days	201,458	207,194	212,950	218,724	224,518	230,331	236,164
Total Southeast King **Hospital** Days	141,132	145,581	150,045	154,522	159,013	163,518	168,037

When the projections of each of the applicants are considered, it becomes apparent that each is looking for year-to-year growth tied to the patient days generated by the planning area's population growth. For example, MultiCare's initial patient days represent growth of a newly constructed hospital, then the forecasts level out to an increase of 5.44% from their second to third year of operation. By comparison, the year-to-year growth forecasted by Auburn and Valley ranges from

6.15 to 6.47%. [Auburn screening April 9, 2010 Supplemental Information, Attachment 3; MultiCare June 11, 2010 Supplemental Information, p5; Valley April 9, 2010 Supplemental Information, p2]

The additional concerns regarding the level of care that residents will receive within the proposed MultiCare hospital were considered and reviewed in relation to the applicant's average length of stay (ALOS) and case-mix index. Considering each hospital's application figures, it appears that MultiCare applies a lower ALOS that the other two applicants. Table 10 shows the ALOS calculated for each applicant. [HPDS MultiCare Analysis, p3; HPDS Valley Analysis, p3]

Table 10
Projected Average Length of Stay

	ALOS
Auburn[17]	3.64
MultiCare	2.65
Valley	3.61

Review of the length of stay and case-mix for hospitals in the state[18] which have between 40-60 beds also indicated that this is not uncommon. For 2009, the three state hospitals[19] of similar size, that do not operate long-term care units or as a critical access hospital, produce an ALOS of 2.70. Comparable to that applied by MultiCare in this application.

These same three hospitals produce an average case-mix score of 0.708. Currently, Auburn has a reported case-mix index of 0.866. Valley, though slightly lower at 0.845, maintains a comparable score. This would indicate that the proposed hospital would likely be treating a lower acuity of patients than that of larger hospitals. The forecasts prepared by MultiCare consistently apply these lower values through the projection years and will be reviewed more completely as part of the financial analysis of the proposed project.

As demonstrated by the department's methodology, summarized previously in Table 5, the Southeast King planning area projects a need for additional acute care bed capacity. Focusing on both the Auburn and Valley applications, neither applicant supplied a methodology which supported their project in the forecast year and their bed requests exceeded the department's projected need by 33% and 22% respectively. By extending the forecast years in the consideration for a new hospital project, the department's need methodology supports the proposed 58-bed MultiCare facility by 2017, only eight years from the most recent available data.

With the growth in projected need for total capacity, consideration was made to apply an extended hospital forecast period of up to 15 years, as applied to new hospitals, for all three of the proposed projects. The 15 year forecasted need in 2024 is 196 beds. Considering current trends for in and out migration, the potential patient days do not support the early years of additional expansions without marked changes in the current trends. [Appendix A]

Table 11
Re-Trending of Patient Day Migration

[17] As reported by HPDS in the Hospital Census & Charge Comparison for Auburn in 2009
[18] As reported by HPDS in the Hospital Census & Charge Comparison From 01/01/2009 to 12/31/2009
[19] The three hospitals identified are Cascade Valley, Island, and Samaritan Hospitals

	2015	2016	2017	2018	2019	2020
Combined Applicant Totals[20]	138,496	149,900	159,950	169,933	180,541	191,812
St. Francis/Enumclaw Totals[21]	34,589	34,589	34,589	34,589	34,589	34,589
Total Above Facility Days	173,094	184,498	194,548	204,531	215,139	226,410
Projected Adjusted Patient Days[22]	145,581	150,045	154,522	159,013	163,518	168,037
% of Adj. Patient days	119%	123%	126%	129%	132%	135%
% of out-migration recaptured	55%	45%	38%	31%	23%	14%

As Table 11 shows, the hospitals would need to reclaim a substantial portion of the current out-migration and develop a growing trend of resident retention to support all three applicant's projected patient days, while the other hospitals experience no change. With 2009 occupancy levels at Auburn and Valley near or below the Department's minimum occupancy standards[23], the degree of outmigration does not appear to simply be a matter of available beds. Adding additional acute care bed capacity will not, in itself, lead to the substantial and necessary changes in current trends to support approval of each of the proposals. [Evaluation, Appendix A; Auburn screening April 9, 2010 Supplemental Information, Attachment 3; MultiCare June 11, 2010 Supplemental Information, p5; Valley April 9, 2010 Supplemental Information, p2, 2009 CHARS]

Even consideration of two of the three options would require a noticeable change in current health care migration patterns necessary to supply the patient days to support the initial years of any two projects. Further, when the MultiCare project is added to the planning area, as depicted previously in Table 7, no need is forecasted until 2017.

Based on the above information and standards, the department's conclusion regarding this sub-criterion follows.

Auburn

The department concludes that the 70-bed expansion presented in the application is not supported in the target year by neither the applicant's nor the Department's need methodology. This sub-criterion is not met.

MultiCare

The department concludes that the proposed 58-bed expansion provided in the application can be supported by the Department's bed need methodology. This sub-criterion is met.

Valley

The department concludes that the 60-bed expansion presented in the application is not supported in the target year by neither the applicant's nor the Department's need methodology. This sub-criterion is not met.

[20] Compiled and forecasted according to applicant pro forma statements

[21] The patient days reported for the other two hospitals in the planning area, St. Francis & Enumclaw, are from 2009 CHARS and, for demonstration purposes, assumes no growth in the projection years

[22] Adjusted patient days projected in Step 10 of Appendix A

[23] Auburn's 2009 Patient days total 31,324 for a 69.2% occupancy (65% standard) and Valley's 2009 Patient days total 54,214 for a 52.5% occupancy (70% standard)

(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.

Auburn

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

To demonstrate compliance with this sub-criterion, Auburn provided a copy of its current Admission Policy that would continue to be used at the hospital. The policy outlines the process/criteria that Auburn will use to admit patients for treatment or care at the hospital. The applicant states that any patient requiring care will be accepted for treatment at Auburn without regard to "race, color, and/or creed". [Auburn Application, Exhibit 6]

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

Auburn currently provides services to Medicare and Medicaid eligible patients. Details provided in the application demonstrate that Auburn intends to maintain this status. For this project, a review of the policies and data provided for Auburn identifies the facility's financial pro forma includes both Medicare and Medicaid revenues [Auburn Application, p43, Exhibit 8]

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

Auburn demonstrated its intent to continue to provide charity care to residents by submitting its current charity care policy that outlines the process a patient would use to access this service. Further, Auburn included a 'charity care' line item as a deduction from revenue within the pro forma financial documents for Auburn. [Application, Exhibits 6 & 8]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Auburn is located in Southeast King and is one of 20 hospitals located within the King County Region. According to 2006-2008 charity care data obtained from HPDS, Auburn has historically provided less than the average charity care provided in the region. Auburn's most recent three years (2006-2008) percentages of charity care for gross and adjusted revenues are detailed in Table 12. [HPDS 2006-2008 charity care summaries]

Table 12
Auburn Charity Care Comparison

	3-Year Average for King County Region	3-Year Average for Auburn
% of Gross Revenue	1.36 %	0.61 %
% of Adjusted Revenue	2.42 %	1.12 %

RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. A review of the applicant's pro forma shows they are predicted to improve upon this trend and begin to exceed the regional average. Though Auburn does propose to exceed the regional average, a charity care condition for the hospital is necessary to approve the project.

> Auburn will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Auburn 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 King County Region. Currently, this amount is 2.42% of adjusted revenue. Auburn will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

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

MultiCare

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

To demonstrate compliance with this sub-criterion, MultiCare provided a copy of its proposed Adult and Children's Admission Policies that would be used at the hospital. The policy outlines the process and parameters that MultiCare will use to admit patients for treatment or care at the proposed hospital. The applicant states that the policy applies to any patient requiring care at a MultiCare facility, but does not address guaranteed admission without regard to a patients race, ethnicity, national origin, citizenship, age, sex, pre-existing condition, physical or mental status, insurance status, economic status or the ability to pay for medical services. [MultiCare Application, Exhibit 15A]

> If this project is approved, a term would be added requiring the MultiCare to provide to the department for review and approval of an executed version of the Admission Policy to be used at the proposed hospital. The adopted policy must specifically address a patient's guaranteed admission without regard to items such as race, ethnicity, national origin, citizenship, age, sex,

pre-existing condition, physical or mental status and be consistent with the proposed agreement provided in the application.

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

MultiCare currently provides services to Medicare and Medicaid eligible patients. Details provided in the application demonstrate that MultiCare intends to apply for this status. For this project, a review of the policies and data provided for MultiCare identifies the facility's financial pro forma includes both Medicare and Medicaid revenues [MultiCare June 11, 2010 Supplemental Information, p63 & Exhibit 19]

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

MultiCare demonstrated its intent to continue to provide charity care to residents by submitting its current charity care and financial assistance policy that outlines the process a patient would use to access this service. Further, MultiCare included a 'provision for charity' line item as a deduction from revenue within the pro forma financial documents for MultiCare. [MultiCare Application, p63; MultiCare June 11, 2010 Supplemental Information, Exhibit 19]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. The proposed MultiCare facility is located in Southeast King and is one of 20 hospitals located within the King County Region. According to 2006-2008 charity care data obtained from HPDS, MultiCare's combined Tacoma General/Allenmore sites in Pierce County have historically provided more than the average charity care provided in that region. The proposed faculty's forecasted percentages (2014-2017) of charity care for gross and adjusted revenues are detailed in Table 13. [HPDS 2006-2008 charity care summaries]

Table 13
MultiCare Charity Care Comparison

	3-Year Average for King County Region	MultiCare Pierce County TG Avg.	4-Year Forecast for MultiCare Coving.
% of Gross Revenue	1.36 %	1.50 %	2.23 %
% of Adjusted Revenue	2.42 %	3.31 %	4.75 %

MultiCare's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 2.23% of gross revenue and 4.75% of adjusted revenue. RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. Figures demonstrate that the amount of comparable charity care historically provided by MultiCare is above the regional averages and MultiCare proposes to provide charity care above the three-year historical gross and adjusted revenue averages for the proposed region.

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

Valley

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

To demonstrate compliance with this sub-criterion, Valley provided a copy of its current Admission Policy that would continue to be used at the hospital. The policy outlines the process/criteria that Valley will use to admit patients for treatment or care at the hospital. The applicant states that any patient requiring care will be accepted for treatment at Valley without regard to "race, color, national origin, sex, marital status, or on the basis of disability or age". [Valley Application, Attachment 12]

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

Valley currently provides services to Medicare and Medicaid eligible patients. Documents provided in the application demonstrate that Valley intends to maintain this status. For this project, a review of the policies and data provided for Valley identifies the facility's financial pro forma includes both Medicare and Medicaid revenues [Valley Application, p6; Valley April 9, 2010 Supplemental Information, Attachment 1]

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

Valley demonstrated its intent to continue to provide charity care to residents by submitting its current charity care policy that outlines the process a patient would use to access this service. Further, Valley included a 'charity care' line item as a deduction from revenue within the pro forma financial documents for Valley. [Valley Application, Appendix 13, Valley April 9, 2010 Supplemental Information, Attachment 1]

The charity care policy provided is not the same as the approved version the department has on file[24]. Therefore, if approved, a term will be added requiring Valley to supply the Charity Policy for program review and approval from the Department of Health's Hospital and Patient Data Systems.

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Valley is located in Southeast King and is one of 20 hospitals located within the King County Region. According to 2006-2008 charity care data obtained from HPDS, Valley has historically provided more than the average charity care provided in the region. Valley's most recent three years (2006-2008) percentages of charity care for gross and adjusted revenues are detailed in Table 14. [HPDS 2006-2008 charity care summaries]

Table 14
Valley Charity Care Comparison

	3-Year Average for King County Region	3-Year Average for Valley
% of Gross Revenue	1.36 %	1.67 %
% of Adjusted Revenue	2.42 %	3.03%

Valley's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 1.67% of gross revenue and 3.03% of adjusted revenue. RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. Figures demonstrate that the charity care historically provided by Valley is above the regional averages and Valley proposes to provide charity care above the three-year historical gross and adjusted revenue averages for the region.

The department concludes that all residents, including low income, racial and ethnic minorities, handicapped, and other under-served groups would have access to the services provided by the hospital. This sub-criterion is met.

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

Based on the source information reviewed, in relation to the need criteria in WAC 246-310-220, (1),(2), and (3)the department determines that:

- Auburn Regional Medical Center's project has met the Financial Feasibility criteria
- MultiCare Health System's project has met the Financial Feasibility criteria
- Valley Medical Center's project has met the Financial Feasibility criteria

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

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

[24] Source: http://www.doh.wa.gov/EHSPHL/hospdata/CharityCare/CharityPolicies/Default.htm

proposed project is meeting its immediate and long-range capital and operating costs by the end of the third complete year of operation.

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

Auburn

HPDS provides a summary of the balance sheets from UHS and Auburn in Table 15.

Table 15
Universal Health Systems Balance Sheets
UHS Fiscal Year End 2009

Assets		Liabilities	
Current	796,197,000	Current	582,817,000
Board Designated	-	Long Term Debt	956,429,000
Property/Plant/Equip	2,312,238,000	Other	435,671,000
Other	853,028,000	Equity	1,989,546,000
Total	3,964,463,000	Total	3,964,463,000

Above figures from CN application

Auburn Regional Medical Center Fiscal Year End 2015

Assets		Liabilities	
Current	31,474,452	Current	20,843,804
Board Designated	-	Long Term Debt	-
Property/Plant/Equip	97,091,855	Other	(94,166,683)
Other	3,283,685	Equity	205,172,871
Total	131,849,992	Total	131,849,992

Above figures from CN application

The reported capital expenditure for the 70 bed expansion is projected to be $34,159,515. The costs will be funded through the parent corporation Universal Health Systems (UHS). The HPDS analysis determined, "The Auburn Regional Medical Center report shows a strong position and that it has the assets to easily handle this project. In detail not shown above, the 2009 Balance Sheet for UHS shows the corporation has $1.88 billion in retained earnings available" for projects such as this. [HPDS Auburn analysis, p2]

As mentioned above, HPDS also reviewed the financial health of the UHS and Auburn for December 31, 2009 to the statewide year 2008 financial ratio guidelines for hospital operations. Statewide 2008 ratios are included as a comparison and are calculated from all community hospitals in Washington State whose fiscal year ended in that year. The data is collected by the Washington State

Dept. of Health Hospital and Patient Data section of the Center for Health Statistics. HPDS compared the financial ratios for current year 2009 and 2014 through 2016—or three years after project completion. Table 16 summarizes the comparison provided by HPDS. [HPDS Auburn analysis, p3]

The A means it is better if the number is above the State number and B means it is better if the number is below the state number. Bold numbers indicate a score that is outside the preferred ratio.

Table 16
UHS Projected Financial Ratios

Ratio Category	Trend	State08	UHS09	Aub09	2014 CONy1	2015 CONy2	2016 CONy3
Long Term Debt to Equity	B	0.527	0.481	-	n/a	n/a	n/a
Current Assets/Current Liabilities	A	1.946	**1.366**	**1.211**	**1.510**	**1.510**	**1.510**
Assets Funded by Liabilities	B	0.432	0.388	0.135	0.148	0.153	0.158
Operating Expense/Operating Rev.	B	0.949	0.909	0.923	**0.986**	**0.979**	**0.972**
Debt Service Coverage	A	4.717	10.559	-	n/a	n/a	n/a

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

The HPDS analysis explains the results in year three by stating, "The two ratios with N/A are because the parent corporation is holding the debt and the hospital has no direct debt assigned to it. This is acceptable practice for a wholly owned entity". As this information indicates, the immediate capital and operating costs can be met [HPDS Auburn analysis, p3]

When Auburn's market share is calculated and compared to the projection year forecasts, current patient day trends can be reviewed. [2009 CHARS; Evaluation Appendix A, Step 10; Auburn April 9, 2010 Supplemental Information, Attachment 3]

Table 17
Auburn Regional Medical Center's Market Share Totals

	2009	**2016**
Number of beds	124	194
% of planning area total beds	22.5%	30.41%
Auburn Patient Days	31,324	53,070
% of Adjusted Patient Days	26.3%	35.37%
Market Share delta to % of acute beds	**3.8%**	**4.96%**
Average Daily Census	85.8	145.4
Occupancy Rate	**69.2%**	**74.95%**

The figures indicate that Auburn is expecting to capture 70% of the projected patient days available within the planning area from 2009-2016[25]. Though this exceeds the current market share of the hospital, the department concludes that Auburn may be able to meet its long term operating costs of the project with an additional 70 acute care beds if the hospital is able to attract the majority of the projected available patient days. This sub-criterion is met.

MultiCare

HPDS provides a summary of the balance sheets from the application in Table 18. [MultiCare Supplemental Information, p2]

Table 18
MultiCare Balance Sheets
MultiCare Fiscal Year End 2008

Assets		Liabilities	
Current	396,255,000	Current	202,176,000
Board Designated	633,165,000	Long Term Debt	695,547,000
Property/Plant/Equip	761,617,000	Other	293,604,000
Other	50,335,000	Equity	650,045,000
Total	1,841,372,000	Total	1,841,372,000

Above figures from CN application

MultiCare Fiscal Year End 2018

Assets		Liabilities	
Current	312,408,000	Current	307,680,000
Board Designated	2,236,666,000	Long Term Debt	784,454,000
Property/Plant/Equip	976,611,000	Other	238,279,000
Other	44,562,000	Equity	2,239,834,000
Total	3,570,247,000	Total	3,570,247,000

Above figures from CN application

The reported capital expenditure for the 58 bed expansion portion of the project[26] is projected to be $158,516,892. MultiCare will use a bond issue for 68% of the costs and available Board reserves for the remainder. As HPDS concludes, "MultiCare pro-forma financials show that most assets are held at a higher corporate level. The MultiCare report shows a strong financial position and that it has the assets to handle this project". [HPDS MultiCare analysis, p2]

As mentioned above, HPDS also compared the financial health of MultiCare for December 31, 2008 to the statewide year 2008 financial ratio guidelines for hospital operations. Statewide 2008 ratios are included as a comparison and are calculated from all community hospitals in Washington State whose fiscal year ended in that year. The data is collected by the Washington State Dept. of Health Hospital and Patient Data section of the Center for Health Statistics. HPDS compared the

[25] The total Adjusted Patent Days outlined in Step 10 of Appendix A indicate an additional 30,950 patient days resulting from population growth within the planning area from 2009-2016.
[26] Costs for a separate project to expand the Emergency room and imaging department of the medical park are reported to total $16,190,006

financial ratios for current year 2009 and 2016 through 2018—or three years after project completion. Table 19 summarizes the comparison provided by HPDS. [HPDS analysis, p3]

The A means it is better if the number is above the State number and B means it is better if the number is below the state number. Bold numbers indicate a score that is outside the preferred ratio range.

Table 19
MultiCare's Current and Projected Financial Ratios

Ratio Category	Trend	State08	MultiCare09	2016 CONy1	2017 CONy2	2018 CONy3
Long Term Debt to Equity	B	0.527	**1.07**	0.446	0.395	0.350
Current Assets/Current Liabilities	A	1.946	1.96	**1.038**	**1.026**	**1.015**
Assets Funded by Liabilities	B	0.432	**0.488**	0.346	0.326	0.306
Operating Expense/Operating Rev.	B	0.949	0.913	**1.000**	**0.971**	0.948
Debt Service Coverage	A	4.717	**-1.867**	**0.673**	**0.777**	**0.861**

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

As HPDS concludes, "While Current Assets to Current Liabilities is out of range, a review of the balance sheet shows MultiCare is diligent in keeping funds in the Board Designated assets category which is not included in this formula". HPDS continues, "The Debt Service Coverage ratio is not useful since the ratio in this application is comparing Covington Income data to MultiCare balance sheet data". The review shows that the hospital is breaking even in CON year 3 (2018) and the ratios are improving each year. [HPDS MultiCare analysis, p3]

The department concludes that MultiCare would be able to meet its short and long term costs of the proposed 58 bed hospital project with the projections presented. This sub-criterion is met.

Valley
HPDS provides a summary of the balance sheets from the application in Table 20.

Table 20
Valley Historical Balance Sheets
Valley Fiscal Year End 2009

Assets		Liabilities	
Current	136,058,170	Current	57,669,968
Board Designated	76,840,356	Long Term Debt	291,952,172
Property/Plant/Equip	346,136,124	Other	2,436,531
Other	6,225,221	Equity	213,201,200
Total	565,259,871	Total	565,259,871

Above figures from CN application

Valley Fiscal Year End 2017

Assets		Liabilities	
Current	166,570,000	Current	67,742,000
Board Designated	280,171,000	Long Term Debt	251,577,000
Property/Plant/Equip	240,672,000	Other	-
Other	5,015,000	Equity	373,109,000
Total	692,428,000	Total	692,428,000

Above figures from CN application

The total reported capital expenditure for the 60 bed expansion and build-out of the 7th floor of the tower is projected to be $34,159,515. Valley will fund the balance of the new expenditures necessary to complete this project with organizational reserves and operating income. The proportions are shown in Table 21. [Valley April 9, 2010 Supplemental Information, p5]

Table 21
Valley 60-bed Expansion Project Financing

	Dollars	% of Total
Organization Reserves	$ 8,904,000	90%
Operational Cash	$ 1,018,500	10%
Total Capital Expenditure	**$ 9,922,500**	**100%**

As mentioned above, HPDS also compared the financial health of the Valley for December 31, 2009 to the statewide year 2008 financial ratio guidelines for hospital operations. HPDS compared the financial ratios for current year 2009 and 2014 through 2016—or three years after project completion. Table 22 summarizes the comparison provided by HPDS. [HPDS Valley analysis, p3]

The A means it is better if the number is above the State number and B means it is better if the number is below the state number. Bold numbers indicate a score that is outside the preferred ratio.

Table 22
Valley Hospital's Current and Projected Financial Ratios

Ratio Category	Trend	State08	Valley09	2014 CONy1	2015 CONy2	2016 CONy3
Long Term Debt to Equity	B	0.527	**1.369**	**0.872**	**0.771**	**0.674**
Current Assets/Current Liabilities	A	1.946	2.359	2.602	2.481	2.459
Assets Funded by Liabilities	B	0.432	**0.619**	**0.517**	**0.491**	**0.461**
Operating Expense/Operating Rev.	B	0.949	**0.954**	**0.957**	**0.955**	0.947
Debt Service Coverage	A	4.717	**3.323**	**3.270**	**2.992**	**3.215**

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

Three of the five fiscal year end ratios for Valley's project projection years are outside of the state averages. As HPDS notes, "Valley Medical Center had almost $140 million in construction in progress which would skew theses ratios". Further, "The hospital has not had time to recoup through operations the debt acquired to do this construction and so the ratios are out of range". [HPDS Valley analysis, p3]

When Valley's market share is calculated and compared to the projection year forecasts, current trends can be reviewed. [2009 CHARS; Evaluation Appendix A, Step 10; Valley April 9, 2010 Supplemental Information, p2]

Table 23
Valley Medical Center's Market Share Totals

	2009	**2016**
Number of beds	283	343
% of planning area total beds	51.4%	54.62%
Valley Patient Days	54,214	83,038
% of Adjusted Patient Days	45.5%	55.34%
Market Share delta to % of acute beds	**-5.9%**	**0.72%**
Average Daily Census	148.5	227.5
Occupancy Rate	**52.5%**	**66.33%**

The figures indicate that Valley is expecting to capture 93% of the projected patient days available within the planning area from 2009-2016[27]. Though the department can conclude that Valley may be able to meet its long term operating costs of the project with an additional 60 acute care beds, adding beds to a facility which has the existing available capacity demonstrated above does not seem to be a reasonable alternative. 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.

Auburn

Auburn proposes to add the 70 acute care beds in multiple phases, beginning in year 2010. The total cost of the project, including the additional beds, is reported to equal $34,159,514. Of the total costs under review, 63% is related to construction; 19% is related to equipment; and the

[27] The total Adjusted Patent Days outlined in Step 10 of Appendix A indicate an additional 30,950 patient days resulting from population growth within the planning area from 2009-2016.

balance related to applicable taxes and planning costs. The totals are outlined below. [Auburn Application, p37]

Table 24
Estimated Capital Costs of Auburn Project

Breakdown Of Capital Costs	Total	% of Total
Leasehold Improvements	$ 21,478,182	63%
Fixed & Moveable Equipment	$ 6,354,000	19%
Architect / Consulting Fees	$ 3,305,129	10%
Financing Costs	$ 0.00	0%
Taxes & Review Fees	$ 3,022,203	9%
Total Estimated Capital Costs	**$ 34,159,514**	**100.00%**

To assist the department in its evaluation of this sub-criterion, HPDS provides a summary of the reasonableness of Auburn's building construction costs in relation to the potential impact on revenue and charges the patients and community will actually see come out of their pocketbook. The following page contains a summary of the HPDS review[28]. [HPDS Auburn analysis, p3]

Table 25
HPDS Analysis of Forecasted Rates at Auburn Hospital

ARMC-UHS			
Rate per Various Items	**2014**	**2015**	**2016**
Patient Days	59,984	63,012	66,236
Adjusted Patient Days	101,640	106,771	112,234
Gross Revenue	617,137,362	648,290,535	681,460,228
Deductions From Revenue	417,880,718	438,975,390	461,435,503
Net Patient Billing	199,256,644	209,315,145	220,024,725
Other Operating Revenue	1,596,025	1,596,025	1,596,025
Net Operating Revenue	200,852,669	210,911,170	221,620,750
Operating Expense	198,126,058	206,506,540	215,443,497
Operating Profit	2,726,611	4,404,630	6,177,253
Other Revenue	-	-	-
Net Profit	2,726,611	4,404,630	6,177,253
Operating Revenue per Patient Day	$ 3,322	$ 3,322	$ 3,322
Operating Expense per Patient Day	$ 3,303	$ 3,277	$ 3,253
Net Profit per Patient Day	$ 45	$ 70	$ 93
Operating Revenue per Adj Pat Days	$ 1,960	$ 1,960	$ 1,960
Operating Expense per Adj Pat Days	$ 1,949	$ 1,934	$ 1,920
Net Profit per Adj Pat Days	$ 27	$ 41	$ 55

[28] Lack of forecasted admission totals prevented calculation of Revenue and Expense values by Admission.

As shown, the net profit by adjusted patient day ranges could range from a low of $27 to a high of $55. Because there is a limit to the increases a hospital can make to it rates before realizing a commensurate increase in the Deductions from Revenue and costs are linked to the number of patient days, which would be lower with fewer total patient days, the hospital could make changes that would not necessarily result in an increase to the charges for service.

The Department concludes that costs of the project to add 70 acute care beds alone is unlikely to have an unreasonable impact upon the costs and charges for health services. This sub-criterion is met.

MultiCare

MultiCare proposes to add 58 acute care beds to the Covington Medical Park. The 52 beds would be added in two phases and the costs are outlined below. [MultiCare Application, p9]

Table 26
Estimated Capital Costs of MultiCare Project

Breakdown Of Capital Costs	Total	% of Total
Land & Construction	$ 92,737,597	59%
Leasehold Improvements	$ 1,680,000	1%
Fixed & Moveable Equipment	$ 21,846,709	14%
Architect / Consulting Fees	$ 17,233,143	11%
Financing Costs	$ 12,617,824	8%
Taxes & Review Fees	$ 12,401,618	8%
Total Estimated Capital Costs	**$158,516,891**	**100.00%**

To assist the department in its evaluation of this sub-criterion, HPDS provides a summary of the reasonableness of building construction costs in relation to the potential impact on revenue and charges. The following page contains a summary of the HPDS review. [HPDS analysis, p4]

Table 27
HPDS Analysis of Forecasted Rates at MultiCare Hospital

Multicare - Covington			
Rate per Various Items	**2016**	**2017**	**2018**
Admissions	5,187	5,690	5,994
Adjusted Admissions	9,754	10,635	11,264
Patient Days	13,791	15,232	16,062
Adjusted Patient Days	25,933	28,471	30,184
Gross Revenue	245,331,000	261,109,000	274,121,000
Deductions From Revenue	159,780,000	170,134,000	178,639,000
Net Patient Billing	85,551,000	90,975,000	95,482,000
Other Operating Revenue	-	-	-
Net Operating Revenue	85,551,000	90,975,000	95,482,000
Operating Expense	85,588,000	88,379,000	90,523,000
Operating Profit	(37,000)	2,596,000	4,959,000
Other Revenue	-	-	-
Net Profit	(37,000)	2,596,000	4,959,000
Operating Revenue per Admission	$ 16,493	$ 15,989	$ 15,930
Operating Expense per Admission	$ 16,500	$ 15,532	$ 15,102
Net Profit per Admission	$ (7)	$ 456	$ 827
Operating Revenue per Patient Day	$ 6,203	$ 5,973	$ 5,945
Operating Expense per Patient Day	$ 6,206	$ 5,802	$ 5,636
Net Profit per Patient Day	$ (3)	$ 170	$ 309
Operating Revenue per Adj Admissions	$ 8,771	$ 8,554	$ 8,477
Operating Expense per Adj Admissions	$ 8,775	$ 8,310	$ 8,036
Net Profit per Adj Admissions	$ (4)	$ 244	$ 440
Operating Revenue per Adj Pat Days	$ 3,299	$ 3,195	$ 3,163
Operating Expense per Adj Pat Days	$ 3,300	$ 3,104	$ 2,999
Net Profit per Adj Pat Days	$ (1)	$ 91	$ 164

As shown, the net profit by adjusted patient day reaches $164 in the third full year of the hospital's operation**.** Because there is a limit to the increases a hospital can make to it rates before realizing a commensurate increase in the Deductions from Revenue and costs are linked to the number of patient days, which would be lower with fewer total patient days, the hospital could make changes that would not necessarily result in an increase to the charges for service. The Department concludes that costs of the project to add 58 acute care beds alone is unlikely to have an unreasonable impact upon the costs and charges for health services. This sub-criterion is met.

Valley

Valley proposes to add the 70 acute care beds in multiple phases, beginning in year 2012. The total cost of the project, inclusive of the allocated costs for the 7th floor of the patient tower, is reported to equal $38,845,000. The costs associated with the bed expansion alone are $19,922,500. Of That total, 85% is related to construction and the remainder is allocated to equipment, Washington State sales tax and related costs. The totals are outlined below. [Valley Application, p30, Valley April 9, 2010 Supplemental Information, p3]

Table 28
Estimated Capital Costs of Valley Project

Breakdown Of Capital Costs	Total	% of Total
Construction	$ 16,974,500	85%
Leasehold Improvements	$ 250,000	1%
Fixed & Moveable Equipment	$ 1,654,000	8%
Architect / Consulting Fees	$ 450,000	2%
Taxes & Review Fees	$ 594,000	3%
Total Estimated Capital Costs	**$ 19,922,500**	**100.00%**

To assist the department in its evaluation of this sub-criterion, HPDS provides a summary of the reasonableness of Valley's building construction costs in relation to the potential impact on revenue and charges. Table 29 on the following page contains a summary of the HPDS review. [HPDS analysis, p3]

Table 29
HPDS Analysis of Forecasted Rates at Valley Hospital

Valley Medical Center 60 Bed addition			
Rate per Various Items	**2015**	**2016**	**2017**
Admissions	20,327	21,593	22,939
Adjusted Admissions	40,027	42,319	44,687
Patient Days	73,584	78,165	83,038
Adjusted Patient Days	144,897	153,196	161,768
Gross Revenue	1,255,855,000	1,325,089,000	1,398,172,000
Deductions From Revenue	792,200,000	843,896,000	894,007,000
Net Patient Billing	463,655,000	481,193,000	504,165,000
Other Operating Revenue	41,836,000	42,254,000	42,677,000
Net Operating Revenue	505,491,000	523,447,000	546,842,000
Operating Expense	483,632,000	499,895,000	518,099,000
Operating Profit	21,859,000	23,552,000	28,743,000
Other Revenue	-	-	-
Net Profit	21,859,000	23,552,000	28,743,000
Operating Revenue per Admission	$ 22,810	$ 22,285	$ 21,979
Operating Expense per Admission	$ 23,793	$ 23,151	$ 22,586
Net Profit per Admission	$ 1,075	$ 1,091	$ 1,253
Operating Revenue per Patient Day	$ 6,301	$ 6,156	$ 6,071
Operating Expense per Patient Day	$ 6,573	$ 6,395	$ 6,239
Net Profit per Patient Day	$ 297	$ 301	$ 346
Operating Revenue per Adj Admissions	$ 11,584	$ 11,371	$ 11,282
Operating Expense per Adj Admissions	$ 12,083	$ 11,812	$ 11,594
Net Profit per Adj Admissions	$ 546	$ 557	$ 643
Operating Revenue per Adj Pat Days	$ 3,200	$ 3,141	$ 3,117
Operating Expense per Adj Pat Days	$ 3,338	$ 3,263	$ 3,203
Net Profit per Adj Pat Days	$ 151	$ 154	$ 178

As shown, the net profit by adjusted patient day ranges could range from a low of $151 to a high of $178. Because there is a limit to the increases a hospital can make to it rates before realizing a commensurate increase in the Deductions from Revenue and costs are linked to the number of patient days, which would be lower with fewer total patient days, the hospital could make changes that would not necessarily result in an increase to the charges for service. The Department concludes that costs of the project to add 60 acute care beds alone is unlikely to have an unreasonable impact upon the costs and charges for health services. This sub-criterion is met.

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

WAC 246-310 does not contain specific source of financing criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how a project of this type and size should be financed. Therefore,

using its experience and expertise the department compared the proposed project's source of financing to those previously considered by the department.

Auburn

Funding for the $34,159,514 expansion will be provided by UHS, Auburn's parent corporation. As HPDS noted, "The parent corporation has adequate funds to finance this project. The 2009 Balance Sheet for UHS shows the corporation has $1.88 billion in retained earnings". The application also includes a letter from UHS confirming their commitment to fund the project. [HPDS Auburn analysis, p4; Auburn Screening Supplemental, Attachment 2]

Based on the source information reviewed for the bed addition project at Auburn and the review performed by HPDS, the department concludes that the proposed financing is a prudent approach. This sub-criterion is met.

MultiCare

As part of the review of the financing of this project, HPDS confirms that with a capital expenditure projected to be $158,516,892. The breakout of the financing is shown below.

Table 30
MultiCare Financing

	Dollars	**% of Total**
Bond Issue	$108,324,606	68 %
Board Reserves	$50,192,287	32 %
Totals	$158,516,893	100 %

HPDS concludes, "MultiCare will finance approximately 68% of the project through tax exempt bonds through the Washington State Health Care Facilities Authority. Review of the application and audited financials show MultiCare has had success using this method in the past. Interest rates are relatively low compared to past interest rates". Further, "[the] use of reserves, which have already been earned, will cover 32% of the project". Information confirms that the MultiCare system has the reserves to cover the projected $50 million that the financing method used is an appropriate business practice. [HPDS analysis, p4]

Based on the source information reviewed for the bed addition project at MultiCare and the review performed by HPDS, the department concludes that the proposed financing for a 58 bed hospital is the a prudent approach, and would not negatively affect MultiCare's total assets, total liability, or general financial health. This sub-criterion is met.

Valley

As part of the review of the financing HPDS reaffirmed, "the funding for the project will come from reserves and operating income. The hospital has the reserves to fund this project" and is an appropriate business practice. [HPDS Valley analysis, p4]

Based on the source information reviewed for the bed addition project at Valley and the review performed by HPDS, the department concludes that the proposed financing is a prudent approach. This sub-criterion is met.

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

Based on the source information reviewed, in relation to the need criteria in WAC 246-310-230, the department determines that:

- Auburn Regional Medical Center's project has met the Structure and Process of Care criteria
- MultiCare Health System's project has met the Structure and Process of Care criteria
- Valley Medical Center's project has met the Structure and Process of Care criteria

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

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

Auburn

If the project is approved, Auburn anticipates adding FTEs (full time equivalents) to the hospital in specific staffing areas of administration, nursing, and other related support positions beginning in 2012. Table 31 shows the breakdown of Auburn's projected FTE increases for an acute care bed expansion. [Auburn's April 9, 2010 Supplemental Information, p6]

Table 31
Auburn Hospital Projected Incremental FTE Additions

Classification	Current	2012	2013	2014	2015	2016	Total
Registered Nurses	210.59	14.40	15.36	16.32	17.60	18.56	292.83
Other Nursing	92.13	6.30	6.72	7.14	7.70	8.12	128.11
Ancillary Care	65.81	4.50	4.80	5.10	5.50	5.80	91.51
Administration	19.74	1.35	1.44	1.53	1.65	1.74	27.45
Other	269.83	18.45	19.68	20.91	22.55	23.78	375.20
Totals	**658.10**	45.00	48.00	51.00	55.00	58.00	**915.10**

As shown above, the staff increases continue steadily throughout the projection years. By the end of year 2018, Auburn expects to add approximately 257 additional employees.

Auburn states it expects no difficulty in recruiting staff for the additional beds for a variety of reasons, including: [Auburn Application, p45]

- A generous befits package which is offered to both full and part-time employees;
- As a clinical training facility which attracts specialists that are often retained to fill permanent positions;
- Recruiting efforts which include national searches, recruiting events and an electronic job posting system will continue to expand the search for new staff; and
- Continued use of professional referral sources and recruitment firms.

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

MultiCare

If this project is approved, MultiCare anticipates adding FTEs (full time equivalents) to the hospital in specific staffing areas of nursing, technicians, and other related support positions beginning in 2013 to support for the proposed hospital. Table 32 shows the breakdown of MultiCare's projected FTE needs for the proposed acute care bed expansion. [MultiCare April 9, 2010 Supplemental Information, Exhibit 21]

Table 32
MultiCare Projected Annual FTE Totals – 58 bed Project

Classification	Current Clinic	2013	2014	2015	2016
Management	17.00	17.00	17.00	17.00	17.00
Nursing	95.00	138.00	152.00	161.00	168.00
Tech/Professional	89.00	109.00	118.00	122.00	126.00
Support	133.00	177.00	191.00	198.00	202.00
Totals	**334.00**	**441.00**	**478.00**	**498.00**	**513.00**

As shown above, the staff increases continue steadily throughout the projection years. MultiCare expects to make the primary hire to expand pertinent staff in 2013 with an additional 107 total FTEs. A steady increase is continued through 2016.

MultiCare states it expects no difficulty in recruiting staff for the additional beds through its practice of, "partnering with local universities and colleges, supporting employee career development, and utilizing a broad range of local, regional and national recruiting strategies". Examples include: [MultiCare Application, p64]

- Talent acquisition and provider service teams to target new hire recruitment;
- Tuition reimbursements and scholarships for qualified employees and volunteers;
- A nurse technician employment program; and,
- Various apprenticeship programs and a comparatively low turn-over rates that help assure retention of necessary staff.

Based on the information provided in the application, the department concludes that MultiCare provided a comprehensive approach to recruit and retain staff necessary for the proposed 58 bed hospital. As a result, the department concludes that qualified staff can be recruited and retained. This sub-criterion is met.

Valley

If the project is approved, Valley anticipates adding FTEs (full time equivalents) to the hospital in specific staffing areas of administration, nursing, and other related support positions beginning in 2011 to prepare for the phased increases. Table 33 shows the breakdown of Valley's projected FTE needs for an acute care bed expansion. [Valley April 9, 2010 Supplemental Information, p6]

Table 33
Valley Hospital Projected Incremental FTE Totals

Classification	2011	2012	2013	2014	2015	2016	Total
Registered Nurses	32.56	6.09	28.24	6.09	30.76	13.47	117.21
PCA	0.00	0.00	19.64	0.00	0.00	19.64	39.28
Administration	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	**32.56**	6.09	47.88	6.09	30.76	33.11	**156.49**

As shown above, the staff increases continue steadily throughout the projection years. By the end of year 2016, Valley expects to have approximately 156 additional employees.

Valley expects no difficulty in recruiting staff due to the majority of staffing requirements are focused upon registered nurses. Valley states that they use a daily labor productivity system to monitor staffing levels on a shift-by-shift basis and that an emphasis on "filling open positions in specialty and nursing care areas which dramatically reduced the need to use overtime and/or agency replacement staff". These factors lead Valley to state, "All of these efforts support the ability of Valley Medical Center to effectively implement the addition of 60 medical surgical beds". [Valley Application, p36]

Based on the information provided in the application, the department concludes that Valley has been able to recruit and retain staff necessary for the current hospital services and past practices should be able to attract staff to support the additional acute care beds. As a result, the department concludes that qualified staff could be recruited and retained. This sub-criterion is met.

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

WAC 246-310 does not contain specific WAC 246-310-230(2) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how to measure ancillary 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.

Auburn

Auburn currently provides health care services to the residents of Southeast King County and the surrounding areas. The applicant states that "all of [Auburn's] ancillary and support departments are currently configured to meet the additional demand resulting from this project". With the additional staff proposed, there is no indication that current programs would not be able to expand related services to accommodate the proposed expansion. [Auburn Application, p46]

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

MultiCare

MultiCare currently provides health care services to the residents of Southeast King County through their existing medical park. The applicant states that the clinic "has been in operation nearly 20 years and is fully integrated into the Covington community". MultiCare adds that integrated health care practices "makes complete patient records, digital imaging and other test results available instantly to providers, improving the safely, quality and efficiency of health care". Since MultiCare will be drawing upon existing infrastructure and ancillary support systems, there is no indication that current support relationships would not be able to expand related services to accommodate the proposed hospital. [MultiCare Application, p67]

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

Valley

Valley currently provides health care services to the residents of Southeast King County and the surrounding areas. The applicant states that "the growth in patient days as a result of this project will result in a modest increases in volume and ancillary support staff through 2016". Valley also states that the patient tower "added sufficient capacity so that the ancillary and support departments can support the increased patient census". [Valley Application, p36]

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

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

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

Auburn

Auburn will continue to provide Medicare and Medicaid services to the residents of Southeast King County and surrounding communities. The hospital contracts with the Joint Commission to survey and accredit the quality of service provided. The Joint Commission lists Auburn in full compliance with all applicable standards following the most recent on-site survey in July 2010.[29]

Complementing reviews performed by the Joint Commission are the surveys conducted by the department's Investigation and Inspection's Office (IIO). IIO completed one licensing survey at

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

the hospital in the past three years.[30] There were no adverse licensing actions as a result of the survey. [Facility survey data provided by DOH Investigations and Inspections Office]

Based on Auburn compliance history, the department concludes that there is reasonable assurance that the hospital would continue to operate in conformance with state and federal regulations with the additional acute care beds. This sub-criterion is met.

MultiCare

MultiCare currently provides Medicare and Medicaid services in its existing facilities and proposes to provide to the residents of Southeast King County and surrounding communities. The MultiCare facilities near the proposed site contract with the Joint Commission to survey and accredit the quality of service provided. The Joint Commission lists MultiCare's Tacoma General/Allenmore and Good Samaritan Hospital in full compliance with all applicable standards following the most recent on-site surveys.[31]

Complementing reviews performed by the Joint Commission are the surveys conducted by the department's Investigation and Inspection's Office (IIO). For the most recent three years, IIO completed one licensing survey at each of the nearby MultiCare hospitals.[32] There were no adverse licensing actions as a result of either of the surveys. [Facility survey data provided by DOH Investigations and Inspections Office]

Based on MultiCare compliance history, the department concludes that there is reasonable assurance that the proposed 58 bed hospital would to operate in conformance with state and federal regulations. This sub-criterion is met.

Valley

Valley will continue to provide Medicare and Medicaid services to the residents of Southeast King County and surrounding communities. The hospital contracts with the Joint Commission to survey and accredit the quality of service provided. The Joint Commission lists Valley in full compliance with all applicable standards following the most recent on-site surveys.[33]

Complementing reviews performed by the Joint Commission are the surveys conducted by the department's Investigation and Inspection's Office (IIO). For the most recent three years, IIO completed one licensing survey at the hospital.[34] There were no adverse licensing actions as a result of the survey. [Facility survey data provided by DOH Investigations and Inspections Office]

Based on Valley compliance history, the department concludes that there is reasonable assurance that the hospital would continue to operate in conformance with state and federal regulations with the additional acute care beds. This sub-criterion is met.

[30] Survey completed February 2007.
[31] http://www.qualitycheck.org including the Accreditation Programs at TG/Allenmore (March, 2008) and Good Samaritan (June, 2008)
[32] Survey completed at TG/Allenmore (June, 2009) and Good Samaritan (February, 2008).
[33] http://www.qualitycheck.org including Accreditation Programs (March, 2008) and Advanced Certification Programs (August, 2009)
[34] Survey completed October 2009.

(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.

Auburn

Auburn states that the additional beds would greatly assist in promoting continuity of care at hospital. Auburn has been providing health care to the residents of Southeast King County and surrounding communities for many years and participates in relationships with community facilities to provide a variety of post acute care services. Approval of this project will not change the relationships in place with the existing health care providers in the service area. [Auburn Application, p47]

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

In reference to this criterion, Auburn stated, "With the additional beds, ARMC will continue the relationships it currently has in the area's existing post-acute care providers. ARMC already works closely with area nursing homes, boarding homes, assisted living facilities, mental health agencies, and adult family homes, as necessary, to ensure timely and appropriate discharge options when going home is not appropriate". [Auburn Application, p47]

Therefore, the department concludes that approval of a 70-bed expansion within the planning area and is not likely to lead to a fragmentation of care within the service area, and this sub-criterion is met.

MultiCare

MultiCare states that they are, "uniquely positioned to meet the health care needs of Southeast King residents" due to factors including existing facilities, knowledge of the community, and innovations in health care delivery. With the current medical park, MultiCare has been providing health care to the residents of Southeast King County and surrounding communities for many years and they estimate that 127,000 residents of the planning area currently receive care from MultiCare specialists and physicians. In addition, the proposed facility will continue to be able to link patients to tertiary hospitals in Puyallup and Tacoma where higher levels of medical and surgical care can be provided. [MultiCare Application, p67]

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

Construction of a hospital in the Southeast King planning area, supported by the projected need, minimizes the potential to increase the cost of care for all providers. With their current integrated system, MultiCare contends, "As technology advances and patient care needs change, more services will be delivered more efficiently and cost-effectively in non-traditional outpatient settings. This evolving health care model emphasizes providing convenient, efficient care at the appropriate level…with the goals of improving the quality of care while containing costs".

Therefore, the department concludes that approval of a 58-bed hospital at their existing clinic meets the need within the planning area and is not likely to lead to a fragmentation of care within the service area, and this sub-criterion is met.

Valley

Valley has been providing health care to the residents of Southeast King County and surrounding communities for many years and participates in relationships with community facilities to provide a variety of post acute care services. Approval of this project is not likely to change the relationships in place with the existing health care providers in the service area. [Valley Application, p36]

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

Valley included documentation of their Patient Care Discharge Planning process which promotes, "a coordinated, multidisciplinary team approach to the assessment of patient discharge planning needs". The plan details coordination with Home Care, Hospice, and Long Term Care facilities according to patient needs and family preferences. [Valley Application, p94]

Therefore, the department concludes that approval of a 60-bed expansion within the planning area and is not likely to lead to a fragmentation of care within the service area, and this sub-criterion is met.

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

D. Cost Containment (WAC 246-310-240)
Based on the source information reviewed, in relation to the need criteria in WAC 246-310-240, the department determines that:

- Auburn Regional Medical Center's project has not met the Cost Containment criteria
- MultiCare Health System's project has met the Cost Containment criteria
- Valley Medical Center's project has not met the Cost Containment criteria

(1) *Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable*.
WAC 246-310 does not contain specific WAC 246-310-240(1) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how to measure cost containment. Therefore, using its experience and expertise the department assessed the materials in the application.

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

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

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

Step One

For this project, MultiCare is the only applicant which has met all the review criteria under WAC 246-310-210, 220, and 230. Both Auburn and Valley failed need, therefore, fail this sub-criterion. The department moves to step two for MultiCare below.

Step Two

MultiCare

Before submitting this application to establish a 58 bed hospital, MultiCare considered four options. The options included: [MultiCare Application, p71]

1. Propose no project.
2. Propose the build-out and operation of a 120 bed hospital in Covington.
3. Propose the build-out and operation of a 58 bed hospital in Covington.
4. Propose the build-out and operation of a 35 bed hospital in Covington.

The criteria MultiCare applied to the come to a decision included, in order of importance, 1) maximizing quality of patient care, including maintaining access; 2) choosing the most efficient and cost effective option over the next 3-7 years; and 3) legal restrictions. Once the 'do nothing' option was eliminated, the applicant considered issues such as costs, service lines, and location to determine that either the 58-bed or 35-bed options were the most appropriate. [MultiCare Application, p71]

In the description of the comparison of these remaining two options, MultiCare ultimately determined that the 34-bed option was insufficient to meet the expected demand in the projection years. Though the application included a break-out for the program to consider the smaller option, MultiCare submitted the application focused upon a 58-bed facility. The applicant states that this option best meets the need for beds in the planning area, is consistent with MultiCare's commitment to give providers access to inpatient care, and that the 58-bed project would best meet patient quality of care and access goals.

The department also considered the occupancy and out-migration issues outlined in the Need portion of this evaluation. With the proposals available to review, the MultiCare project offers the most likely opportunity to serve the residents going outside the service area for care. With current occupancy levels at or below minimum standards, the proposed hospital is the only project that will allow for additional access while providing an additional choice to the residents of Southeast King County.

Considering the forecasted need and the proposals available to evaluate, the department concludes:

Auburn

Not reviewed under this criterion

MultiCare

The proposal to establish a new 58-bed acute care hospital is the best available option and this sub-criterion has been met.

Valley

Not reviewed under this criterion

Step Three

This step is used to determine between two or more approvable projects which is the best alternative. Since only one applicant met the previous review criteria this step is not applicable to this project.

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

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

WAC 246-310 does not contain specific WAC 246-310-240(2)(a) criteria as identified in WAC 246-310-200(2)(a)(i). There are known minimum building and engergy standards that healthcare facilities must meet to be licensed or certified to provide care. If built to only the minimum stanardards all construction projects could be determined to be resonable. However, the department, through its experience knows that construction projects are usually built to exceed these minimum standards. Therefore, the department considered information in the applications that addressed the reasonalbeness of their constuction projects that exceeded the minimum standards.

Auburn

Auburn states that it intends to pursue sustainable design and products in the construction of the proposed tower. By incorporating these standards, Auburn believes it will make progress towards a, "high performance healing environment". Auburn also intends to pursue "green principles in the new tower because our experience has demonstrated that, in addition to being environmentally friendly, they also result in efficiencies of operation". Staff from HPDS examined the construction costs of this project and provided the following analysis. [Auburn Application, p51]

Table 34
Auburn Total Project Construction Projections

Acute Care Bed Expansion	Totals
Total Construction	$ 34,159,515
Beds	70
Total Capital per Bed	$ 487,993

As HPDS states, "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." The new tower construction will also include design features affected by voluntary efforts to improve the healing environment with green practices. [HPDS Auburn analysis, p4; Auburn Application, p51]

The Department is satisfied the applicant's plans, if approved, are appropriate. This sub-criterion is met.

MultiCare

Comment and rebuttal received from Premera Blue Cross expresses concern that the costs of the proposed hospital "will result in an unreasonable impact upon the costs and charges for

health services". Staff from HPDS examined the construction costs of this project and provided the following analysis. [Premera Comment, p4]

Table 35
MultiCare Total Project Construction Projections

Acute Care Bed Expansion	Totals
Total Construction	$ 158,516,893
Beds	58
Total Capital per Bed	$ 2,733,050

As HPDS determined that the costs shown are within the range of past construction costs reviewed by this office. Also construction cost can vary quite a bit due to type of construction, quality of material, custom vs. standard design, building site and other factors. MultiCare is building a new facility and will construct the facility to the latest energy and hospital standards and is prepared to qualify for LEED® Silver certification. By comparison, the cost per bed for the most recent approval for a new hospital, within the same HSA, produced a comparable cost per bed calculation[35]. [HPDS Analysis, p5; CN historical records]

Regarding the existing clinic, MultiCare also contends, "The proposed facility had been designed to maximize the existing building footprint while minimizing the amount of new construction necessary to support the proposed service offering". By applying available design and construction guidelines, MultiCare intends to construct a facility which is designed to achieve a LEED® construction accreditation". These efforts in cost and energy efficiencies addressing areas such as lighting, cooling systems, and exterior construction materials lead MultiCare to conclude, "Implementation of these strategies will result in lower operational costs throughout the life of the project". [MultiCare Application, p77]

Meeting the LEED® Silver accreditation level, as indicated in the MultiCare application, represents a comprehensive design commitment beyond the standard construction standards. With this certification obligating an organization to consider design, material, and water use issues throughout the construction process, the effort indicates a commitment to the surrounding community and environment. Applying these building standards would likely lead to larger initial construction cost which would allow for lower long-term operating costs. Further, documentation available indicates that current projects active within the MultiCare system are making strides to achieve this level of certification and the department can conclude that the proposed facility in Covington will continue to apply the standards as reported. [DOH Construction Review records; MultiCare Application, p77]

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

Valley

Staff from HPDS and the program examined the construction costs of the 60-bed expansion project and the total allocated project costs. The results are provided in Table 36.

[35] CN Application 09-37 approving a 10-bed hospital in Friday Harbor at a calculated rate of $2,485,225 per bed

Table 36
Valley Total Project Construction Projections

60 Bed Project	**Totals**
Total Construction	$ 19,922,500
Beds	60
Total Capital per Bed	$ 332,042
Total Hospital Expansion	**Totals**
Total Construction	$ 38,845,000
Beds	60
Total Capital per Bed	$ 647,417

As Valley states, "this project achieves capital cost reductions through the use of an existing nursing wing NW-A and NW-B and the build-out of a shelled floor in the 2010 patient tower". Further, HPDS confirms, "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". [Valley Application, p43; HPDS Analysis, p5]

The Department is satisfied the applicant's plans, if approved, are appropriate. This sub-criterion is met.

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

Auburn
This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2) and has not been met.

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

Valley
This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2) and has not been met.

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

WAC 246-310 does not contain specific WAC 246-310-240(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how to measure cost containment. Therefore, using its experience and expertise the department assessed the materials in the application.

Auburn

The HPDS review states that, contingent upon an applicant meeting a forecasted need for additional capacity, "a facility servicing an area which has unmet bed need will not have an unreasonable impact of the costs and charges to the public of providing services by other persons". [HPDS Auburn Analysis, p5]

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

MultiCare

As HPDS concludes, "a new 58 bed hospital servicing a bed need area which has a need for more acute care beds and where the population is growing in number will not have an unreasonable impact of the costs and charges to the public of providing services". [HPDS MultiCare Analysis, p6]

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

Valley

The HPDS review states that, contingent upon an applicant meeting a forecasted need for additional capacity, "a facility servicing an area which has unmet bed need will not have an unreasonable impact of the costs and charges to the public of providing services by other persons". [HPDS Valley Analysis, p5]

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

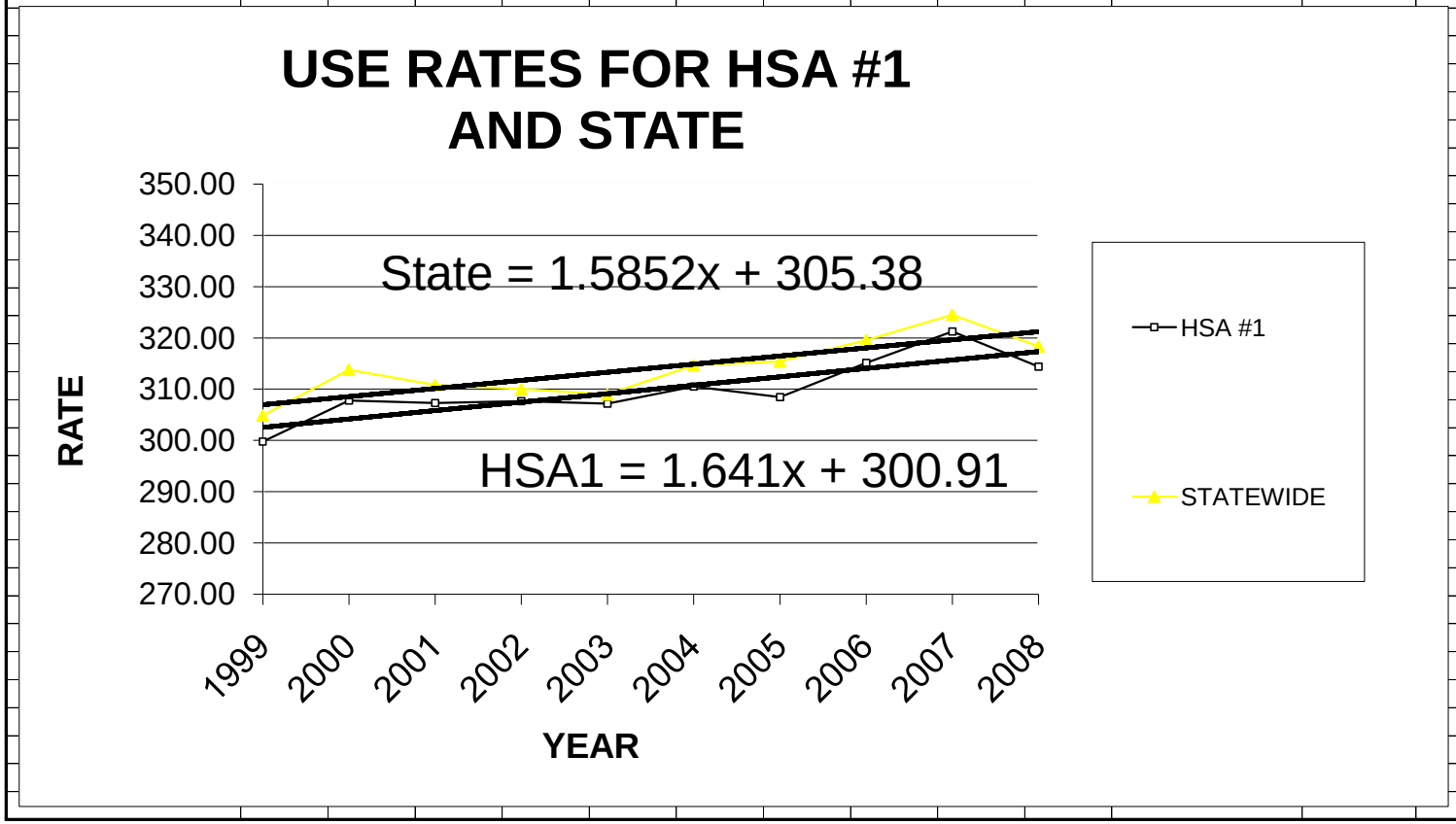
Appendix A
Acute Bed Need Methodology

2000-2009 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**
HSA #1	1,116,008	1,162,777	1,173,852	1,185,068	1,194,260	1,223,414	1,235,319	1,282,804	1,328,827	1,321,575	**12,223,904**
SEK											**0**
STATEWIDE TOTAL	**1,797,558**	**1,875,612**	**1,878,385**	**1,891,439**	**1,906,739**	**1,969,331**	**2,007,868**	**2,068,766**	**2,135,745**	**2,130,225**	**19,661,668**
2000-2009 CHARS wo all MDC19 and MDC15.xlsx											

2000-2009 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**
HSA #1	1,116,008	1,162,777	1,173,852	1,185,068	1,194,260	1,223,414	1,235,319	1,282,804	1,328,827	1,321,575	**12,223,904**
SEK	0	0	0	0	0	0	0	0	0	0	**0**
STATEWIDE TOTAL	1,797,558	1,875,612	1,878,385	1,891,439	1,906,739	1,969,331	2,007,868	2,068,766	2,135,745	2,130,225	**19,661,668**
1998-2007 HSA TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS											
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**
HSA #1	407	502	492	741	717	662	616	805	1067	1713	**7,722**
SEK**											**0**
STATEWIDE TOTAL	**451**	**608**	**530**	**970**	**898**	**799**	**716**	**954**	**1,152**	**2,006**	**9,084**
****MultiCare Application**											
1998-2007 HSA TOTAL NUMBER OF PATIENT DAYS MINUS PSYCH DAYS											
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**
HSA #1	1,115,601	1,162,275	1,173,360	1,184,327	1,193,543	1,222,752	1,234,703	1,281,999	1,327,760	1,319,862	**12,216,182**
SEK	0	0	0	0	0	0	0	0	0	0	**0**
STATEWIDE TOTAL	**1,797,107**	**1,875,004**	**1,877,855**	**1,890,469**	**1,905,841**	**1,968,532**	**2,007,152**	**2,067,812**	**2,134,593**	**2,128,219**	**19,652,584**

2000-2009 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS MINUS PSYCH DAYS												
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**	
HSA #1	1,115,601	1,162,275	1,173,360	1,184,327	1,193,543	1,222,752	1,234,703	1,281,999	1,327,760	1,319,862	**12,216,182**	
SEK	0	0	0	0	0	0	0	0	0	0	**0**	
STATEWIDE TOTAL	**1,797,107**	**1,875,004**	**1,877,855**	**1,890,469**	**1,905,841**	**1,968,532**	**2,007,152**	**2,067,812**	**2,134,593**	**2,128,219**	**19,652,584**	
TOTAL POPULATIONS												
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**	
HSA #1	3,721,775	3,776,110	3,818,510	3,849,500	3,885,500	3,938,000	4,003,059	4,068,118	4,133,178	4,198,237	**39,391,987**	
SEK											**0**	
STATEWIDE TOTAL	**5,894,143**	**5,974,910**	**6,041,710**	**6,098,300**	**6,167,800**	**6,256,400**	**6,363,584**	**6,470,767**	**6,577,951**	**6,685,134**	**62,530,699**	
USE RATE PER 1,000												
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**	
HSA #1	299.75	307.80	307.28	307.66	307.18	310.50	308.44	315.13	321.24	314.38	**3,099**	
SEK	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0!**	
STATEWIDE	**304.90**	**313.81**	**310.82**	**310.00**	**309.00**	**314.64**	**315.41**	**319.56**	**324.51**	**318.35**	**3,141**	

RESIDENT USE RATE PER 1,000													
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**10-YEAR TOTAL**		**Trendline**
HSA #1	299.75	307.80	307.28	307.66	307.18	310.50	308.44	315.13	321.24	314.38	**3,099.37**		1.6410
SEK											**0.00**		
STATEWIDE	**304.90**	**313.81**	**310.82**	**310.00**	**309.00**	**314.64**	**315.41**	**319.56**	**324.51**	**318.35**	**3,141.00**		**1.5852**



STEP #5												
2009 DATA												
	# of Pat days	Less OOS	TOTAL LESS OOS									
SEK				%								
0-64	64,204	697	**63,507**	1.09%								
65+	55,932	611	**55,321**	1.09%								
TOTAL	**120,136**	**1,308**	**118,828**									
WA - SEK												
0-64	1,228,850	60,922	**1,167,928**	4.96%								
65+	881,518	38,049	**843,469**	4.32%								
TOTAL	**2,110,368**	**98,971**	**2,011,397**									
	TO SEK	**TO WA**				**TOTAL # OF DAYS FOR RESIDENTS BY HSA (LESS PATS FROM OOS)**	**ADD DAYS PROVIDED IN OREGON ****	**TOTAL # OF DAYS FOR RESIDENTS BY HSA**				
FROM SEK												
0-64	47,089	60,472				107,561	201	107,762				
65+	41,282	23,861				65,143	161	65,304				
TOTAL	**88,371**	**84,333**				**172,704**	**362**	**173,066**				
FROM WA												
0-64	16,418	1,107,456				1,123,874	39,871	1,163,745				
65+	14,039	819,608				833,647	19,786	853,433				
TOTAL	**30,457**	**1,927,064**				**1,957,521**	**59,657**	**2,017,178**				
	118,828	**2,011,397**					** Patient Days as reported by 2008 HCUP data for Oregon CHARS					
MARKET SHARE												
PERCENTAGE OF PATIENT DAYS												
	TO SEK	**TO WA**		**TO OREGON**								
% OF SEK RESIDENTS												
0-64	43.70%	56.12%		0.19%								
65+	63.22%	36.54%		0.25%								
TOTAL												
% OF WA - SEK RESIDENTS												
0-64	1.41%	95.16%		3.43%								
65+	1.65%	96.04%		2.32%								
TOTAL												
2009 POPULATIONS BY PLANNING AREA												
	SEK	**TO WA**										
0-64	478,191	5,410,094										
65+	50,670	746,180										
TOTAL	**528,861**	**6,156,274**										
STEP #6												
USE RATE BY PLANNING AREA												
	SEK	**TO WA**										
USE RATES												
0-64	225.35	215.11										
65+	1,288.81	1,143.74										

USE RATE BY PLANNING AREA FROM STEP 6							
	SEK						
YEAR 2009 USE RATES							
0-64	225.35						
65+	1,288.81						
PROJECTED POPULATION	YEAR 2016						
	SEK						
0-64	498,194						
65+	73,199						
TOTALS	**571,393**						
PROJECTED 2016 USE RATE							
	SEK						
USE RATES*							
0-64 using HSA Trend	236.84						
0-64 using Statewide Trend	**236.45**						
65+ using HSA Trend	1,300.30						
65+ using Statewide Trend	**1,299.91**						
* Projected by applying either HSA trend or Statewide trend, whichever trend would result in the smaller adjustment							
Bold Print indicates use rate closest to current value							

USE RATE BY HSA FROM STEP 7A	
PROJECTED USE RATE - 2016	**SEK**
USE RATES	
0-64	236.45
65+	1,299.91
PROJECTED POPULATION - 2016	
	SEK
0-64	498,194
65+	73,199
TOTALS	**571,393**
PROJECTED # OF PATIENT DAYS	YEAR 2016
	SEK
0-64	117,798
65+	95,152
TOTALS	**212,950**

PROJECTED # OF PATIENT DAYS					
YEAR 2016	**SEKing**	**WA - SEKing**		**TOTAL**	
0-64	117,798	1,296,815		1,414,613	
65+	95,152	1,124,039		1,219,191	
TOTALS	**212,950**	**2,420,854**		**2,633,804**	
MARKET SHARE % OF PATIENT DAYS FROM STEP 5					
% OF SEKing RESIDENTS	**SEKing**	**WA - SEKing**		**TO OREGON**	
0-64	43.70%	56.12%		0.19%	
65+	63.22%	36.54%		0.25%	
% OF WA - SEKing RESIDENTS	**SEKing**	**WA - SEKing**		**TO OREGON**	
0-64	1.41%	95.16%		3.43%	
65+	1.65%	96.04%		2.32%	
# OF SEKing RESIDENTS	**SEKing**	**WA - SEKing**		**TO OREGON**	**Total**
0-64	51,474	66,104		220	117,798
65+	60,150	34,767		235	95,152
					212,950
# OF WA - SEKing RESIDENTS	**SEKing**	**WA - SEKing**		**TO OREGON**	**Total**
0-64	18,295	1,234,090		44,430	1,296,815
65+	18,490	1,079,489		26,060	1,124,039
					2,420,854
# OF RESIDENT PAT DAYS PROJECTED IN SEK					
0-64	69,770				
65+	78,641				
# OF RESIDENT PAT DAYS PROJECTED IN WA - SEK					
0-64	1,300,193				
65+	1,114,256				
# OF WA RESIDENT PAT DAYS PROJECTED IN OREGON					
0-64	44,650				
65+	26,294				
OUT OF STATE % OF PATIENT DAYS FROM STEP 5					
SEK	%				
0-64	1.10%				
65+	1.10%				
WA - SEKing					
0-64	5.22%				
65+	4.51%				
PROJECTED # OF PATIENT DAYS 2016					
PLUS OUT OF STATE RESIDENTS					
SEK					
0-64	70,536	0.598783807			
65+	79,509	0.835605914			
TOTAL	**150,045**				

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
SEK Planning Area											
Population 0-64(1)	478,191	481,049	483,906	486,764	489,621	492,479	495,337	498,194	501,052	503,909	506,767
0-64 Use Rate	225.35	226.94	228.52	230.11	231.69	233.28	234.86	236.45	238.04	239.62	241.21
Population 65+(1)	50,670	53,888	57,107	60,325	63,544	66,762	69,980	73,199	76,417	79,636	82,854
65+ Use Rate	1,288.81	1290.40	1291.98	1293.57	1295.15	1296.74	1298.32	1299.91	1301.49	1303.08	1304.66
Total Population	528,861	534,937	541,013	547,089	553,165	559,241	565,317	571,393	577,469	583,545	589,621
Total SEK Res Days	173,066	178,706	184,365	190,043	195,741	201,458	207,194	212,950	218,724	224,518	230,331
Total Days in SEK Hospitals (2)	119,095	123,474	127,868	132,275	136,697	141,132	145,581	150,045	154,522	159,013	163,518
Available Beds (3)											
Auburn Regional	124	124	124	124	124	124	124	124	124	124	124
Enumclaw	25	25	25	25	25	25	25	25	25	25	25
FHS/St Francis	118	118	118	136	136	136	136	136	136	136	136
Valley Medical Center	283	283	283	283	283	283	283	283	283	283	283
Total	**550**	**550**	**550**	**568**	**568**	**568**	**568**	**568**	**568**	**568**	**568**
Wtd Occ Std(4)	66.89%	66.89%	66.89%	66.83%	66.83%	66.83%	66.83%	66.83%	66.83%	66.83%	66.83%
Gross Bed Need	**488**	**506**	**524**	**542**	**560**	**579**	**597**	**615**	**633**	**652**	**670**
Net Bed Need/(Surplus)	(62)	(44)	(26)	(26)	(8)	**11**	**29**	**47**	**65**	**84**	**102**
								7 yr			**10 yr**
(1) Source: Claritas 2009											
(2) Adjusted to reflect referral patterns into and out of SEK Planning Area to other planning areas and Oregon											
(3) Source: Fall 2008 Hospital Survey returns											
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,											

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
SEK Planning Area											
Population 0-64(1)	478,191	481,049	483,906	486,764	489,621	492,479	495,337	498,194	501,052	503,909	506,767
0-64 Use Rate	225.35	226.94	228.52	230.11	231.69	233.28	234.86	236.45	238.04	239.62	241.21
Population 65+(1)	50,670	53,888	57,107	60,325	63,544	66,762	69,980	73,199	76,417	79,636	82,854
65+ Use Rate	1,288.81	1290.40	1291.98	1293.57	1295.15	1296.74	1298.32	1299.91	1301.49	1303.08	1304.66
Total Population	528,861	534,937	541,013	547,089	553,165	559,241	565,317	571,393	577,469	583,545	589,621
Total SEK Res Days	173,066	178,706	184,365	190,043	195,741	201,458	207,194	212,950	218,724	224,518	230,331
Total Days in SEK Hospitals (2)	119,095	123,474	127,868	132,275	136,697	141,132	145,581	150,045	154,522	159,013	163,518
Available Beds (3)											
Auburn Regional	124	124	124	**178**	178	**194**	194	194	194	194	194
Enumclaw	25	25	25	25	25	25	25	25	25	25	25
FHS/St Francis	118	118	118	136	136	136	136	136	136	136	136
Valley Medical Center	283	283	283	283	283	283	283	283	283	283	283
Total	**550**	**550**	**550**	**622**	**622**	**638**	**638**	**638**	**638**	**638**	**638**
Wtd Occ Std(4)	66.89%	66.89%	66.89%	66.67%	66.67%	66.63%	66.63%	66.63%	66.63%	66.63%	66.63%
Gross Bed Need	**488**	**506**	**524**	**544**	**562**	**580**	**599**	**617**	**635**	**654**	**672**
Net Bed Need/(Surplus)	(62)	(44)	(26)	(78)	(60)	(58)	(39)	(21)	(3)	**16**	**34**
								7 yr			**10 yr**
(1) Source: Claritas 2009											
(2) Adjusted to reflect referral patterns into and out of SEK Planning Area to other planning areas and Oregon											
(3) Source: Fall 2008 Hospital Survey returns											
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,											

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
SEK Planning Area																
Population 0-64(1)	478,191	481,049	483,906	486,764	489,621	492,479	495,337	498,194	501,052	503,909	506,767	509,625	512,482	515,340	518,197	521,055
0-64 Use Rate	225.35	226.94	228.52	230.11	231.69	233.28	234.86	236.45	238.04	239.62	241.21	242.79	244.38	245.96	247.55	249.13
Population 65+(1)	50,670	53,888	57,107	60,325	63,544	66,762	69,980	73,199	76,417	79,636	82,854	86,072	89,291	92,509	95,728	98,946
65+ Use Rate	1,288.81	1290.40	1291.98	1293.57	1295.15	1296.74	1298.32	1299.91	1301.49	1303.08	1304.66	1306.25	1307.83	1309.42	1311.00	1312.59
Total Population	528,861	534,937	541,013	547,089	553,165	559,241	565,317	571,393	577,469	583,545	589,621	595,697	601,773	607,849	613,925	620,001
Total SEK Res Days	173,066	178,706	184,365	190,043	195,741	201,458	207,194	212,950	218,724	224,518	230,331	236,164	242,016	247,887	253,777	259,687
Total Days in SEK Hospitals (2)	119,095	123,474	127,868	132,275	136,697	141,132	145,581	150,045	154,522	159,013	163,518	168,037	172,571	177,118	181,679	186,253
Available Beds (3)																
Auburn Regional	124	124	124	124	124	124	124	124	124	124	124	124	124	124	124	124
Enumclaw	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
FHS/St Francis	118	118	118	136	136	136	136	136	136	136	136	136	136	136	136	136
Valley Medical Center	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283
MultiCare -proposed						**34**	**58**	58	58	58	58	58	58	58	58	58
Total	**550**	**550**	**550**	**568**	**568**	**602**	**626**	**626**	**626**	**626**	**626**	**626**	**626**	**626**	**626**	**626**
Wtd Occ Std(4)	66.89%	66.89%	66.89%	66.83%	66.83%	65.88%	66.20%	66.20%	66.20%	66.20%	66.20%	66.20%	66.20%	66.20%	66.20%	66.20%
Gross Bed Need	**488**	**506**	**524**	**542**	**560**	**587**	**603**	**621**	**640**	**658**	**677**	**695**	**714**	**733**	**752**	**771**
Net Bed Need/(Surplus)	(62)	(44)	(26)	(26)	(8)	(15)	(23)	(5)	**14**	**32**	**51**	**69**	**88**	**107**	**126**	**145**
								7 yr			**10 yr**					**15yr**
(1) Source: Claritas 2009																
(2) Adjusted to reflect referral patterns into and out of SEK Planning Area to other planning areas and Oregon																
(3) Source: Fall 2008 Hospital Survey returns																
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,																

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
SEK Planning Area											
Population 0-64(1)	478,191	481,049	483,906	486,764	489,621	492,479	495,337	498,194	501,052	503,909	506,767
0-64 Use Rate	225.35	226.94	228.52	230.11	231.69	233.28	234.86	236.45	238.04	239.62	241.21
Population 65+(1)	50,670	53,888	57,107	60,325	63,544	66,762	69,980	73,199	76,417	79,636	82,854
65+ Use Rate	1,288.81	1290.40	1291.98	1293.57	1295.15	1296.74	1298.32	1299.91	1301.49	1303.08	1304.66
Total Population	528,861	534,937	541,013	547,089	553,165	559,241	565,317	571,393	577,469	583,545	589,621
Total SEK Res Days	173,066	178,706	184,365	190,043	195,741	201,458	207,194	212,950	218,724	224,518	230,331
Total Days in SEK Hospitals (2)	119,095	123,474	127,868	132,275	136,697	141,132	145,581	150,045	154,522	159,013	163,518
Available Beds (3)											
Auburn Regional	124	124	124	124	124	124	124	124	124	124	124
Enumclaw	25	25	25	25	25	25	25	25	25	25	25
FHS/St Francis	118	118	118	136	136	136	136	136	136	136	136
Valley Medical Center	283	283	283	**313**	**343**	343	343	343	343	343	343
Total	**550**	**550**	**550**	**598**	**628**	**628**	**628**	**628**	**628**	**628**	**628**
Wtd Occ Std(4)	66.89%	66.89%	66.89%	69.61%	69.86%	69.86%	69.86%	69.86%	69.86%	69.86%	69.86%
Gross Bed Need	**488**	**506**	**524**	**521**	**536**	**553**	**571**	**588**	**606**	**624**	**641**
Net Bed Need/(Surplus)	(62)	(44)	(26)	(77)	(92)	(75)	(57)	(40)	(22)	(4)	**13**
								7 yr			**10 yr**
(1) Source: Claritas 2009											
(2) Adjusted to reflect referral patterns into and out of SEK Planning Area to other planning areas and Oregon											
(3) Source: Fall 2008 Hospital Survey returns											
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,											

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
SEK Planning Area																
Population 0-64(1)	478,191	481,049	483,906	486,764	489,621	492,479	495,337	498,194	501,052	503,909	506,767	509,625	512,482	515,340	518,197	521,055
0-64 Use Rate	225.35	226.94	228.52	230.11	231.69	233.28	234.86	236.45	238.04	239.62	241.21	242.79	244.38	245.96	247.55	249.13
Population 65+(1)	50,670	53,888	57,107	60,325	63,544	66,762	69,980	73,199	76,417	79,636	82,854	86,072	89,291	92,509	95,728	98,946
65+ Use Rate	1,288.81	1290.40	1291.98	1293.57	1295.15	1296.74	1298.32	1299.91	1301.49	1303.08	1304.66	1306.25	1307.83	1309.42	1311.00	1312.59
Total Population	528,861	534,937	541,013	547,089	553,165	559,241	565,317	571,393	577,469	583,545	589,621	595,697	601,773	607,849	613,925	620,001
Total SEK Res Days	173,066	178,706	184,365	190,043	195,741	201,458	207,194	212,950	218,724	224,518	230,331	236,164	242,016	247,887	253,777	259,687
Total Days in SEK Hospitals (2)	119,095	123,474	127,868	132,275	136,697	141,132	145,581	150,045	154,522	159,013	163,518	168,037	172,571	177,118	181,679	186,253
Available Beds (3)																
Auburn Regional	124	124	124	124	124	124	124	124	124	124	124	124	124	124	124	124
Enumclaw	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
FHS/St Francis	118	118	118	136	136	136	136	136	136	136	136	136	136	136	136	136
Valley Medical Center	283	283	283	**313**	**343**	343	343	343	343	343	343	343	343	343	343	343
MultiCare -proposed						**34**	**58**	58	58	58	58	58	58	58	58	58
Total	**550**	**550**	**550**	**598**	**628**	**662**	**686**	**686**	**686**	**686**	**686**	**686**	**686**	**686**	**686**	**686**
Wtd Occ Std(4)	66.89%	66.89%	66.89%	69.61%	69.86%	68.84%	69.03%	69.03%	69.03%	69.03%	69.03%	69.03%	69.03%	69.03%	69.03%	69.03%
Gross Bed Need	**488**	**506**	**524**	**521**	**536**	**562**	**578**	**596**	**613**	**631**	**649**	**667**	**685**	**703**	**721**	**739**
Net Bed Need/(Surplus)	(62)	(44)	(26)	(77)	(92)	(100)	(108)	(90)	(73)	(55)	(37)	(19)	(1)	**17**	**35**	**53**
								7 yr			**10 yr**					**15yr**
(1) Source: Claritas 2009																
(2) Adjusted to reflect referral patterns into and out of SEK Planning Area to other planning areas and Oregon																
(3) Source: Fall 2008 Hospital Survey returns																
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,																

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
SEK Planning Area																
Population 0-64(1)	478,191	481,049	483,906	486,764	489,621	492,479	495,337	498,194	501,052	503,909	506,767	509,625	512,482	515,340	518,197	521,055
0-64 Use Rate	225.35	226.94	228.52	230.11	231.69	233.28	234.86	236.45	238.04	239.62	241.21	242.79	244.38	245.96	247.55	249.13
Population 65+(1)	50,670	53,888	57,107	60,325	63,544	66,762	69,980	73,199	76,417	79,636	82,854	86,072	89,291	92,509	95,728	98,946
65+ Use Rate	1,288.81	1290.40	1291.98	1293.57	1295.15	1296.74	1298.32	1299.91	1301.49	1303.08	1304.66	1306.25	1307.83	1309.42	1311.00	1312.59
Total Population	528,861	534,937	541,013	547,089	553,165	559,241	565,317	571,393	577,469	583,545	589,621	595,697	601,773	607,849	613,925	620,001
Total SEK Res Days	173,066	178,706	184,365	190,043	195,741	201,458	207,194	212,950	218,724	224,518	230,331	236,164	242,016	247,887	253,777	259,687
Total Days in SEK Hospitals (2)	119,095	123,474	127,868	132,275	136,697	141,132	145,581	150,045	154,522	159,013	163,518	168,037	172,571	177,118	181,679	186,253
Available Beds (3)																
Auburn Regional	124	124	124	**178**	178	**194**	194	194	194	194	194	194	194	194	194	194
Enumclaw	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
FHS/St Francis	118	118	118	136	136	136	136	136	136	136	136	136	136	136	136	136
Valley Medical Center	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283
MultiCare -proposed						**34**	**58**	58	58	58	58	58	58	58	58	58
Total	**550**	**550**	**550**	**622**	**622**	**672**	**696**	**696**	**696**	**696**	**696**	**696**	**696**	**696**	**696**	**696**
Wtd Occ Std(4)	66.89%	66.89%	66.89%	66.67%	66.67%	65.79%	66.08%	66.08%	66.08%	66.08%	66.08%	66.08%	66.08%	66.08%	66.08%	66.08%
Gross Bed Need	**488**	**506**	**524**	**544**	**562**	**588**	**604**	**622**	**641**	**659**	**678**	**697**	**716**	**734**	**753**	**772**
Net Bed Need/(Surplus)	(62)	(44)	(26)	(78)	(60)	(84)	(92)	(74)	(55)	(37)	(18)	**1**	**20**	**38**	**57**	**76**
								7 yr			**10 yr**					**15yr**

(1) Source: Claritas 2009

(2) Adjusted to reflect referral patterns into and out of SEK Planning Area to other planning areas and Oregon

(3) Source: Fall 2008 Hospital Survey returns

(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
SEK Planning Area																
Population 0-64(1)	478,191	481,049	483,906	486,764	489,621	492,479	495,337	498,194	501,052	503,909	506,767	509,625	512,482	515,340	518,197	521,055
0-64 Use Rate	225.35	226.94	228.52	230.11	231.69	233.28	234.86	236.45	238.04	239.62	241.21	242.79	244.38	245.96	247.55	249.13
Population 65+(1)	50,670	53,888	57,107	60,325	63,544	66,762	69,980	73,199	76,417	79,636	82,854	86,072	89,291	92,509	95,728	98,946
65+ Use Rate	1,288.81	1290.40	1291.98	1293.57	1295.15	1296.74	1298.32	1299.91	1301.49	1303.08	1304.66	1306.25	1307.83	1309.42	1311.00	1312.59
Total Population	528,861	534,937	541,013	547,089	553,165	559,241	565,317	571,393	577,469	583,545	589,621	595,697	601,773	607,849	613,925	620,001
Total SEK Res Days	173,066	178,706	184,365	190,043	195,741	201,458	207,194	212,950	218,724	224,518	230,331	236,164	242,016	247,887	253,777	259,687
Total Days in SEK Hospitals (2)	119,095	123,474	127,868	132,275	136,697	141,132	145,581	150,045	154,522	159,013	163,518	168,037	172,571	177,118	181,679	186,253
Available Beds (3)																
Auburn Regional	124	124	124	**178**	178	**194**	194	194	194	194	194	194	194	194	194	194
Enumclaw	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
FHS/St Francis	118	118	118	136	136	136	136	136	136	136	136	136	136	136	136	136
Valley Medical Center	283	283	283	**313**	**343**	343	343	343	343	343	343	343	343	343	343	343
Total	**550**	**550**	**550**	**652**	**682**	**698**	**698**	**698**	**698**	**698**	**698**	**698**	**698**	**698**	**698**	**698**
Wtd Occ Std(4)	66.89%	66.89%	66.89%	69.23%	69.48%	69.38%	69.38%	69.38%	69.38%	69.38%	69.38%	69.38%	69.38%	69.38%	69.38%	69.38%
Gross Bed Need	**488**	**506**	**524**	**524**	**539**	**557**	**575**	**593**	**610**	**628**	**646**	**664**	**681**	**699**	**717**	**736**
Net Bed Need/(Surplus)	(62)	(44)	(26)	(128)	(143)	(141)	(123)	(105)	(88)	(70)	(52)	(34)	(17)	**1**	**19**	**38**
								7 yr			**10 yr**					**15yr**
(1) Source: Claritas 2009																
(2) Adjusted to reflect referral patterns into and out of SEK Planning Area to other planning areas and Oregon																
(3) Source: Fall 2008 Hospital Survey returns																
(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,																

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
SEK Planning Area																
Population 0-64(1)	478,191	481,049	483,906	486,764	489,621	492,479	495,337	498,194	501,052	503,909	506,767	509,625	512,482	515,340	518,197	521,055
0-64 Use Rate	225.35	226.94	228.52	230.11	231.69	233.28	234.86	236.45	238.04	239.62	241.21	242.79	244.38	245.96	247.55	249.13
Population 65+(1)	50,670	53,888	57,107	60,325	63,544	66,762	69,980	73,199	76,417	79,636	82,854	86,072	89,291	92,509	95,728	98,946
65+ Use Rate	1,288.81	1290.40	1291.98	1293.57	1295.15	1296.74	1298.32	1299.91	1301.49	1303.08	1304.66	1306.25	1307.83	1309.42	1311.00	1312.59
Total Population	528,861	534,937	541,013	547,089	553,165	559,241	565,317	571,393	577,469	583,545	589,621	595,697	601,773	607,849	613,925	620,001
Total SEK Res Days	173,066	178,706	184,365	190,043	195,741	201,458	207,194	212,950	218,724	224,518	230,331	236,164	242,016	247,887	253,777	259,687
Total Days in SEK Hospitals (2)	119,095	123,474	127,868	132,275	136,697	141,132	145,581	150,045	154,522	159,013	163,518	168,037	172,571	177,118	181,679	186,253
Available Beds (3)																
Auburn Regional	124	124	124	**178**	178	**194**	194	194	194	194	194	194	194	194	194	194
Enumclaw	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25	25
FHS/St Francis	118	118	118	136	136	136	136	136	136	136	136	136	136	136	136	136
Valley Medical Center	283	283	283	**313**	**343**	343	343	343	343	343	343	343	343	343	343	343
MultiCare -proposed						**34**	**58**	58	58	58	58	58	58	58	58	58
Total	**550**	**550**	**550**	**652**	**682**	**732**	**756**	**756**	**756**	**756**	**756**	**756**	**756**	**756**	**756**	**756**
Wtd Occ Std(4)	66.89%	66.89%	66.89%	69.23%	69.48%	68.48%	68.66%	68.66%	68.66%	68.66%	68.66%	68.66%	68.66%	68.66%	68.66%	68.66%
Gross Bed Need	**488**	**506**	**524**	**524**	**539**	**565**	**581**	**599**	**617**	**635**	**653**	**671**	**689**	**707**	**725**	**743**
Net Bed Need/(Surplus)	(62)	(44)	(26)	(128)	(143)	(167)	(175)	(157)	(139)	(121)	(103)	(85)	(67)	(49)	(31)	(13)
								7 yr			**10 yr**					**15yr**

(1) Source: Claritas 2009

(2) Adjusted to reflect referral patterns into and out of SEK Planning Area to other planning areas and Oregon

(3) Source: Fall 2008 Hospital Survey returns

(4) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,

Southeast King Zips

SHP	Map	Dept	MultiCare	Valley	Auburn			2000 0-64	65+		2008 0-64	65+		2013 0-64	65+	
	98001	98001	98001	98001	98001	Auburn	Not in SHP	23841								
98002	98002	98002	98002	98002	98002	Auburn		26263								
98003	98003	98003	98003	98003	98003	Federal Way		38389								
98010	98010	98010	98010	98010	98010	Black Diamond		3768								
98015			98015	98015			Now E. King									
98022	98022	98022	98022	98022	98022	Enumclaw		19444								
	98023	98023	98023	98023	98023	Federal Wa	Not in SHP	44255								
98025	98025	98025	98025	98025	98025	Hobart										
		98030	98030	98030	98030	Kent	Not in SHP	28191								
98031	98031	98031	98031	98031	98031	Kent		31490								
	98032	98032	98032	98032	98032	Kent	Not in SHP	26310								
98035	98035	98035	98035	98035	98035	Kent										
98038	98038	98038	98038	98038	98038	Maple Valley		22104								
	98042	98042	98042	98042	98042	Kent	Not in SHP	34785								
98047	98047	98047	98047	98047	98047	Pacific		5024								
98048			98048	98048		Not Found										
98051	98051	98051	98051	98051	98051	Ravensdale		2504								
98054	98054	98054	98054	98054	98054	Redondo										
98055	98055	98055	98055	98055	98055	Renton		16275								
	98056	98056	98056	98056	98056	Renton	Not in SHP	23004								
		98057	98057	98057	98057	Renton	Not in SHP	8178								
	98058	98058	98058	98058	98058	Renton	Not in SHP	34877								
	98059	98059	98059	98059	98059	Renton	Not in SHP	23876								
		98063	98063	98063	98063	Federal Wa	Not in SHP									
98064		98064	98064	98064	98064	Kent										
	98071	98071	98071	98071	98071	Auburn	Not in SHP									
		98089	98089	98089	98089	Kent	Not in SHP									
	98092	98092	98092	98092	98092	Auburn	Not in SHP	26098								
	98093	98093			98093	Auburn	Not in SHP									
								438676	0	**438676**		0	0	**0**	0	0	**0**

Claritas Total Pop Worksheet

1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
472,371	**477,449**	483,161	488,874	494,586	500,299	506,011	511,724	517,436	523,149	**528,861**	534,937	541,013	547,089	553,165	**559,241**	565,317	571,393	577,469	583,545	589,621

>64 Population Worksheet

2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
438,676	443,067	447,457	451,848	456,238	460,629	465,019	469,410	473,800	**478,191**	481,049	483,906	486,764	489,621	**492,479**	495,337	498,194	501,052	503,909	506,767

65+ Population Worksheet

2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
38,773	40,095	41,417	42,739	44,061	45,382	46,704	48,026	49,348	**50,670**	53,888	57,107	60,325	63,544	**66,762**	69,980	73,199	76,417	79,636	82,854