EXECUTIVE SUMMARY

EVALUATIONS OF THE FOLLOWING CERTIFICATE OF NEED APPLICATIONS PROPOSING ADDITIONAL GENERAL ACUTE CARE PEDIATRIC BEDS:

- **SEATTLE CHILDREN'S PROPOSING TO ADD 100 GENERAL ACUTE CARE PEDIATRIC BEDS AND 21 PSYCIATRIC BEDS AT ITS EXISTING HOSPITAL IN SEATTLE**
- **MULTICARE HEALTH SYSTEM PROPOSING TO ADD 25 GENERAL ACUTE CARE PEDIATRIC BEDS TO MARY BRIDGE CHILDREN'S HOSPITAL AND HEALTH CENTER IN TACOMA**

BRIEF PROJECT DESCRIPTIONS

Seattle Children's

Seattle Children's Hospital and Regional Medical Center (Children's) is owned by Children's Health Care System, a Washington not-for-profit, public benefit 501(c)(3) tax exempt organization, founded in 1907 as Children's Orthopedic Hospital. Children's provides health care services through its main hospital campus in Seattle's Laurelhurst neighborhood, through local satellite clinics, via partnerships with other hospitals in Washington, Alaska, Montana, and Idaho and a home care agency. [Source: Seattle Children's Hospital website]

Children's proposes two separate, but connected, expansion projects. First, Children's proposes to add 100 general acute care pediatric beds to the existing hospital's 250 licensed beds and located at 4800 Sand Point Way NE in Seattle, Washington. The new beds would be housed in available space of the existing hospital and in a new 9-story patient care building built across the street from the current hospital campus. The second associated project proposes an additional 21 psychiatric beds. At project completion Children's will have 311 general medical surgical beds, 41 psychiatric beds and 19 NICU level III bassinettes.

The capital expenditure associated with the entire expansion plans is $444,251,164. Of this total, $216,554,633 is attributed to the portion requiring Certificate of Need approval. If this project is approved, Children's anticipates that all the beds would become operational by November, 2015. Under this timeline, year 2016 would be the facility's first full calendar year of operation. [Children's Application, p19 & 40]

MultiCare Health System / Mary Bridge

MultiCare Health System (MultiCare) proposes to add 25 general acute care pediatric beds to the organization's Mary Bridge Children's Hospital and Health Center (Mary Bridge) located at 315 Martin Luther King Way in Tacoma, Washington. The new beds would add to the current 72 licensed beds and be housed in a new space constructed atop the campus's Milgard Pavilion tower. At project completion Mary Bridge will have 97 general medical surgical beds. [MultiCare Application, p18]

The capital expenditure associated with the total tower expansion is $28,419,426. Of this amount, $22,815,205 is attributed to the 6th and 7th floor beds requiring Certificate of Need approval. If this project is approved, MultiCare anticipates that the beds would become operational by September, 2014. Under this timeline, year 2015 would be the facility's first full calendar year of operation. [MultiCare Application, p18 & 48]

APPLICABILITY OF CERTIFICATE OF NEED LAW

These projects are subject to Certificate of Need review as the bed addition to a health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

CONCLUSIONS

Seattle Children's

For the reasons stated in this evaluation, the application submitted on behalf of Seattle Children's proposing to add 100 general acute care pediatric and 21 psychiatric beds to the hospital's is consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need should be approved. At project completion Children's will have 311 general medical surgical beds, 41 psychiatric beds and 19 NICU level III bassinettes.

Approved Capital Costs: $216,554,633

MultiCare Health System

For the reasons stated in this evaluation, the application submitted on behalf of MultiCare Health System proposing to add 25 acute care beds to Mary Bridge Children's Hospital and Health Center is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

EVALUATIONS OF THE FOLLOWING CERTIFICATE OF NEED APPLICATIONS PROPOSING ADDITIONAL GENERAL ACUTE CARE PEDIATRIC BEDS:

- **SEATTLE CHILDREN'S PROPOSING TO ADD 100 GENERAL ACUTE CARE PEDIATRIC BEDS AND 21 PSYCIATRIC BEDS AT ITS EXISTING HOSPITAL IN SEATTLE**
- **MULTICARE HEALTH SYSTEM PROPOSING TO ADD 25 GENERAL ACUTE CARE PEDIATRIC BEDS TO MARY BRIDGE CHILDREN'S HOSPITAL AND HEALTH CENTER IN TACOMA**

PROJECT DESCRIPTIONS

Seattle Children's

Seattle Children's Hospital and Regional Medical Center (Children's) is owned by Children's Health Care System, a Washington not-for-profit, public benefit 501(c)(3) tax exempt organization, founded in 1907 as Children's Orthopedic Hospital. Children's provides health care services through its main hospital campus in Seattle's Laurelhurst neighborhood, through local satellite clinics, via partnerships with other hospitals in Washington, Alaska, Montana and Idaho and a home care agency.

Seattle Children's hospital is a tertiary provider of pediatric care that draws patients from throughout Washington, Alaska, Idaho and Montana for acute care, hematology/oncology, infectious disease, organ transplantation, rehabilitation, cardiology, and other specialized pediatric services. Seattle Children's Hospital also currently operates a pediatric specialty outpatient center in Bellevue on the Overlake Hospital Medical Center campus. Children's is currently licensed for 250 beds. Of these beds, 211 are used as general medical surgical beds, 20 as psychiatric beds, and 19 for NICU services. [Seattle Children's Hospital website; Children's Application, p9 & 23; DOH licensing records]

Children's proposes two separate, but connected, expansion projects. First, Children's proposes to add 100 general acute care pediatric beds to the existing hospital located at 4800 Sand Point Way NE in Seattle, Washington. The new beds would be housed in available space at the existing hospital and in a new 9-story patient care building built across the street from the current hospital campus. The second associated project proposes an additional 21 psychiatric beds.

The capital expenditure associated with the entire expansion plans is $444,251,164. Of this total, $216,554,633 is attributed to the projects requiring Certificate of Need approval. If approved, Children's anticipates that the beds would become operational by 2015. [Children's Application, p19 & 40]

Phase One (1a)

Children's intends to erect 4 of the approved beds into space currently available within three separate areas of the hospital. These beds would be activated upon CN approval and would increase the total bed capacity to 254. At this point, Children's will have 215 general medical surgical beds, 20 psychiatric beds and 19 NICU level III bassinettes.

Phase Two (1b)

This phase will begin to use space construction in the new patient tower. New general acute care pediatric capacity will be added to three floors of the new construction and 8 of the psychiatric beds will become available for services in vacated space within the existing hospital. Once the reconfiguration is completed in the Fall of 2013, 66 beds will be added and the total licensed bed capacity will increase to 320. At this point, Children's will have 273 general medical surgical beds, 28 psychiatric beds and 19 NICU level III bassinettes.

Phase Three (1c)
This phase will continue to use space construction in the new patient tower. New general acute care pediatric capacity will be added to two new floors of the planned construction and the remaining 13 psychiatric beds will become available for services in vacated space within the existing hospital. Once the reconfiguration is completed in late 2015, the remaining beds will be added and the total bed capacity will increase to 371. The total licensed bed capacity at the proposed project completion would consist of 311 general acute care pediatric beds, 19 NICU bassinettes and 41 psychiatric beds. [Children's Application, p9 & 19]

Once Children's completes a final phase (1d) to finish building out the proposed tower, the capital expenditure for the entire expansion project will total $444,251,164. Of this amount, $216,554,633 is attributed to the projects requiring Certificate of Need approval. The amount attributed for the general acute care pediatric bed expansion accounts for 96% of this and totals $208,744,868. If approved, Children's anticipates that the beds would become operational by November, 2015. Under this timeline, year 2016 would be the facility's first full calendar year of operation. The project's breakdown of its capital expenditures is listed below. [Children's Application, p19 & 40]

Item	General Acute Care Beds	Psychiatric Beds	Total Both Projects
Land & Leasehold Improvements	$ 135,351,719	$ 4,274,730	$ 138,007,684
Fixed & Moveable Equipment	$ 16,580,000	$ 866,880	$ 17,446,880
Architect / Consulting Fees	$ 12,589,771	$ 531,484	$ 13,121,255
Supervision and Inspection	$ 4,364,016	$ 247,144	$ 6,229,925
Taxes & Review Fees	$ 9,144,833	$ 415,206	$ 41,748,889
Other Project Costs	$ 30,714,529	$ 1,474,321	$ 32,188,850
Total Estimated Capital Costs	$ **208,744,868**	$ **7,809,765**	**$ 216,554,633**

To avoid confusion in this evaluation, beginning with the Need review criteria, each of the two projects proposed by Children's will be addressed separately. Pages 10 through 37 and Appendix A will address Children's acute care bed addition project; Children's psychiatric bed project criteria review begins on page 38 and includes Appendix C.

MultiCare Health System / Mary Bridge
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; MultiCare Application, p7]

- Tacoma General / Allenmore, Tacoma[1]
- Mary Bridge Children's Hospital and Health Center, Tacoma[2]
- Good Samaritan Hospital, Puyallup

Mary Bridge Children's Hospital and Health Center (Mary Bridge) was established in 1955 as a pediatric hospital in southwest Washington and is located at 311 South 'L' Street in Tacoma, Washington. Mary Bridge provides comprehensive and multidisciplinary inpatient pediatric services to the residents of Thurston, Lewis,

[1] Tacoma General Hospital and Allenmore Hospital are located at two separate sites; they are operated under the same hospital license of "Tacoma General/Allenmore Hospital."
[2] Mary Bridge Children's Hospital is located within Tacoma General Hospital; each facility is licensed separately.

King, Pierce, Kitsap, Mason, Grays Harbor, Jefferson and Pacific counties. Mary Bridge currently holds the designation as a level II trauma center and has recently expanded the size of its 24-hour emergency department.

MultiCare proposes to add 25 general acute care pediatric beds to Mary Bridge's current licensed capacity of 72 beds. The new beds would be housed in the addition of a 6th, and shelled in 7th, floor to the existing Milgard Pavilion. All 25 would be activated once the 6th floor is completed and would expand the Mary Bridge portion of the total Tacoma General/Mary Bridge campus. At project completion Mary Bridge will have 97 general medical surgical beds. [MultiCare Application, p18]

The capital expenditure associated with the total expansion is $28,419,426. Of this amount, $22,815,205 is attributed to the portion requiring Certificate of Need approval. If this project is approved, MultiCare anticipates that the beds would become operational by September, 2014. Under this timeline, year 2015 would be the facility's first full calendar year of operation. [MultiCare Application, p18 & 48]

Of the total costs under review, 65% is related to construction and improvements; 15% is allocated to equipment; and the remainder distributed between taxes and fees. The totals are outlined below. [MultiCare Application, p48]

Breakdown Of Capital Costs	Total	% of Total
Construction & Leasehold Improvements	$ 14,793,284	65%
Fixed & Moveable Equipment	$ 3,400,000	15%
Architect / Consulting Fees	$ 2,785,532	12%
Taxes & Review Fees	$ 1,836,389	8%
Total Estimated Capital Costs	**$ 22,815,205**	**100.00%**

APPLICABILITY OF CERTIFICATE OF NEED LAW

These projects are subject to Certificate of Need review as the bed addition to a health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

CRITERIA EVALUATION

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

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

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

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

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

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

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

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

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

APPLICATION CHRONOLOGY

Action	Children's	MultiCare
Letter of Intent Submitted	April 16, 2010	June 11, 2010
Application Submitted	June 1, 2010	July 14, 2010
Department's pre-review Activities including screening and responses	July 15, 2010 through September 16, 2010	
Beginning of Review	September 17, 2010	
End of Public Comment	October 22, 2010	
Rebuttal Comments Received	November 8, 2010	
Department's Anticipated Decision Date	December 23, 2010	
Department's Actual Decision Date	March 15, 2011	

CONCURRENT 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 Children's and MultiCare, 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 applicants, one additional entity sought and received affected person status under WAC 246-310-010.

- Providence Health System/Sacred Heart Medical Center

SOURCE INFORMATION REVIEWED

- Seattle Children's Certificate of Need application submitted June 1, 2010
- MultiCare Health System's Certificate of Need application submitted July 14, 2010
- Seattle Children's updated methodology dated August 30, 2010
- Seattle Children's supplemental information dated September 8, 2010
- MultiCare Health System's supplemental information dated September 9, 2010
- Department of Health's Office of Hospital and Patient Data Systems (HPDS) financial feasibility and cost containment analysis for Seattle Children's dated December 10, 2010
- Department of Health's Office of Hospital and Patient Data Systems (HPDS) financial feasibility and cost containment analysis for MultiCare Health System dated December 16, 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
- Acute care bed capacity surveys submitted by Seattle Children's and Mary Bridge Children's Hospital
- Seattle Children's rebuttal comments dated November 8, 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 Seattle Children's website
- Data obtained from the MultiCare Health System website
- Certificate of Need Historical files
- Department of Health's Investigation and Inspection's Office (IIO) files

CONCLUSIONS

Seattle Children's 100 General Acute Care bed addition.

For the reasons stated in this evaluation, the application submitted on behalf of Seattle Children's proposing to add 100 general acute care pediatric beds to the hospital is consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is approved.

Approved Capital Costs: $208,744,868

MultiCare Health System

For the reasons stated in this evaluation, the application submitted on behalf of MultiCare Health System proposing to add 25 acute care beds to Mary Bridge Children's Hospital and Health Center 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:

- Seattle Children's project has met the need criteria
- MultiCare Health System'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.

In relation to these two applications, the Department had multiple, but separate, meetings with representatives of both applicants to discuss the use of the traditional numeric acute care bed methodology for the forecast of beds within a hospital which focuses upon pediatric care. Though the Department determined the 10-step process would continue to allow for a mathematical tool to forecast potential need, each applicant expressed concerns regarding the age groups, patient days, and use rates traditionally applied.

Though specifics varied, there was constancy in the applicant's concerns about how to account for the differing use rates of the traditional 0-14 pediatric population and that of the patients that were 15 years and above that each hospital regularly served. Agreement was achieved with each applicant to maintain the traditional construct of the acute care bed methodology with changes in the data applied by each applicant.

Children's applied a statewide planning area. The methodology reflected a facility based approach rather than upon the Central County planning area in which it resides. The growth trend applied in the forecast figures was to be calculated based upon the hospital's 0-14 pediatric patient days. Capacity and use rates would be determined through a separation of the two applicable age cohorts of 0-14 and 15-20 years, in the same manor where the department would traditionally compute differing use rates for 0-64 and 65+ age cohorts.

For Mary Bridge, MultiCare would apply an eight-county planning area determined by the percentage of Mary Bridge's patient days currently provided to the surrounding counties[3]. In this manor, the MultiCare methodology reflected a traditional planning area approach defined by the facility's actual patient day totals. Trends, capacity, and use rates would be determined through a concentration upon the 8-county planning area and the population of 0-17.

Further, each applicant contended that their respective hospitals would be the only capacity considered in step 10 of their supporting methodologies. In review of the information, the Department determined that, though most other hospitals would have some pediatric patient days as a part of their day-to-day operations, each of these two applicants could be shown to stand alone in their facilities dedication to specific specialties related to pediatric care. Because of these relevant distinctions, the department accepted each applicant's proposed capacity limitations.

With these alterations applied, the Department reviewed and prepared bed need forecasts to determine baseline need for pediatric acute care capacity. These projections were completed prior to determining whether the applicant should be approved to meet any projected need.

[3] MultiCare limited the counties to include only those in which 10% or more of the facility's current patient days could be demonstrated.

Summary of Children's Numeric Methodology

Children's proposes to add 100 general acute care pediatric beds to the hospitals capacity in multiple phases. Given that this proposal involves construction, Children's began working on the project in 2010. The general acute care pediatric beds would be added in multiple phases detailed in the project description. Under the proposed timeline, 2018 would be Children's third year of operation with 311 general acute care pediatric beds. [Children's Application, p16, CN Historical files]

Children's 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 for the years between 1999 and 2008. The method submitted during the screening of the application updated the discharge data to include 2009 and separated the projections into two age cohorts of 0-14 and 15-20. The methodology submitted during screening will be used in the review of this bed request. [Children's Application, Exhibit 7; Seattle Children's August 30, 2010 methodology 2]

Children's followed each step of the methodology as discussed above. The entirety of Washington State was the applied planning area and patient days and population figures followed this premise. As a result, Children's computed a current need for additional beds. The need expands in each forecast year, reaching 104 beds in 2016. A complete summary of the applicant's projections are shown in Table 1.

Table 1
Summary of the Children's Need Methodology

	2010	2011	2012	2013	2014	2015	2016
Patient Days	66,533	68,594	70,923	73,296	75,543	77,993	80,505
Planning Area Beds	211	211	211	211	211	211	211
Gross Need	260	268	278	287	296	305	315
Net Need	49	57	67	76	85	94	104

* All numbers are rounded accordingly.

Summary of MultiCare's Numeric Methodology

MultiCare proposes to add 25 general acute care pediatric beds in the expansion of the Mary Bridge Campus. Given that this proposal involves construction, MultiCare intends to begin the project in the Spring of 2012. The general acute care pediatric beds would be added upon completion of the additional tower floor. Under the proposed timeline, 2017 would be Children's third year of operation with 97 general acute care pediatric beds. [MultiCare Application, p18 & 27]

MultiCare 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 for the years between 1999 and 2008. The method submitted during the screening of the application updated the discharge data to include 2009 and considered a single age cohort of 0-17. The methodology submitted during screening will be used in the review of this bed request. [MultiCare Application, Exhibit 9; MultiCare Supplemental Information, Exhibit 1]

MultiCare followed each step of the methodology as discussed above. The applicant identified a service area of eight specific counties which contributed 10% or more of the hospitals current patient day totals[4]. MultiCare computed a current need for additional beds, increasing in each subsequent year; reaching 39 beds in 2016. A complete summary of the MultiCare's projections are shown in Table 2. [MultiCare Application, p16]

[4] The counties included are Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Pierce, and Thurston

Table 2
Summary of the MultiCare Need Methodology

	2010	2011	2012	2013	2014	2015	2016
Patient Days	22,968	23,171	23,377	23,588	23,802	24,028	24,347
Planning Area Beds	72	72	72	72	72	72	72
Adjusted Gross Need	105	106	107	108	109	110	111
Net Need	33	34	35	36	37	38	39

* 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. Though, the underlying data necessary to complete step 11 as originally intended is no longer available.

The completed methodology for each applicant is presented as a series of steps in Appendix A (Children's) and B (MultiCare) of this evaluation. The methodologies presented here incorporate all considerations that were discussed with the applicants and account for their differing approaches to establishing numeric need. Where necessary, both adjusted and un-adjusted computations are provided as the calculations progress.

When preparing acute care bed need projections, the department traditionally relies upon population forecasts published by OFM. Because OFM does not provide population estimates at the age breakouts necessary for the intermediate ages applied in these applications, and to maintain data integrity, the department relied upon estimates and projections developed by Claritas, Inc. for the applicable populations in the respective planning areas or to the applicant as necessary.

A seven-year horizon for forecasting acute care bed projections will be used in the evaluation of the 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". 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 set the target year as 2016.

This portion of the evaluation will describe the calculations made at each step and the assumptions and adjustments made in that process. It will also include a review of any additional deviations related to the assumptions or adjustments made by the applicant's in their application of the methodology. A general deviation both applicants and the department made in apply the SHP method is in age and service area as describe on page 9. The titles for each step are excerpted from the 1987 SHP and are use to convey the concept being measured in that step.

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

For this step, attached as Step 1, the department considered planning areas 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 by age in the respective planning areas, excluding psychiatric patient days (Major Diagnostic Category, MDC-19) and tertiary neonatal bassinette patient days (Major Diagnostic Category, MDC-15), according to the county in which care was provided.

Children's

Children's followed this step as described above applying the 0-14 patient days recorded for the Seattle Children's Hospital.

MultiCare

MultiCare followed this step as described above applying the 0-17 totals for the Mary Bridge Planning Area (MBPA)

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.

Children's

Children's followed this step as described above.

MultiCare

MultiCare followed this step as described above.

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

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each group by that group's population and multiplied by 1,000.

Children's

Children's followed this step as described above with values computed from the State of Washington Office of Financial Management (OFM) county population forecasts and updates.

MultiCare

MutiCare followed this step as described above with values computed from the State of Washington Office of Financial Management (OFM) county population forecasts. It is noted that the 1999-2008 totals reported in the initial application do not seem to coincide with the column totals in the updated screening

methodology when considered with 2000-2008 historical figures. Appendix B recasts the population figures according to what could be derived from the MultiCare application.

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

The department has computed a trend line based upon the use rates from these ten years and has included them as Step 4. The resulting trend lines show an upward slope, in each case, meaning use rates are increasing. This conclusion is supported by increasing utilization reported by hospitals throughout the state in recent years, and is indicative of a growing population.

Children's

Children's followed this step as described above and established a growth slope for the 0-14 use rates of Seattle Children's Hospital.

MultiCare

MultiCare followed this step as described above and established a series of slopes for the State, the HSA, and the MBPA. The applicant applied the most conservative result (the State slope of 0.147). In Appendix B, the department calculated only the planning area slope and, with the revised population totals, applied a slope of 0.5204.

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 respective planning areas. In order to forecast the availability of services for the residents of a given region, patient days must also be identified for the facilities available within the planning area. Step 5 identifies referral patterns in and out of the planning areas and illustrates where residents of the planning area currently receive care. For this review, the department separated patient days according to the changes detailed above. The Children's method includes a 0-14 and a 15-20 year cohort and MultiCare had a single 0-17 year cohort.

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 the planning areas as described by each of the applicants. Step 5 illustrates the age-specific patient days for residents of the respective planning areas and for the rest of the state; where applicable.

Children's

Children's followed this step as described above with 2009 CHARS data for the two age cohorts recorded for Seattle Children's Hospital.

MultiCare

MultiCare followed this step as described above with 2009 CHARS data for a single 0-17 age cohort. The applicant considered the total days for the planning area in its entirety and those recorded statewide.

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 respective planning areas and for the rest of the state.

Children's
Children's followed this step as described above except its two age cohorts were 0-14 and 15-20.

MultiCare
MultiCare followed this step as described above except Mulicare used a single age cohort of 0-17. Appendix B details the figures applied and re-calculated the applicable use rate in relation to the revised 2009 population total.

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 the ten-year use rate trend line recorded in step 4.

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.

Children's
Children's applied the hospital's use rate and followed this step as described above with no deviations.

MultiCare
MultiCare applied the statewide use rate and followed this step as described, but applied a forecast target year of 2011. Appendix B establishes a target year of 2016.

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 the respective planning area residents are illustrated in Step 8. Forecasts have been prepared for a series of years and are presented in summary in Step 10 under "Total Res Days."

Children's
Children's applied this step as described above applying population totals with values computed from the State of Washington Office of Financial Management (OFM) county population forecasts and updates.

MultiCare
MultiCare followed this step as described above and computed projections through 2022. These figures were used as the basis for the historical and forecasted annual population totals applied in steps 3 and 8 in Appendix B.

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 respective planning areas 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 applied in the calculation of the adjusted patient days in Step 10.

Children's
Children's followed this step as described above to establish the facility's projected patient days

MultiCare
MultiCare followed this step as described, though maintained a 2011 target year. This affected the accuracy of the Projected Total Patient Day worksheet. Appendix B constructs step 9 according to the population growth identified by the applicant (1%) for the years up to 2016. The resulting increased the immigration rate to 0.781, increasing the number of patient days allocated to the hospitals.

Step 10: Applying weighted average occupancy standards, determine each planning area's non-psychiatric bed need. Calculate the weighted average occupancy standard as described in Hospital Forecasting Standard 11.f. This should be based on the total number of beds in each hospital (Standard 11.b), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculation.
The number of available beds in the planning area was identified in accordance with the SHP standard 12.a., which identifies:

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

SHP determines the number of available beds in each planning area, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information was gathered through a capacity survey of the state hospitals, inclusive of the applicant 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. Below are a summary of the applicant's facilities and the Department's determination of the capacity values used in the production of the bed need methodology.

Seattle Children's
Seattle Children's Hospital is located at 4800 Sandpoint Way Northeast in Seattle, within King County. Children's currently maintains a licensed capacity of 250 acute care beds. Of these beds, 19 are reported as providing neonatal care and 20 are providing psychiatric services. Children's will be recorded to have a total capacity of 211 general acute care pediatric beds. [Seattle Children's Utilization Survey; Children's Application, p9; CN licensing records]

MultiCare / Mary Bridge
Mary Bridge Hospital is located at 317 Martin Luther king Jr. Way in Tacoma, within Pierce County. Mary Bridge is currently maintains a licensed capacity of 72 beds. Of these beds, none are reported as providing services precluded from acute care services. Mary Bridge will be recorded to have a total capacity of 72 general acute care pediatric beds. [Mary Bridge Utilization Survey; MultiCare Application, p18 & 36; CN licensing records]

While the methodology states that short-stay psychiatric beds should be included in the above totals, the fact that all psychiatric patient days were excluded from the patient days analyzed elsewhere in the methodology makes their inclusion inconsistent with the patient days used to determine need. The totals represented by each applicant are displayed in Table 3. [Children's Application, p9; MultiCare Application, p18 & 36]

Table 3
Applied Hospital Acute Care Bed Capacity Totals

Hospital	Children's Total	MultiCare Total	Department Total
Seattle Children's	211	-	211
Mary Bridge Hospital	-	72	72

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 respective planning area's weighted occupancy has been determined to be 70% for the Children's need methodology and 60% for the MultiCare need methodology. The weighted occupancy standard assumptions detailed above, is reflected in the line "Wtd Occ Std" in Step 10.

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from step 10 above to the psychiatric inpatient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.
The applicant is not proposing to add psychiatric services at the facility. In step 10, the department excluded the short stay psychiatric beds from the bed count total. For these reasons, the department concluded that psychiatric services should not be forecast while evaluating this project.

Children's
Children's also did not provide psychiatric forecasts within its methodology for the 100 bed addition.

MultiCare
MultiCare omitted this step.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, out-of-area use and occupancy rates, following the guidelines in section IV of this Guide.
Within the department's application of the methodology, adjustments have been made where applicable and described above.

Children's
Children's omitted this step.

MultiCare
MultiCare omitted this step.

Department Methodology – Appendix A - Children's

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

Table 4
Summary of Department's Children's Methodology
Appendix A, Step 10A – Without Proposed Children's Project

	2010	2011	2012	2013	2014	2015	2016
Planning Area # of beds	211	211	211	211	211	211	211
Adjusted Gross Need	258	267	275	283	292	300	309
Projected Need– Without Project (Step 10a)	47	56	64	72	81	89	98

As shown in Table 4, need for additional capacity currently exists throughout the forecast years. Step 10A indicates that without the addition of new beds to the planning area, the need may reach 98 by 2016. [Appendix A, Step 10a]

Step 10B demonstrates the impact of Children's adding 100 additional pediatric beds to the planning area. New beds are added in 2011, 2013, and 2015. The additional beds also increase the applied occupancy rate applied after 2014. A summary of those results are shown in Table 5.

Table 5
Appendix A, Step 10B – With Children's Project – Summary

	2010	2011	2012	2013	2014	2015	2016
Planning Area # of beds	215	**215**	215	**273**	273	**311**	311
Adjusted Gross Need	258	267	275	283	292	280	288
Need/(Surplus) - With Project (Step 10b)	43	52	60	10	19	(31)	(23)

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

Step 10B illustrates the effect on the planning area if Children's begins to add acute care beds to the planning area in year 2010. In that year, when considering the results in 10B, the net planning area need decreases, but maintains a need until the final year of the phased implementation. [Appendix A, Step 10b]

Department Methodology – Appendix B - MultiCare

The results of the department's methodology are available in Appendix B as Steps 10A through 10B attached to this evaluation. Step 10A calculates the MultiCare planning area bed need as proposed by the applicant. It also recasts the population figures in the forecast years, applies a greater growth slope, and resets the target year as described above. [Appendix B]

Table 6
Summary of Department's Revised MultiCare Methodology
Appendix B, Step 10A – Without Proposed MultiCare Project

	2010	2011	2012	2013	2014	2015	2016
Planning Area # of beds	72	72	72	72	72	72	72
Adjusted Gross Need	107	108	109	110	111	112	114
Projected Need– Without	**35**	**36**	**37**	**38**	**39**	**40**	**42**

Project (Step 10a)							

This methodology considers all 0-17 patient days in the 8-county MBPA to establish a total bed need. But it only applies the capacity of Mary Bridge Children's Hospital without consideration of the other hospitals[5] in the MBPA that will continue to provide some service to this defined population.

The department can accept the general approach MultiCare took for projecting 100% of the likely patient days for the MBPA. To determine if it was reasonable for MultiCare to serve 100% of the projected patient days in the MBPA, the department evaluated Mary Bridge's 2009 market share for that planning area. That market share was 67.42%. Based on the market share of Mary Bridge, the department does not agree with Mary Bridge's bed need projections that rely on Mary Bridge serving 100% of the projected patient days.

It is reasonable to project Mary Bridge's bed need based on its current market share of 67.42% of the MBPA. Step 10b of Appendix B applied Mary Bridge's current market share to the MBPA total patient days to determine the likely projected patients days for Mary Bridge. A summary of those results are shown in Table 7.

Table 7
Appendix B, Step 10B – With MultiCare Market Share Adjustment

	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Planning Area # of beds	72	72	72	72	72	72	72
Adjusted Gross Need for Mary Bridge	72	73	74	75	76	78	79
Need/(Surplus) - With Project (Step 10b)	**0**	**1**	**2**	**3**	**4**	**6**	**7**

As shown, the need for additional capacity is one bed in 2011 and climbs slowly to seven beds in the target year. [Appendix B, Step 10b]

The forecasted need does not support a 25 bed addition. Further, based upon 2009 CHARS, the hospital is operating at an Average Daily Census of 39.6[6] in the 72-bed facility. This equates to an occupancy rate of 54%. A facility of this size has a minimum occupancy standard of 60%. The current occupancy of Mary Bridge along with the bed need projections do not support the 25 bed addition proposed by MultiCare.

Throughout the comment period, the department received letters of support and personal testimony regarding each project. The letters of support were submitted by residents of the planning area as well as other state hospitals and health care providers. The letters expressed concerns with access to available pediatric services and the increased bed need due, in part, to population growth within the respective planning areas. These comments compliment, in differing degrees, the need forecasts detailed above. [Public comment provided during the review]

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

Children's The department concludes that the proposed 100-bed general acute care pediatric expansion proposed in the application can be supported by the bed need methodology. **This sub-criterion is met**.

[5]The MBPA has fourteen hospitals that provide some level of pediatric inpatient services.
[6] 14,446 total Mary Bridge 2009 patient days

MultiCare

The department concludes that the proposed 25-bed general acute care pediatric expansion proposed in the application cannot be supported by the bed need methodology. **This sub-criterion is not met**.

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

Children's

Children's 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, Children's 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, Children's provided a copy of its current Admission Policy that would continue to be used at the hospital. The policy outlines the process/criteria that Children's 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 Children's without regard to "race, sex, creed, ethnicity, or disability". [Children's 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.

Children's currently provides services primarily to Medicaid eligible patients. Details provided in the application demonstrate that Children's intends to maintain this status. For this project, a review of the policies and data provided for Children's identifies the facility's financial pro forma includes Medicaid revenues.

Children's also provides a small degree of services to Medicare eligible patients. Details provided in the application demonstrate that Children's intends to maintain this status. For this project, a review of the policies and data provided for Children's identifies the facility's financial pro forma includes Medicare revenues. [Children's Application, p47, Exhibit 11]

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.

Children's 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, Children's included a 'charity care' line item as a deduction from revenue within the pro forma financial documents for Children's. [Application, Exhibits 6 & 11]

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. Children's is located in King County and is one of 20 hospitals located within the King County Region. According to 2006-2008 charity care data obtained from HPDS, Children's has historically provided charity care above that provided in the region. Children's most recent three years (2006-2008) percentages of charity care for gross and adjusted revenues are detailed in Table 8. [HPDS 2006-2008 charity care summaries]

Table 8
Children's Charity Care Comparison

	3-Year Average for King County Region [7]	3-Year Average for Children's
% of Gross Revenue	1.36 %	1.66 %
% of Adjusted Revenue	2.42 %	2.94 %

Children's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 1.66% of gross revenue and 2.94% 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 Children's is above the regional averages and Children's proposes to provide charity care above the three-year historical gross and adjusted revenue averages for the proposed 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**.

MultiCare

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

To demonstrate compliance with this sub-criterion, Mary Bridge provided a copy of its Adult and Children's Admission Policies that are used at the hospital. The policy outlines the process and parameters that Mary Bridge will use to admit patients for treatment or care. The applicant states that the policy applies to any patient requiring care at a MultiCare facility, but does not address guaranteed admission without regard to items such as 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, Exhibits 12A & B]

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

> Mary Bridge will provide to the department, for review and approval, a revised version of the Admission Policy used at the hospital. The revised policy must specifically address a patient's guaranteed admission without regard to items such as race, ethnicity, national origin, citizenship, age, sex, pre-

[7] Harborview Medical Center is subsidized by the state legislature to provide charity care services. Charity care percentages for Harborview make up almost 50% of the total percentages provided in the King County Region. Therefore, for comparison purposes, the department excluded Harborview Medical Center's percentages.

existing condition, physical or mental status and be consistent with the other components of the proposed agreement provided in the application.

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

Mary Bridge currently provides services primarily to Medicaid eligible patients, with no anticipated revenue from Medicare. Details provided in the application demonstrate that Mary Bridge intends to maintain this status. For this project, a review of the policies and data provided for Mary Bridge identifies the facility's financial pro forma includes Medicaid revenues. [MultiCare Application, p23 & Exhibit 18]

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 & Exhibit 10]

For charity care reporting purposes, the Department of Health's Hospital and Patient Data Systems program (HPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. The proposed MultiCare facility is located in Pierce County and is one of 18 hospitals located within the region. According to 2006-2008 charity care data obtained from HPDS, Mary Bridge has historically provided less than the average charity care provided in the region. Mary Bridge's most recent three years (2006-2008) percentages of charity care for gross and adjusted revenues are detailed in Table 9. [HPDS 2006-2008 charity care summaries; MultiCare Application, p40]

Table 9
Mary Bridge Charity Care Comparison

	3-Year Average for Pierce County Region	3-Year Average for Mary Bridge
% of Gross Revenue	1.95 %	0.39 %
% of Adjusted Revenue	4.23 %	0.79 %

MultiCare and Mary Bridge provide a variety of community programs and investment. Although, historical financial reports indicate that Mary Bridge has previously provided charity care below the regional average of 1.95% of gross revenue and 4.23% of adjusted revenue. 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 Mary Bridge does propose to exceed the regional average, a charity care condition for the hospital is necessary to approve the project. [MultiCare Application, p40 & Exhibit 11]

Mary Bridge will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Mary Bridge will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the Pierce County Region. Currently, this amount is 4.23% of adjusted revenue. Mary Bridge

will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

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

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

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

- Seattle Children's project meets the Financial Feasibility criteria
- MultiCare Health System's project does not meet the Financial Feasibility criteria

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

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

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

Children's

HPDS provides a summary of the balance sheets from Children's in Table 10.

Table 10
Children's Balance Sheets
Children's Fiscal Year End 2009

Assets		Liabilities	
Current	178,435,000	Current	96,933,000
Board Designated	459,580,000	Long Term Debt	481,936,000
Property/Plant/Equip	602,607,000	Other	-
Other	104,059,000	Equity	765,812,000
Total	1,344,681,000	Total	1,344,681,000

Above figures from HPDS data

Table 10 (Continued)
Children's Balance Sheets

Children's Fiscal Year End 2018

Assets		Liabilities	
Current	251,479,000	Current	164,543,000
Board Designated	1,099,342,000	Long Term Debt	657,282,000
Property/Plant/Equip	932,714,000	Other	38,868,000
Other	23,285,000	Equity	1,446,127,000
Total	2,306,820,000	Total	2,306,820,000

Above figures from CN application

The reported capital expenditure for the additional 100 pediatric beds is projected to be $208,744,868. The costs will be funded through a combination of debt through tax exempt bonds and cash reserves/philanthropy. The HPDS analysis determined, "Seattle Children's in 2009 and in the third year of the project balance sheet shows Board Designated assets in a strong position and that it has the assets to fund the portion expected to come from reserves for this project". In addition, HPDS concludes, "Seattle Children's is very experienced obtaining tax exempt bonds as shown in their 2009 audited financial report, The audit report lists six Revenue Bonds currently active totaling over $400 million in long term debt at the end of 2009". [HPDS Children's analysis, p2, Children's Application, p42]

As mentioned above, HPDS also reviewed the financial health of Children's for December 31, 2009 to the statewide year 2009 financial ratio guidelines for hospital operations. Statewide 2009 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 2016 through 2018—or three years after project completion. Table 11 summarizes the comparison provided by HPDS. [HPDS Children's 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 11
Children's Projected Financial Ratios

Ratio Category	Trend	State09	Children's 2009	2016 Year 1	2017 Year 2	2018 Year 3
Long Term Debt to Equity	B	0.551	**0.629**	0.438	0.498	0.455
Current Assets/Current Liabilities	A	2.223	**1.841**	**1.645**	**1.593**	**1.528**
Assets Funded by Liabilities	B	0.433	0.430	0.346	0.371	0.356
Operating Expense/Operating Rev.	B	0.942	0.929	**0.951**	0.940	0.942
Debt Service Coverage	A	6.056	**5.304**	**4.509**	**5.178**	**4.557**

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 observing that, "fiscal year end ratios for Seattle Children's are within acceptable range of the 2009 State average". With regards to the Current Assets/Current Liabilities ratios, HPDS concludes that, though these ratios are out of range, a review of the balance sheet shows the Board Designated Assets is very strong which means the hospital is diligent about keeping extra cash in investments. [HPDS Children's analysis, p3]

The department concludes that Children's would be able to meet its long term operating costs of the project with an additional 100 general acute care pediatric beds relying upon the projected patient days. **This sub-criterion is met.**

MultiCare

HPDS provides a summary of the balance sheets from the application in Table 12. [HPDS MultiCare analysis, p2]

Table 12
MultiCare Balance Sheets
MultiCare Fiscal Year End 2009

Assets		Liabilities	
Current	541,857,000	Current	184,935,000
Board Designated	557,026,000	Long Term Debt	791,275,000
Property/Plant/Equip	964,788,000	Other	198,345,000
Other	49,742,000	Equity	938,858,000
Total	2,113,413,000	Total	2,113,413,000

Above figures from CN application

MultiCare Fiscal Year End 2017

Assets		Liabilities	
Current	288,451,000	Current	294,586,000
Board Designated	1,314,731,000	Long Term Debt	816,402,000
Property/Plant/Equip	1,585,353,000	Other	186,388,000
Other	46,659,000	Equity	1,937,818,000
Total	3,235,194,000	Total	3,235,194,000

Above figures from CN application

The reported capital expenditure for the 25 bed expansion portion of the project is projected to be $22,815,205. MultiCare will use available cash reserves from within the organization. As HPDS concludes, "MultiCare in 2009 and in the third year of the project balance sheet shows Board Designated assets in a strong position and that it has the assets to fund the project from reserves". [HPDS MultiCare analysis, p2]

As mentioned above, HPDS also compared the financial health of MultiCare for December 31, 2009 to the statewide year 2009 financial ratio guidelines for hospital operations. Statewide 2009 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 2015 through 2017—or three years after project completion. Table 13 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 13
MultiCare's Current and Projected Financial Ratios

Ratio Category	Trend	State09	M. Bridge 2009	2015 Year 1	2016 Year 2	2017 Year 3
Long Term Debt to Equity	B	0.551	**0.843**	0.508	0.462	0.421
Current Assets/Current Liabilities	A	2.223	2.930	**1.000**	**0.988**	**0.978**
Assets Funded by Liabilities	B	0.433	**0.462**	0.375	0.359	0.343
Operating Expense/Operating Rev.	B	0.942	0.849	0.884	0.873	0.862
Debt Service Coverage	A	6.056	**3.373**	n/a	n/a	n/a

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

As HPDS concludes, "Most of the CON year 2017 fiscal year end ratios for Mary Bridge Children's are within acceptable range of the 2009 State average". HPDS continues, "[The] Current Assets/Current Liabilities is out of range but a review of the balance sheet shows the Board Designated Assets is very strong which means the hospital is diligent about keeping extra cash in investments". Further, "Debt Service Coverage is not reviewed because it mixes the income statement from Mary Bridge and the balance sheet of its parent MultiCare". The review shows that the hospital is breaking even in CON year 3 (2017) and the ratios are improving each year. [HPDS MultiCare analysis, p3]

These future assets are based upon revenue that is not supported in the need forecast. Based upon the patient days forecasted in the department's need methodology, the facility would need to increase its market share from 67% to 79% of the total patient days in the MBPA in the first complete year of operation. This would increase to 82.7% of the total patient days in the MBPA by the third complete year of operation. The department concludes that MultiCare/Mary Bridge may not be able to meet its short and long term costs of the 25-bed expansion relying upon their projected patient days. **This sub-criterion is not 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.

Children's

Children's proposes to add the 100 general acute care pediatric beds in multiple phases, beginning in year 2010. The total cost of the general acute care pediatric bed project is $208,744,868. Of the total costs under review, 65% is related to construction; 8% is related to equipment; and the balance related to applicable taxes and project costs. The totals are outlined below. [Children's Application, p40]

Table 14
Estimated Capital Costs of Children's Project

Item	Pediatric Beds	% of Total
Land & Leasehold Improvements	$ 135,351,719	65 %
Fixed & Moveable Equipment	$ 16,580,000	8 %
Architect / Consulting Fees	$ 12,589,771	6 %
Supervision and Inspection	$ 4,364,016	2 %
Taxes & Review Fees	$ 9,144,833	4 %
Other Project Costs	$ 30,714,529	15 %
Total Estimated Capital Costs	$ **208,744,868**	**100 %**

To assist the department in its evaluation of this sub-criterion, HPDS provides a summary of the reasonableness of Children'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. [HPDS Children's analysis, p3]

Table 15
HPDS Analysis of Forecasted Rates at Children's Hospital

Seattle Childrens			
Rate per Various Items	**2016**	**2017**	**2018**
Admissions	15,133	15,602	16,082
Adjusted Admissions	23,032	23,805	24,556
Patient Days	95,249	98,024	100,871
Adjusted Patient Days	144,967	149,564	154,021
Gross Revenue	1,527,480,000	1,582,124,000	1,635,210,000
Deductions From Revenue	694,070,000	718,957,000	742,924,000
Net Patient Billing	833,410,000	863,167,000	892,286,000
Other Operating Revenue	145,598,000	154,478,000	163,994,000
Net Operating Revenue	979,008,000	1,017,645,000	1,056,280,000
Operating Expense	930,763,000	956,217,000	994,536,000
Operating Profit	48,245,000	61,428,000	61,744,000
Other Revenue	23,399,000	26,307,000	30,158,000
Net Profit	71,644,000	87,735,000	91,902,000
Operating Revenue per Admission	$ 55,072	$ 55,324	$ 55,484
Operating Expense per Admission	$ 61,506	$ 61,288	$ 61,842
Net Profit per Admission	$ 4,734	$ 5,623	$ 5,715
Operating Revenue per Patient Day	$ 8,750	$ 8,806	$ 8,846
Operating Expense per Patient Day	$ 9,772	$ 9,755	$ 9,859
Net Profit per Patient Day	$ 752	$ 89	$ 911
Operating Revenue per Adj Admissions	$ 36,185	$ 36,259	$ 36,337
Operating Expense per Adj Admissions	$ 40,411	$ 40,168	$ 40,501
Net Profit per Adj Admissions	$ 3,111	$ 3,686	$ 3,743
Operating Revenue per Adj Pat Days	$ 5,749	$ 5,771	$ 5,793
Operating Expense per Adj Pat Days	$ 6,421	$ 6,393	$ 6,457
Net Profit per Adj Pat Days	$ 494	$ 587	$ 59
Above figures from CN Application			

As shown, the net profit by adjusted patient day ranges could be from $494 to a high of $597. These values are directly related to the net profit calculated for each of the forecast years, which reaches $91.9 million in 2018. 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 100 general acute care pediatric 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 25 acute care beds to the Mary Bridge facility. The 25 beds would be added in by the end of 2014 and the costs are outlined below. [MultiCare Application, p49]

Table 16
Estimated Capital Costs of MultiCare Project

Breakdown Of Capital Costs	Total	% of Total
Construction & Leasehold Improvements	$ 14,793,284	65%
Fixed & Moveable Equipment	$ 3,400,000	15%
Architect / Consulting Fees	$ 2,785,532	12%
Taxes & Review Fees	$ 1,836,389	8%
Total Estimated Capital Costs	**$ 22,815,205**	**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 17
HPDS Analysis of Forecasted Rates at Mary Bridge

Mary Bridge Add 25 Beds			
Rate per Various Items	**2015**	**2016**	**2017**
Admissions	4,952	5,155	5,367
Adjusted Admissions	10,277	10,698	11,138
Patient Days	19,623	20,427	21,265
Adjusted Patient Days	40,723	42,391	44,130
Gross Revenue	570,330,000	593,714,000	618,056,000
Deductions From Revenue	358,356,000	373,048,000	388,343,000
Net Patient Billing	211,974,000	220,666,000	229,713,000
Other Operating Revenue	6,436,000	6,565,000	6,696,000
Net Operating Revenue	218,410,000	227,231,000	236,409,000
Operating Expense		198,283,000	203,711,000
Operating Profit	25,341,000	28,948,000	32,698,000
Other Revenue	(23,000)	(24,000)	(24,000)
Net Profit	25,318,000	28,924,000	32,674,000
Operating Revenue per Admission	$ 42,806	$ 42,806	$ 42,801
Operating Expense per Admission	$ 38,988	$ 38,464	$ 37,956
Net Profit per Admission	$ 5,113	$ 5,611	$ 6,088
Operating Revenue per Adj Admissions	$ 20,627	$ 20,627	$ 20,624
Operating Expense per Adj Admissions	$ 18,787	$ 18,535	$ 18,290
Net Profit per Adj Admissions	$ 2,464	$ 2,704	$ 2,934
Operating Revenue per Patient Day	$ 10,802	$ 10,803	$ 10,802
Operating Expense per Patient Day	$ 9,839	$ 9,707	$ 9,580
Net Profit per Patient Day	$ 1,290	$ 1,416	$ 1,537
Operating Revenue per Adj Pat Days	$ 5,205	$ 5,205	$ 5,205
Operating Expense per Adj Pat Days	$ 4,741	$ 4,677	$ 4,616
Net Profit per Adj Pat Days	$ 622	$ 682	$ 740
Above figures from CN Application			

As shown, the net profit by adjusted patient day ranges could be from $622 to a high of $740. These values are directly related to the net profit calculated for each of the forecast years, reaching $32.6 million in 2017. 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 25 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.

Children's

Funding for the $216,594,633 expansion will be provided by tax exempt bonds and cash reserves. The proportional amounts are outlined below. [HPDS Children's analysis, p4]

Table 18
Children's Financing

	Total	CN Only	% of Total
Bond Issue	$ 249,000,000	$ 200,000,000	80.3 %
Cash Reserves	$ 195,251,164	$ 16,594,633	8.5 %
Totals	$ 444,251,164	$ 216,594,633	48.8 %

According to HPDS's analysis of the project, the review states, "Seattle Children's expects to open three more tax exempt revenue bonds at separate times, in 2010, 2012 and 2014 through the Washington Health Care Facilities Authority. A portion of each of these three will be used to fund CN project capital expenditures". [HPDS Children's analysis, p5]

Table 19
Summary of Children's Funding Sources and Related Percentages

Seattle Childrens			
CN Project		Bonds	Reserves/Other
Capital Expenditure	$ 216,554,633	$ 200,000,000	$ 16,594,633
Percent of Total Assets	16.1%	14.9%	1.2%
Percent of Board Designated Assets	47.1%	43.5%	3.6%
Percent of Equity	28.3%	26.1%	2.2%
100 Acute Care Beds			
Capital Expenditure	$ 208,744,868		
Percent of Total Assets	15.5%		
Percent of Board Designated Assets	45.4%		
Percent of Equity	27.3%		
21 Psychiatric Beds			
Capital Expenditure-Reserves Portion	$ 7,809,765		
Percent of Total Assets	0.58%		
Percent of Board Designated Assets	1.70%		
Percent of Equity	1.02%		
Total Project CN + Non CN			
Capital Expenditure-Reserves Portion	$ 444,251,164	$ 249,000,000	$ 195,251,164
Percent of Total Assets	33.04%	18.52%	14.52%
Percent of Board Designated Assets	96.66%	54.18%	42.48%
Percent of Equity	58.01%	32.51%	25.50%
Above figures from CN Application	.		

Based on the source information reviewed for the bed addition project at Children's and the review performed by HPDS, the department concludes that the proposed financing for a 100 bed expansion is a

prudent approach, and would not negatively affect Children's total assets, total liability, or general financial health. **This sub-criterion is met**.

MultiCare

As part of the review of the financing of this project, HPDS confirms that, "Mary Bridge Children's CN capital expenditure for the 25 acute care bed expansion is projected to be $22,815,205. The funding will come from available cash reserves currently available within the MultiCare organization. [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 25 bed expansion is a prudent approach, and would not negatively affect MultiCare's total assets, total liability, or general financial health. **This sub-criterion is met**.

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

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

- Seattle Children'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

(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.

Children's

If the acute care bed project is approved, Children's anticipates adding FTEs (full time equivalents) to the hospital in specific staffing areas of nursing, and other related support positions beginning in 2013. Table 20 shows the breakdown of Children's projected FTE increases for an acute care bed expansion. [Children's Application, p48 & Exhibit 11]

Table 20
Children's Hospital Projected Incremental FTE Additions

Classification	Current	2013	2014	2015	2016	2017	2018	Total
Registered Nurses	595	18	19	19	18	19	21	709
Support - Other [8]	56	24	25	17	88	22	20	252
Totals	**651**	**42**	**44**	**36**	**106**	**41**	**41**	**961**

As shown above, the staff increases continue steadily throughout the projection years. Beginning with the completion of Phase 1b in 2013, Children's expects to add FTE's each year as the project progresses, with the largest addition occurring in 2016 after project completion.

Children's states it expects no difficulty in recruiting staff for the additional beds due to their standing as an academic and research facility. Children's affirms, "employee recruitment and retention of the best staff is critical to the success of Seattle Children's". Through competitive salaries, benefits packages, paid time off,

[8] Distributed proportional to the number of project FTE's reported by Applicant

and tuition reimbursement programs, Children's does not anticipate difficulties in recruiting or retaining the necessary staff. [Children's Application, p49]

Based on the information provided in the application, the department concludes that Children's provided a comprehensive approach to recruit and retain staff necessary for the additional general acute care pediatric beds. As a result, the department concludes that qualified staff 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 and positions beginning in 2013. Table 21 shows the breakdown of MultiCare's projected FTE needs for the proposed acute care bed expansion. [MultiCare Application, p275]

Table 21
Mary Bridge Projected Annual FTE Totals

Classification	Current	2010	2011	2012	2013	2014	2015
Management	64	64	64	64	64	64	64
Nursing	226	232	242	251	260	270	280
Tech/Professional	275	283	295	306	317	329	341
Support	258	262	267	272	278	283	289
Totals	**823**	**841**	**868**	**893**	**919**	**946**	**974**

As shown above, the staff increases continue steadily throughout the projection years. MultiCare expects to incremental hires to expand pertinent staff. At project completion in year 2013, Mary Bridge expects to add approximately 55 additional employees in the first two years with the additional capacity.

MultiCare states it expects no difficulty in recruiting staff for the additional beds through its practice of partnering with local universities and colleges, supporting employee career development, and utilizing a broad range of local, regional and national recruiting strategies. MultiCare states that due to their historical hiring volume, "Coupled with better-than-average employee retention rates, has enabled MultiCare to staff new programs and open new facilities in both acute care and out-patient settings". [MultiCare Application, p56]

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

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

WAC 246-310 does not contain specific WAC 246-310-230(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are 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.

Children's

Children's currently provides health care services to the residents of King County and throughout the state. The applicant states that "an in-depth analysis of the capacity of our existing auxiliary services to accommodate the new 121[9] beds" determined that current and planned expansions will accommodate the expected growth. 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. [Children's Application, p50]

Therefore, the department concludes that there is reasonable assurance that Children's 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 Pierce County and throughout the region. The applicant states that the hospital currently has the ancillary and support service infrastructure required to perform in-patient and out-patient services. MultiCare adds, "It is not expected that there will be significant incremental demand from the addition of 25 additional general acute care pediatric beds". 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. [MultiCare Application, p58]

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

Children's

Children's will continue to provide Medicare and Medicaid services to the residents of 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 Children's in full compliance with all applicable standards following the most recent on-site survey in July 2008.[10]

The department's Investigation and Inspection's Office (IIO) completed two licensing surveys at Seattle Children's in the past three years.[11] There were no adverse licensing actions as a result of the licensing surveys. In addition, the IIO completed a recent investigation at Children's. The results of that investigation led to a citation and plan of correction. The IIO continues to work with Children's to ensure ongoing compliance. [Facility survey data provided by DOH Investigations and Inspections Office]

[9] Total of 100 general acute care pediatric and 21 psych beds
[10] http://www.qualitycheck.org
[11] Survey completed February 2007.

Based on Children's 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

Mary Bridge will continue to provide Medicare and Medicaid services to the residents of Pierce County and surrounding communities. The hospital contracts with the Joint Commission to survey and accredit the quality of service provided. The Joint Commission lists Mary Bridge in full compliance with all applicable standards following the most recent on-site survey in February 2010.[12]

The department's Investigation and Inspection's Office (IIO) completed two licensing surveys at Mary Bridge in the past four years.[13] There were no adverse licensing actions as a result of the licensing surveys. In addition, the IIO completed a recent investigation at Mary Bridge. No citations were issued or plans of corrections required. [Facility survey data provided by DOH Investigations and Inspections Office]

Based on MultiCare compliance history, the department concludes that there is reasonable assurance that the proposed 25 bed hospital would to operate in conformance with state and federal regulations. **This sub-criterion is met**.

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

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

Children's

Children's states that the hospital has a long and extensive history of working with organizations throughout the state to advance the continuity for the patients they serve. Children's will continue to operate outreach clinics which allow Children's to collaborate, "with local providers, state agencies, and others to ensure continuity of care, access, family support, and education". [Children's Application, p51]

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.

Expansion of a hospital in the planning area, supported by the projected need, minimizes the potential to increase the cost of care for all providers. Therefore, the department concludes that approval of a 100-bed

[12] http://www.qualitycheck.org
[13] Survey completed October 2006.

expansion of the hospital 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**.

MultiCare
MultiCare states that the hospital has established formal relationships with many of their community and regional partners. Mary Bridge will continue to be able to provide pediatric hospitalists and satellite services to pediatric programs within the region. When combined with formal transfer agreements and discharge policies, Mary Bridge, "promotes the continuity in the provision of health care as patients". [MultiCare Application, p58 & Exhibits 21 & 22]

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. Expansion of a hospital in the Applicant's defined planning area, when sufficient need has not been demonstrated, has the potential to increase the cost of care for all providers if the number of patients is not sufficient to support the bed capacity of the areas hospitals.

The department has previously determined that a market share shift to reach MutliCare's patient day projections has not been supported by the application. Therefore the addition of 25 beds, if approved, would create more under-used capacity at Mary Bridge or other hospitals in the 8-county region. The department does not believe this under used capacity alone would result in a fragmentation of servicers. As an existing provider the department agrees that MultiCare has existing relationships with MBPA providers, therefore **this sub-criterion is met.**

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.
This sub-criterion is addressed in sub-section (3) above for both Children's and MultiCare and is **determined to be me**t.

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:

- Seattle Children's project has met the Cost Containment criteria
- MultiCare Health System'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 review, both applicants met all the review criteria under WAC 246-310-210, 220, and 230. Therefore, the department moves to step two below.

Step Two

Children's

Before submitting this application to expand the hospital, Children's considered the forecasted need and the status of the current facilities. Through a Continuous Process Improvement review, Children's applied for satellites locations in Bellevue and North King County. The applicant concluded that, even with the inclusion of these planed locations, additional space was a necessity for the existing campus and that the inclusion of addition capacity was a reasonable component of any expansion. The project proposed in this application was the conclusion of the hospitals review and lesser alternatives were not discussed. [Children's Application, p54]

The applicant states that this option best "meets clinical demands, provides efficient connections to the existing hospital and ancillary support systems, and is located such that future expansions can occur without disrupting patient care".

The application does not include any specific information regarding what the hospital considered as an alternative to this bed expansion or the inclusion of shelled in space. Though the applicant does state that numerous iterations of phasing and bed additions were considered, "This proposal was deemed the superior alternative". [Children's Application, p54, September 8, 2010 Supplemental Information, p13]

MultiCare

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

1. Propose no project, do nothing.
2. Propose the addition of 25 general acute care pediatric beds.
3. Propose the addition of 40 general acute care pediatric beds.

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 3-5 years; and 3) legal restrictions. Once the 'do nothing' option was eliminated, the applicant considered issues such as costs, service lines, and location to determine that either the 25-bed or 40-bed options were the most appropriate. [MultiCare Application, p62]

In the description of the comparison of these remaining two options, MultiCare ultimately determined that the 25-bed option was sufficient to meet the expected demand in the projection years. The applicant states that this option addresses the need for beds in the planning area and is better suited for the build-out options to the Milgard Pavilion. The applicant believes the expansion will, "meet community need, align departments to optimize patient care, and provide single patient rooms that are acuity adaptable". [MultiCare Application, p63]

The project as proposed is not supported by the application; therefore it can not be considered the best available alternative.

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

Children's
Based upon the considerations supplied by the Applicant, the proposal to add 100 general acute care pediatric beds to the hospital is the best available option and **this sub-criterion has been met**.

MultiCare
Based upon the considerations supplied by the Applicant, the proposal to add 25 general acute care pediatric beds to the hospital is not supported as the best available option and **this sub-criterion has not been met**.

Step Three
This step is used to determine between two or more approvable projects which is the best alternative. Since each applicant met the previous review criteria in their respective planning areas, this step is not applicable to this review.

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

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

Children's
Children's states that it intends to pursue sustainable design and products in the construction of the proposed tower. By incorporating LEED standards in the conceptual design, Children's is "looking at all forms of energy reduction and long-term sustainable practices". Children's also intends to pursue plans to enhance the construction that will consider the environment and surrounding community by creating additional outdoor spaces while "minimizing the impact to the natural environment". [Children's Application, p56]

Staff from HPDS examined the construction costs of this entire project (acute care and psychiatric) and provided the following analysis.

Table 22
Children's Total Project Construction Projections

Acute Care Bed Expansion	Totals
Total Construction	$ 216,594,633
General acute care pediatric Beds	121
Total Capital per Bed	$ 1,790,038

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. Seattle Children's is building a new facility on newly purchased land and will construct the facility to the latest energy and hospital standards". [HPDS Children's analysis, p6]

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**.

MultiCare
MultiCare states that the pavilion was constructed within the framework of AIA Design Guidelines and 2006 Guidelines for Design and Construction of Healthcare Facilities. As part of this proposed project, MultiCare has retained an architectural firm to "ensure the latest and most innovative design and construction techniques are implemented". [MultiCare Application, p68]

Staff from HPDS examined the construction costs of this project and provided the following analysis.

Table 23
MultiCare Total Project Projections

Acute Care Bed Expansion	Totals
Total Construction	$ 22,815,205
General acute care pediatric Beds	25
Total Capital per Bed	$ 912,608

As HPDS determined, "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. Mary Bridge Children's is adding on to a currently existing building". [HPDS MultiCare Analysis, p5]

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

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

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

MultiCare

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

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

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

Children's

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

MultiCare

As HPDS concludes, "adding a new 25 acute care servicing a bed need area which has bed need will not have an unreasonable impact of the costs and charges to the public of providing services by other persons". [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**.

EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY SEATTLE CHILDREN'S PROPOSING TO ADD 21 PEDIATRIC PSYCIATRIC BEDS IN AN EXPANSION OF THE EXISTING HOSPITAL IN SEATTLE

PROJECT DESCRIPTIONS

Seattle Children's

Seattle Children's Hospital and Regional Medical Center (Children's) is owned by Children's Health Care System, a Washington not-for-profit, public benefit 501(c)(3) tax exempt organization, founded in 1907 as Children's Orthopedic Hospital. Children's provides health care services through its main hospital campus in Seattle's Laurelhurst neighborhood, through local satellite clinics, via partnerships with other hospitals in Washington, Alaska, Montana and Idaho and a home care agency.

Seattle Children's hospital is a tertiary provider of pediatric care that draws patients from throughout Washington, Alaska, Idaho and Montana for acute care, hematology/oncology, infectious disease, organ transplantation, rehabilitation, cardiology, and other specialized pediatric services. Seattle Children's Hospital also currently operates a pediatric specialty outpatient center in Bellevue on the Overlake Hospital Medical Center campus. Children's is currently holds a license for 250 beds[14]. [Seattle Children's Hospital website; Children's Application, p9 & 23; DOH licensing records]

In conjunction with the 100 general acute care pediatric beds evaluated above, Children's proposes adding 21 psychiatric beds to the existing hospital located at 4800 Sand Point Way NE in Seattle, Washington. The new beds would be housed within the existing facility in space that will be vacated by the transfer of medical surgical beds to a new patient care building built to expand the hospitals current capacity.

The capital expenditure associated with the entire expansion plans is $444,251,164. Of this total, $216,554,633 is attributed to the projects requiring Certificate of Need approval, with $7,809,765 allocated to the psychiatric bed expansion. If approved, Children's anticipates that all the beds would become operational by 2015. [Children's Application, p19 & 40]

Phase One (1a)

Children's does not intent to activate any of the proposed psychiatric beds in this phase.

Phase Two (1b)

This phase will begin to use space construction in the new patient tower. In this phase, 8 of the psychiatric beds will become available for services in vacated space within the existing hospital. Once the reconfiguration is completed in the Fall of 2013, and the total bed capacity will reach 320.

Phase Three (1c)

This phase will continue to use space construction in the new patient tower. The remaining 13 psychiatric beds will become available for services in vacated space within the existing hospital. Once the reconfiguration is completed in late 2015, the total bed capacity will increase to 371[15]. [Children's Application, p9 & 19]

[14] The approval of 100 general acute care pediatric beds would increase this total to 350.

[15] The total licensed bed capacity at project completion would consist of 311 general acute care pediatric beds, 19 neonatal level III bassinettes and 41 psychiatric beds

Once Children's completes a final phase (1d) to finish building out the proposed tower, the capital expenditure for the entire expansion project will total $444,251,164. Of this amount, $216,554,633 is attributed to the projects requiring Certificate of Need approval. The amount attributed for the psychiatric bed expansion accounts for 4% of this and totals $7,809,765. If approved, Children's anticipates that the beds would become operational by 2015. Under this timeline, year 2016 would be the facility's first full calendar year of operation. [Children's Application, p19 & 40]

Item	Psych Beds	Total	% of Total
Land & Leasehold Improvements	$ 4,274,730	$ 138,007,684	2.0%
Fixed & Moveable Equipment	$ 866,880	$ 17,446,880	0.4%
Architect / Consulting Fees	$ 531,484	$ 13,121,255	0.2%
Supervision and Inspection	$ 247,144	$ 6,229,925	0.1%
Taxes & Review Fees	$ 415,206	$ 41,748,889	0.2%
Other Project Costs	$ 1,474,321	$ 32,188,850	0.7%
Total Estimated Capital Costs	$ **7,809,765**	**$ 216,554,633**	**4%**

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need Review as a change in bed capacity of a health care facility as defined in Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

CRITERIA EVALUATION

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

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

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

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

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

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

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

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

(i) Nationally recognized standards from professional organizations;

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

(iii) Federal Medicare and Medicaid certification requirements;

(iv) State licensing requirements;
(v) Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to a proposed undertaking; and
(vi) The written findings and recommendations of individuals, groups, or organizations with recognized expertise related to a proposed undertaking, with whom the department consults during the review of an application."

APPLICATION CHRONOLOGY

Action	Date
Letter of Intent Submitted	April 16, 2010
Application Submitted	June 1, 2010
Department's pre-review Activities including screening and responses	July 15, 2010 through September 16, 2010
Beginning of Review	September 17, 2010
End of Public Comment	October 22, 2010
Rebuttal Comments Received	November 8, 2010
Department's Anticipated Decision Date	December 23, 2010
Department's Actual Decision Date	March 15, 2011

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 Children's and MultiCare, 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 applicants, one additional entity sought and received affected person status under WAC 246-310-010.

- Providence Health System/Sacred Heart Medical Center

SOURCE INFORMATION REVIEWED

- Seattle Children's Certificate of Need application submitted June 1, 2010
- Seattle Children's updated methodology dated August 30, 2010
- Seattle Children's supplemental information dated September 8, 2010
- Department of Health's Office of Hospital and Patient Data Systems (HPDS) financial feasibility and cost containment analysis for Seattle Children's dated December 10, 2010
- 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
- Seattle Children's rebuttal comments dated November 8, 2010
- Population estimates and forecasts obtained from the Claritas, Inc.
- Data obtained from the Seattle Children's website
- Data obtained from the BHC Fairfax website
- Certificate of Need Historical files

- Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds Adults & Children, Final Report, November 2004, State of Washington Department of Social and Health Services (DSHS) Mental Health Division
- Department of Health's Investigation and Inspection's Office (IIO) files

CONCLUSIONS

Children's Regional Medical Center

For the reasons stated in this evaluation, the application submitted on behalf of Seattle Children's proposing to add 25 psychiatric beds is consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is approved.

Approved Capital Expenditure: $7,809,765

A. Need (WAC 246-310-210)

Based on the source information reviewed, the department determines that the applicant has met the need criteria in WAC 246-310-210(1) and (2).

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

The determination of numeric need for acute care hospital beds is performed using the Hospital Bed Need Forecasting method contained in the 1987 Washington State Health Plan (SHP). Though the SHP was "sunset" in 1989, the department has concluded that this methodology remains a reliable tool for predicting baseline need for acute care beds. The 1987 SHP also has a methodology for projecting psychiatric bed need but the department is not able to get the necessary data to use this methodology. Given that the department is not able to use the psychiatric bed need methodology, the evaluation of the need criterion begins with an evaluation of the methodology provided by the applicant.

Applicant's methodology and Assumptions

Children's is located in the King County Planning Area. The applicant reports that approximately 45% of the patients using the psychiatric space come from King County and the remainder comes from state residents outside of King County (53%) and out of state (2%). The applicant focuses upon King County as the primary service area for the production of the methodology supporting the bed expansion. The applicant also identifies one additional King County provider of dedicated pediatric psychiatric services supplied at Fairfax Hospital with an additional 21 beds[16]. [1987 Washington State Health Plan, pB20; Children's Application, p25 & 35-37]

The applicant approached the issue of need by comparing the national average of 29.9 beds per 100,000 residents for all inpatient psychiatric beds. These ratios identify the current bed supply per 100,000 residents and are generally higher than the 13 beds per 100,000 identified in the 1987 SHP and higher than the current 8.2 short term psychiatric beds per 100,000 populations identified for Washington State. Table 24 below summarizes the Applicant's forecast methodology. [Children's Application, p37; Children's September 8, 2010 Supplemental Information, Exhibit 5, p534 & 547]

Table 24
Children's Psychiatric Bed Need Summary

	2010	2011	2012	2013	2014	2015
King County Population 0-20 Years	480,756	483,115	485,485	487,867	490,260	492,549
Need per 100,000 applying 29.9 National Average	144	144	145	146	147	147
Current Supply						
Seattle Children's	20	20	20	20	20	20
Fairfax Hospital	21	21	21	21	21	21
Total	41	41	41	41	41	41
Net Need	**103**	**103**	**104**	**105**	**106**	**106**
Applicant's 50% Reduction	**52**	**52**	**52**	**52**	**53**	**53**

[16] Children's also acknowledges that there are an undermined number of beds at Overlake Hospital and Medical Center, located within King County, and the applicant does not believe Overlake accepts adolescent patients. Overlake did not apply or qualify for Affected Party status on this application.

The applicant projected these calculations out to 2015 and determined that an additional 106 psychiatric beds are needed for 2015 in King County. The applicant also considered that the pediatric use rate may be as much as 50% less than the total population ratio of 29.9, thus reducing the need by half in the forecast years. [Children's Application, p37]

The Department's Determination of Numeric Need

As stated previously, the department was not able to use the psychiatric bed need formula. Also, the 1987 SHP defines the applicable planning area for psychiatric services as King County. Since the applicant's project is located in King County, the focus of the department's analysis will also be on the King County psychiatric services planning area.

The prevailing alternative to using the bed need formula is to evaluate the number of dedicated inpatient psychiatric beds per 100,000 residents. The 1987 SHP used 13 short stay psychiatric Hospital beds per 100,000 residents on a state wide basis. The state of Washington is reported to have 8.2 short stay psychiatric hospital beds per 100,000 residents; inclusive of all age groups. The Western states average is 27.3 and the average of all states is 29.9. Using population data available for the proposed age groups[17], the program produced a need projection for psychiatric beds within King County based upon the SHP ratio of 13.0. This information is summarized in Table 25. [Children's September 8, 2010 Supplemental Information, Exhibit 5, p534 & 547]

Table 25
King County Beds per 100,000

	2010	2011	2012	2013	2014	2015
King County Population 0-20 Years	477,974	480,605	483,236	485,867	488,498	491,129
Need per 100,000 applying 13.0 SHP ratio	62	62	63	63	64	64
Current Supply						
Seattle Children's	20	20	20	20	20	20
Fairfax Hospital	21	21	21	21	21	21
Total	41	41	41	41	41	41
Net Need	**21**	**21**	**22**	**22**	**23**	**23**

As shown, applying the SHP recommendation of 13 per 100,000 residents still produces the need necessary to substantiate the proposed expansion. Further, the State of Washington DSHS Mental Health Division contracted for a study on capacity and demand for inpatient psychiatric hospital and community residential beds for adults and children. This study found that the number of inpatient psychiatric beds has been declining since 2000.

Throughout the comment period, the department received letters of support and personal testimony regarding the entire project, and the psychiatric project in particular. A number of residents directly commented on the care received and the need for additional psychiatric capacity. Overlake Hospital, identified by the applicant as having limited pediatric capacity, joined with other mental health

[17] Due to the proposed age breakout of 0-20 years, Claritas population projections were applied rather than the OFM medium series data which does not allow for a specific breakout of a 0-20 age grouping.

organizations to express support of the proposed expansion. These comments compliment the need forecasts detailed above. [Public comment]

The Department concludes that this project will appropriately address a projected need for pediatric psychiatric services in King County. Based on information submitted by the applicant and analysis by staff, the 21 psychiatric beds proposed by the applicant for this project can be supported. **This sub criterion is met**.

b. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;

BHC Fairfax is identified by the applicant as a facility with a psychiatric unit that accepts pediatric patients. The applicant contends that Fairfax uses 21 of the 42 bed unit for pediatric patients; though the set-up bed count of 83 psychiatric beds is considered by the department below[18]. Table 26 provides historical utilization for each facility. [Children's September 8, 2010 Supplemental Information, p1; 2007-2009 CHARS]

Table 26
Pediatric Psychiatric Service Occupancies for 2007 – 2009

Facility	2007 ADC	% Occ.	2008 ADC	% Occ.	2009 ADC	% Occ.
Children's *	19.8	94.2 %	19.3	92.0 %	18.2	86.9 %
Fairfax **	62.8	75.7 %	64.0	77.1 %	61.0	73.5 %

*Application ** CHARS data

The 1987 SHP had recommended an occupancy standard of 85% for hospital with a short stay psychiatric ADC of 11 or more. Children's exceeds the standard in their psychiatric unit in each of the last three years. The Fairfax facility provides care specific to psychiatric and chemical dependency services and have able to maintain a 75% average occupancy rate in their psychiatric beds through an expanded service area of 23 counties[19]. These figures also represent a predominately adolescent and adult patient population[20] which omits the 0-12 age group entirely. Additional support for this expansion of pediatric psychiatric services was also expressed in comments submitted by Overlake Hospital and Sound Mental Health, two organizations providing similar care in the region. [Public Comment, State Health Plan, pC47]

Based on information submitted by the applicant and analysis by staff the department concludes that the use of existing facilities and services similar to those proposed is appropriate. **This sub-criterion is met**.

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

Children's 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,

[18] The BHC Fairfax DOH licensed bed application indicates that 83 beds, of the 133 licensed beds, are set-up and available for psychiatric services

[19] Patient days recorded for residents of the following counties: Chelan, Clallam, Clark, Cowlitz, Douglas, Grays Harbor, Island, Jefferson, Kitsap, Kittitas, Lewis, Mason, King, Okanogan, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Whatcom, Whitman, and Yakima

[20] According to information available at the hospitals website, BHC Fairfax defines pediatric care to include the ages of 13 through 17.

Children's 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, Children's provided a copy of its current Admission Policy that would continue to be used at the hospital. The policy outlines the process/criteria that Children's 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 Children's without regard to "race, sex, creed, ethnicity, or disability". [Children's 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.

Children's currently provides services primarily to Medicaid eligible patients. Details provided in the application demonstrate that Children's intends to maintain this status. For this project, a review of the policies and data provided for Children's identifies the facility's financial pro forma includes Medicaid revenues.

Children's also provides a small degree of services to Medicare eligible patients. Details provided in the application demonstrate that Children's intends to maintain this status. For this project, a review of the policies and data provided for Children's identifies the facility's financial pro forma includes Medicare revenues. [Children's Application, p47, Exhibit 11]

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.

Children's 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, Children's included a 'charity care' line item as a deduction from revenue within the pro forma financial documents for Children's. [Application, Exhibits 6 & 11]

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. Children's is located in King County and is one of 20 hospitals located within the King County Region. According to 2006-2008 charity care data obtained from HPDS, Children's has historically provided charity care above that provided in the region. Children's most recent three years (2006-2008) percentages of charity care for gross and adjusted revenues are detailed in Table 27. [HPDS 2006-2008 charity care summaries]

Table 27
Children's Charity Care Comparison

	3-Year Average for King County Region [21]	3-Year Average for Children's
% of Gross Revenue	1.36 %	1.66 %
% of Adjusted Revenue	2.42 %	2.94 %

Children's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 1.66% of gross revenue and 2.94% 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 Children's is above the regional averages and Children's proposes to provide charity care above the three-year historical gross and adjusted revenue averages for the proposed 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:

- Seattle Children's project has met the Financial Feasibility criteria

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

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

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

HPDS provides a summary of the balance sheets from the Children's application in Table 28.

[21] Harborview Medical Center is subsidized by the state legislature to provide charity care services. Charity care percentages for Harborview make up almost 50% of the total percentages provided in the King County Region. Therefore, for comparison purposes, the department excluded Harborview Medical Center's percentages.

Table 28
Children's Balance Sheets
Children's Fiscal Year End 2009

Assets		Liabilities	
Current	178,435,000	Current	96,933,000
Board Designated	459,580,000	Long Term Debt	481,936,000
Property/Plant/Equip	602,607,000	Other	-
Other	104,059,000	Equity	765,812,000
Total	1,344,681,000	Total	1,344,681,000

Above figures from HPDS data

Children's Fiscal Year End 2018

Assets		Liabilities	
Current	251,479,000	Current	164,543,000
Board Designated	1,099,342,000	Long Term Debt	657,282,000
Property/Plant/Equip	932,714,000	Other	38,868,000
Other	23,285,000	Equity	1,446,127,000
Total	2,306,820,000	Total	2,306,820,000

The reported capital expenditure for the 21 psychiatric bed expansion is projected to be $7,809,765 and represents 4% of the CN portion of the proposed projects. The costs will be funded through a combination of debt through tax exempt bonds and cash reserves/philanthropy. The HPDS analysis determined, "Seattle Children's in 2009 and in the third year of the project balance sheet shows Board Designated assets in a strong position and that it has the assets to fund the portion expected to come from reserves for this project". [HPDS Children's analysis, p2, Children's Application, p42]

As mentioned above, HPDS also reviewed the financial health of Children's for December 31, 2009 to the statewide year 2009 financial ratio guidelines for hospital operations. Statewide 2009 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 2016 through 2018—or three years after project completion. Table 11 summarizes the comparison provided by HPDS. [HPDS Children's 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 29
Children's Projected Financial Ratios

Ratio Category	Trend	State09	SC09	2016 CONy1	2017 CONy2	2018 CONy3
Long Term Debt to Equity	B	0.551	**0.629**	0.438	0.498	0.455
Current Assets/Current Liabilities	A	2.223	**1.841**	**1.645**	**1.593**	**1.528**
Assets Funded by Liabilities	B	0.433	0.430	0.346	0.371	0.356
Operating Expense/Operating Rev.	B	0.942	0.929	**0.951**	0.940	0.942
Debt Service Coverage	A	6.056	**5.304**	**4.509**	**5.178**	**4.557**

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 observing that, "fiscal year end ratios for Seattle Children's are within acceptable range of the 2009 State average". With regards to the Current Assets/Current Liabilities ratios, HPDS concludes that, though these ratios are out of range, a review of the balance sheet shows the Board Designated Assets is very strong which means the hospital is diligent about keeping extra cash in investments. [HPDS Children's analysis, p3]

The department concludes that Children's would be able to meet its long term operating costs of the project with an additional 21 psychiatric beds relying upon the projected patient days. **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.

Children's

Children's proposes to add the 21 psychiatric beds in multiple phases, beginning in year 2013. The total cost of the psychiatric bed project is $7,809,765. Of the total, 55% is related to construction; 11% is related to equipment; and the balance related to applicable taxes and project costs. The totals are outlined below. [Children's Application, p40]

Table 30
Estimated Capital Costs of Children's Psychiatric Project

Item	Psychiatric Beds	% of Total
Leasehold Improvements	$ 4,274,730	55 %
Fixed & Moveable Equipment	$ 866,880	11 %
Architect / Consulting Fees	$ 531,484	7 %
Supervision and Inspection	$ 247,144	3 %
Taxes & Review Fees	$ 1,889,527	24 %
Total Estimated Capital Costs	$ **7,809,765**	**100 %**

To assist the department in its evaluation of this sub-criterion, HPDS provides a summary of the reasonableness of Children'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 review considers the entire project as the Applicant reports the 21 psychiatric beds are not feasible without the entire project approved. The following page contains a summary of the HPDS review. [HPDS Children's analysis, p3, Children's September 8, 2010 Supplemental Information, p2]

Table 31
HPDS Analysis of Forecasted Rates at Children's Hospital

Seattle Childrens			
Rate per Various Items	**2016**	**2017**	**2018**
Admissions	15,133	15,602	16,082
Adjusted Admissions	23,032	23,805	24,556
Patient Days	95,249	98,024	100,871
Adjusted Patient Days	144,967	149,564	154,021
Gross Revenue	1,527,480,000	1,582,124,000	1,635,210,000
Deductions From Revenue	694,070,000	718,957,000	742,924,000
Net Patient Billing	833,410,000	863,167,000	892,286,000
Other Operating Revenue	145,598,000	154,478,000	163,994,000
Net Operating Revenue	979,008,000	1,017,645,000	1,056,280,000
Operating Expense	930,763,000	956,217,000	994,536,000
Operating Profit	48,245,000	61,428,000	61,744,000
Other Revenue	23,399,000	26,307,000	30,158,000
Net Profit	71,644,000	87,735,000	91,902,000
Operating Revenue per Admission	$ 55,072	$ 55,324	$ 55,484
Operating Expense per Admission	$ 61,506	$ 61,288	$ 61,842
Net Profit per Admission	$ 4,734	$ 5,623	$ 5,715
Operating Revenue per Patient Day	$ 8,750	$ 8,806	$ 8,846
Operating Expense per Patient Day	$ 9,772	$ 9,755	$ 9,859
Net Profit per Patient Day	$ 752	$ 895	$ 911
Operating Revenue per Adj Admissions	$ 36,185	$ 36,259	$ 36,337
Operating Expense per Adj Admissions	$ 40,411	$ 40,168	$ 40,501
Net Profit per Adj Admissions	$ 3,111	$ 3,686	$ 3,743
Operating Revenue per Adj Pat Days	$ 5,749	$ 5,771	$ 5,793
Operating Expense per Adj Pat Days	$ 6,421	$ 6,393	$ 6,457
Net Profit per Adj Pat Days	$ 494	$ 587	$ 597
Above figures from CN Application			

As shown, the net profit by adjusted patient day ranges could range from $494 to a high of $597. These values are directly related to the net profit calculated for each of the forecast years, reaching $91.9 million in 2018. 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 a cost of the project to add 21 psychiatric beds 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.

Funding for the $216,594,633 cost of the entire expansion will be provided by tax exempt bonds and available cash reserves. The applicant reports that he psychiatric bed expansion is not approvable independent of the acute care bed expansion. Therefore, considering the combined cost of the project, the proportional amounts are outlined below. [HPDS Children's analysis, p4; Children's September 8, 2010 Supplemental Information, p2]

Table 32
Children's Financing

	Total	CN Only	% of Total
Bond Issue	$ 249,000,000	$ 200,000,000	80.3 %
Board Reserves	$ 195,251,164	$ 16,594,633	8.5 %
Totals	$ 444,251,164	$ 216,594,633	48.8 %

According to HPDS's analysis of the project, the review states, "Seattle Children's expects to open three more tax exempt revenue bonds at separate times, in 2010, 2012 and 2014 through the Washington Health Care Facilities Authority. A portion of each of these three will be used to fund CN project capital expenditures". [HPDS Children's analysis, p5]

Table 33
Summary of Children's Funding Sources and Related Percentages

Seattle Childrens CN Project		Bonds	Reserves/Other
Capital Expenditure	$ 216,554,633	$200,000,000	$ 16,594,633
Percent of Total Assets	16.1%	14.9%	1.2%
Percent of Board Designated Assets	47.1%	43.5%	3.6%
Percent of Equity	28.3%	26.1%	2.2%
100 Acute Care Beds			
Capital Expenditure	$ 208,744,868		
Percent of Total Assets	15.5%		
Percent of Board Designated Assets	45.4%		
Percent of Equity	27.3%		
21 Psychiatric Beds			
Capital Expenditure-Reserves Portion	$ 7,809,765		
Percent of Total Assets	0.58%		
Percent of Board Designated Assets	1.70%		
Percent of Equity	1.02%		
Total Project CN + Non CN			
Capital Expenditure-Reserves Portion	$ 444,251,164	$249,000,000	$ 195,251,164
Percent of Total Assets	33.04%	18.52%	14.52%
Percent of Board Designated Assets	96.66%	54.18%	42.48%
Percent of Equity	58.01%	32.51%	25.50%
Above figures from CN Application	.		

Based on the source information reviewed for the bed addition project at Children's and the review performed by HPDS, the department concludes that the proposed financing for a 21 psychiatric bed expansion is a prudent approach, and would not negatively affect Children's total assets, total liability, or general financial health. **This sub-criterion is met**.

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

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

- Seattle Children'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.

If the psychiatric bed project is approved, Children's anticipates adding FTEs (full time equivalents) to the hospital in specific staffing areas of nursing, and other related support positions beginning in 2013. Table 31 shows the breakdown of Children's projected FTE increases for the psychiatric program expansion. [Children's Application, p48 & Exhibit 11]

Table 34
Children's Hospital Projected Incremental FTE Additions - Psychiatric

Classification	Current	2013	2014	2015	2016	2017	2018	Total
Registered Nurses	595	21	0	34	0	0	0	650
Support - Other [22]	56	28	0	30	0	0	0	114
Totals	**651**	**49**	**0**	**64**	**0**	**0**	**0**	**764**

As shown above, the staff increase years follow when the beds are available for service. By year 2015, Children's expects to be fully staffed for the additional psychiatric beds and will add approximately 55 FTE's related to direct care.

Children's states it expects no difficulty in recruiting staff for the additional beds due to their standing as an academic and research facility. Children's affirms, "employee recruitment and retention of the best staff is critical to the success of Seattle Children's". Through competitive salaries, benefits packages, paid time off, and tuition reimbursement programs, Children's does not anticipate difficulties in recruiting or retaining the necessary staff. [Children's Application, p49]

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

[22] Distributed proportional to the number of project FTE's reported by Applicant

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

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

Children's currently provides health care services to the residents of King County and throughout the state. The applicant states that "an in-depth analysis of the capacity of our existing auxiliary services to accommodate the new 121 beds" determined that current and planned expansions will accommodate the expected growth. 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. [Children's Application, p50]

Therefore, the department concludes that there is reasonable assurance that Children's 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.

Children's will continue to provide Medicare and Medicaid services to the residents of 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 Children's in full compliance with all applicable standards following the most recent on-site survey in July 2008.[23]

The department's Investigation and Inspection's Office (IIO) completed two licensing surveys at Seattle Children's in the past three years.[24] There were no adverse licensing actions as a result of the licensing surveys. In addition, the IIO completed a recent investigation at Children's. The results of that investigation led to a citation and plan of correction. The IIO continues to work with Children's to ensure ongoing compliance. [Facility survey data provided by DOH Investigations and Inspections Office]

Based on Children's 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 psychiatric beds. **This sub-criterion is met**.

[23] http://www.qualitycheck.org
[24] Survey completed February 2007.

(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.

Children's states that the hospital has a long and extensive history of working with organizations throughout the state to advance the continuity for the patients they serve. Children's will continue to operate outreach clinics which allow Children's to collaborate, "with local providers, state agencies, and others to ensure continuity of care, access, family support, and education". [Children's Application, p51]

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.

Expansion of a hospital in the planning area, supported by the projected need, minimizes the potential to increase the cost of care for all providers. Therefore, the department concludes that approval of 21 additional psychiatric beds at the hospital 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**.

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

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

- Seattle Children's project has met the Cost Containment criteria

(3) 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, Children's is the only applicant reviewed for a psychiatric bed expansion under WAC 246-310-210, 220, and 230. Therefore, the department moves to step two below.

Step Two

Children's

Before submitting this application to expand the hospital, Children's considered the forecasted need and the status of the current facilities. Through a Continuous Process Improvement review, the applicant concluded that additional space was a necessity and that the inclusion of addition capacity was a reasonable component of any expansion. The project proposed in this application was the conclusion of the hospitals review and lesser alternatives were not discussed. [Children's Application, p54]

The applicant states that this option best "meets clinical demands, provides efficient connections to the existing hospital and ancillary support systems, and is located such that future expansions can occur without disrupting patient care".

The application does not include any specific information regarding what the hospital considered as an alternative to this bed expansion or the inclusion of shelled in space. Though the applicant does state that numerous iterations of phasing and bed additions were considered, "This proposal was deemed the superior alternative". [Children's Application, p54, September 8, 2010 Supplemental Information, p13]

Children's

Based upon the considerations supplied by the Applicant, the proposal to add 21 psychiatric beds to the hospital is the best available option and **this sub-criterion has been met**.

Step Three

This step is used to determine between two or more approvable projects which is the best alternative. Since each applicant met the previous review criteria in their respective planning areas, this step is not applicable to this project.

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

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

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

Children's states that it intends to pursue sustainable design and products in the construction of the proposed tower that will allow for the additional space to be vacated in the existing hospital to house the proposed psychiatric beds. By incorporating LEED standards in the conceptual design, Children's is "looking at all forms of energy reduction and long-term sustainable practices". Children's also intends to pursue plans to enhance the construction that will consider the environment and surrounding community by creating additional outdoor spaces while "minimizing the impact to the natural environment". [Children's Application, p56]

Staff from HPDS examined the construction costs of this entire project (acute care and psychiatric) and provided the following analysis.

Table 35
Children's Total Project Construction Projections

Acute Care Bed Expansion	**Totals**
Total Construction	$ 216,594,633
General acute care pediatric Beds	121
Total Capital per Bed	$ 1,790,038

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. Seattle Children's is building a new facility on newly purchased land and will construct the facility to the latest energy and hospital standards". [HPDS Children's analysis, p6]

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

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

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

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

WAC 246-310 does not contain specific WAC 246-310-240(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and

(b) that directs how to measure cost containment. Therefore, using its experience and expertise the department assessed the materials in the application.

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

Appendix A

Children's Pediatric Acute Bed Need Methodology

Appendix A

Seattle Children's Pediatric Acute Care Bed Need

Step 1

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**
Children's 0-14 yrs**	36,590	35,439	34,952	36,962	37,952	40,680	39,141	41,237	47,168	46,271	**396,392**
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											
** Childrens Screening - reported 0-14 years											

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**
Children's 0-14	36,590	35,439	34,952	36,962	37,952	40,680	39,141	41,237	47,168	46,271	**396,392**
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**
Children's**	0	0	0	0	0	0	0	0	0	0	**0**
STATEWIDE TOTAL	**451**	**608**	**530**	**970**	**898**	**799**	**716**	**954**	**1,152**	**2,006**	**9,084**

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**
Children's 0-14	36,590	35,439	34,952	36,962	37,952	40,680	39,141	41,237	47,168	46,271	**396,392**
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**

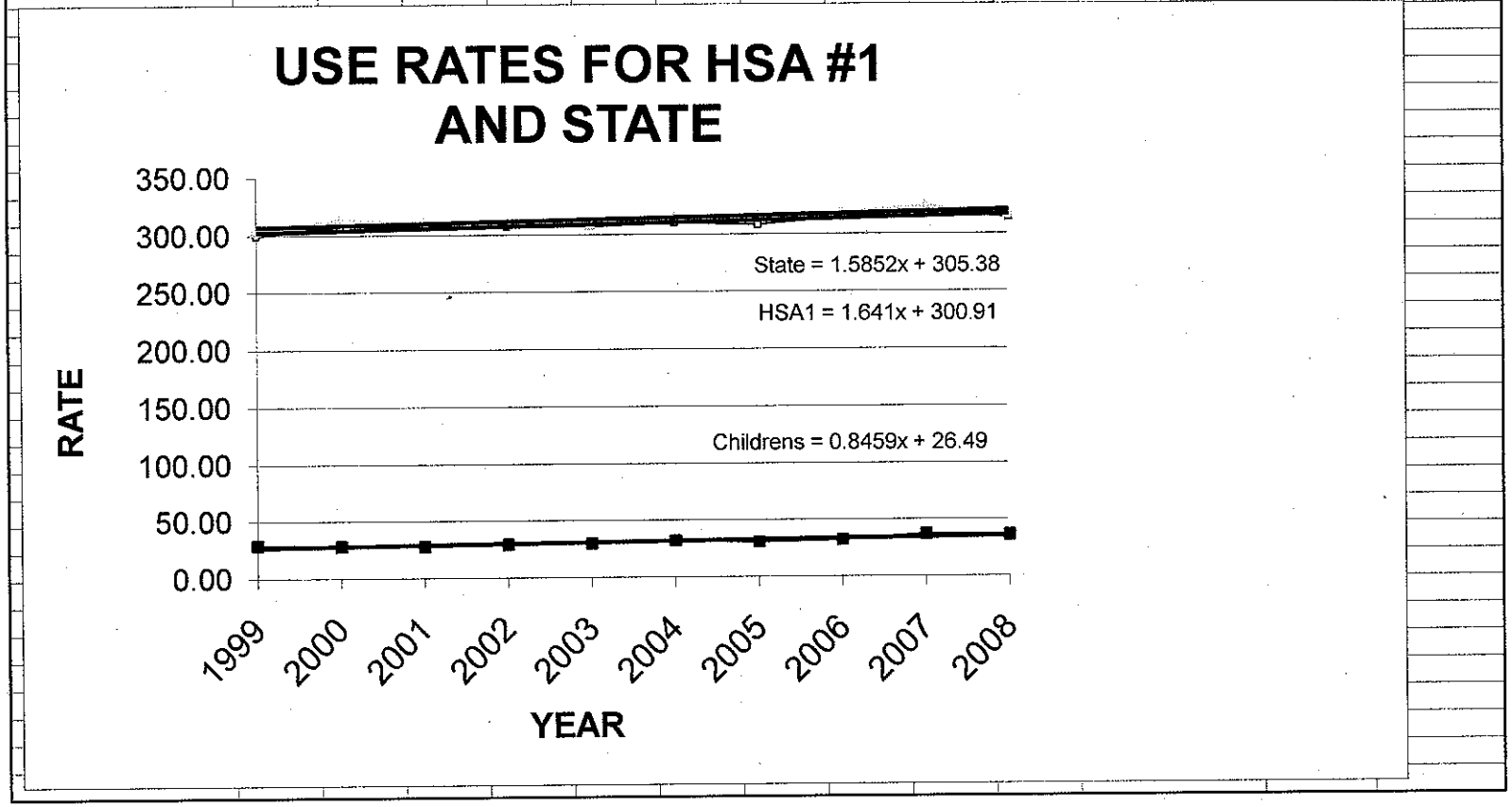
** Childrens Screening - reported 0-14 years

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**
Children's 0-14	36,590	35,439	34,952	36,962	37,952	40,680	39,141	41,237	47,168	46,271	**396,392**
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**
Children's 0-14	1,255,084	1,257,797	1,260,509	1,263,222	1,265,934	1,268,647	1,271,359	1,274,072	1,276,784	1,279,497	**12,672,905**
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**
Children's 0-14	29.15	28.18	27.73	29.26	29.98	32.07	30.79	32.37	36.94	36.16	**313**
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
Children's 0-14	29.15	28.18	27.73	29.26	29.98	32.07	30.79	32.37	36.94	36.16	**312.62**		0.8459
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					
Children's				%				
0-14	53,074	6,803	46,271	12.82%				
15-20	10,860	938	9,922	8.64%				
TOTAL	63,934	7,741	56,193					
WA - Children's								
0-14	1,239,980	54,816	1,185,164	4.42%				
15-20	926,590	37,722	888,868	4.07%				
TOTAL	2,166,570	92,538	2,074,032					
	TO Children's	TO WA			TOTAL # OF DAYS FOR	ADD DAYS	TOTAL # OF DAYS FOR	
					RESIDENTS BY HSA	PROVIDED IN	RESIDENTS BY HSA	
FROM Children's					(LESS PATS FROM OOS)	OREGON **		
0-14	46,271	0			46,271	5,423	51,694	
15-20	9,922	0			9,922	3,328	13,250	
TOTAL	56,193	0			56,193	8,751	64,944	
FROM WA								
0-14	0	1,185,164			1,185,164	34,649	1,219,813	
15-20	0	888,868			888,868	16,619	905,487	
TOTAL	0	2,074,032			2,074,032	51,268	2,125,300	
	56,193	2,074,032				** Patient Days as reported by Applicant		
MARKET SHARE								
PERCENTAGE OF PATIENT DAYS								
	TO Children's	TO WA		TO OREGON				
% OF Children's RESIDENTS								
0-14	89.51%	0.00%		10.49%				
15-20	74.88%	0.00%		25.12%				
TOTAL								
% OF WA - Children's RESIDENTS								
0-14	0.00%	97.16%		2.84%				
15-20	0.00%	98.16%		1.84%				
TOTAL								
2009 POPULATIONS BY PLANNING AREA								
	Children's	TO WA						
0-14	1,279,497	4,608,788						
15-20	543,478	253,372						
TOTAL	1,822,975	4,862,160						
STEP #6								
USE RATE BY PLANNING AREA								
	Children's	TO WA						
USE RATES								
0-14	40.40	264.67						
15-20	24.38	3,573.75						

Seattle Children's Pediatric Acute Care Bed Need
Step 7A

USE RATE BY PLANNING AREA FROM STEP 6							
	Children's						
YEAR 2009 USE RATES							
0-14	40.40						
15-20	24.38						
PROJECTED POPULATION	YEAR 2016						
	Children's						
0-14	1,366,840						
15-20	560,636						
TOTALS	**1,927,477**						
PROJECTED 2016 USE RATE							
	Children's						
USE RATES*							
0-14 using Childrens Trend	**46.32**						
0-14 using Statewide Trend	51.50						
15-20 using Childrens Trend	**30.30**						
15-20 using Statewide Trend	35.48						
* 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	**Children's**
USE RATES	
0-14	46.32
15-20	30.30
PROJECTED POPULATION - 2016	
	Children's
0-14	1,366,840
15-20	560,636
TOTALS	**1,927,477**
PROJECTED # OF PATIENT DAYS	YEAR 2016
	Children's
0-14	63,316
15-20	16,988
TOTALS	**80,304**

PROJECTED # OF PATIENT DAYS				
YEAR 2016	**Children's**	**WA - Children's**	**TOTAL**	
0-14	63,316	1,491	64,807	
15-20	16,988	0	16,988	
TOTALS	**80,304**	**1,491**	**81,795**	
MARKET SHARE % OF PATIENT DAYS FROM STEP 5				
% OF Children's RESIDENTS	**Children's**	**WA - Children's**	**TO OREGON**	
0-14	89.51%	0.00%	10.49%	
15-20	74.88%	0.00%	25.12%	
% OF WA - Children's RESIDENT	**Children's**	**WA - Children's**	**TO OREGON**	
0-14	0.00%	97.16%	2.84%	
15-20	0.00%	98.16%	1.84%	
# OF Children's RESIDENTS	**Children's**	**WA - Children's**	**TO OREGON**	**Total**
0-14	56,674	0	6,642	63,316
15-20	12,721	0	4,267	16,988
				80,304
# OF WA - Children's RESIDENTS	**Children's**	**WA - Children's**	**TO OREGON**	**Total**
0-14	0	1,448	42	1,491
15-20	0	0	0	0
				1,491
# OF RESIDENT PAT DAYS PROJECTED IN Children's				
0-14	56,674			
15-20	12,721			
# OF RESIDENT PAT DAYS PROJECTED IN WA - Children's				
0-14	1,448			
15-20	0			
# OF WA RESIDENT PAT DAYS PROJECTED IN OREGON				
0-14	6,685			
15-20	4,267			
OUT OF STATE % OF PATIENT DAYS FROM STEP 5				
Children's	%			
0-14	14.70%			
15-20	9.45%			
WA - Children'sing				
0-14	4.63%			
15-20	4.24%			
PROJECTED # OF PATIENT DAYS 2016				
PLUS OUT OF STATE RESIDENTS				
Children's				
0-14	65,007	1.026695555		
15-20	13,924	0.819622642		
TOTAL	**78,930**			

Seattle Children's Pediatric Acute Care Bed Need
Step 10a

	2009	2010	2011	2012	2013	2014	2015	2016
Children's Planning Area								
Population 0-14(1)	1,279,497	1,291,975	1,304,452	1,316,930	1,329,407	1,341,885	1,354,363	1,366,840
0-14 Use Rate	40.40	41.25	42.09	42.94	43.79	44.63	45.48	46.32
Population 15-20(2)	543,478	545,929	548,380	550,832	553,283	555,734	558,185	560,636
15-20 Use Rate	24.38	25.23	26.07	26.92	27.76	28.61	29.46	30.30
Total Population	1,822,975	1,837,904	1,852,833	1,867,761	1,882,690	1,897,619	1,912,548	1,927,477
Total Children's Res Days	64,944	67,063	69,206	71,375	73,570	75,789	78,034	80,304
Total Days in Children's Hospitals (3)	63,934	66,001	68,093	70,211	72,353	74,520	76,713	78,930
Available Beds (4)								
Seattle Childrens	211	211	211	211	211	211	211	211
Total	**211**	**211**	**211**	**211**	**211**	**211**	**211**	**211**
Wtd Occ Std(5)	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%
Gross Bed Need	**250**	**258**	**267**	**275**	**283**	**292**	**300**	**309**
Net Bed Need/Surplus	**39**	**47**	**56**	**64**	**72**	**81**	**89**	**98**

(1) Source: Claritas 0-14 yrs.
(2) Source: Claritas 15-20 yrs.
(3) Adjusted to reflect referral patterns into and out of Children's Planning Area to other planning areas and Oregon
(4) Source: Fall 2008 Hospital Survey returns
(5) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,

Seattle Children's Pediatric Acute Care Bed Need
Step 10b

	2009	2010	2011	2012	2013	2014	2015	2016
Children's Planning Area								
Population 0-14(1)	1,279,497	1,291,975	1,304,452	1,316,930	1,329,407	1,341,885	1,354,363	1,366,840
0-14 Use Rate	40.40	41.25	42.09	42.94	43.79	44.63	45.48	46.32
Population 15-20(2)	543,478	545,929	548,380	550,832	553,283	555,734	558,185	560,636
15-20 Use Rate	24.38	25.23	26.07	26.92	27.76	28.61	29.46	30.30
Total Population	1,822,975	1,837,904	1,852,833	1,867,761	1,882,690	1,897,619	1,912,548	1,927,477
Total Children's Res Days	64,944	67,063	69,206	71,375	73,570	75,789	78,034	80,304
Total Days in Children's Hospitals (3)	63,934	66,001	68,093	70,211	72,353	74,520	76,713	78,930
Available Beds (4)								
Seattle Childrens	211	**215**	215	215	**273**	273	**311**	311
Total	**211**	**215**	**215**	**215**	**273**	**273**	**311**	**311**
Wtd Occ Std(5)	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	75.00%	75.00%
Gross Bed Need	**250**	**258**	**267**	**275**	**283**	**292**	**280**	**288**
Net Bed Need/Surplus	**39**	**43**	**52**	**60**	**10**	**19**	(31)	(23)

(1) Source: OFM 0-14 yrs.
(2) Source: Claritas 15-20 yrs.
(3) Adjusted to reflect referral patterns into and out of Children's Planning Area to other planning areas and Oregon
(4) Source: Applicant
(5) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,

Appendix B

Mary Bridge Pediatric Acute Bed Need Methodology

Appendix B

Deprtment Revison of Mary Bridge Application Methodology

Step 1

2000-2009 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**
HSA#1	66,669	68,693	66,901	66,887	70,547	71,800	67,338	69,166	74,893	73,197	
MBPA	25,143	26,927	27,001	24,963	26,650	27,452	26,897	26,406	29,379	29,662	**270,480**
Statewide	**112,609**	**114,000**	**113,931**	**112,699**	**114,318**	**119,615**	**112,983**	**115,608**	**121,366**	**120,782**	
As reported by Mary Bridge											

Deprtment Revison of Mary Bridge Application Methodology
Step 2

2000-2009 HSA TOTAL NUMBER OF RESIDENT PATIENT DAYS											
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**
HSA#1	66,669	68,693	66,901	66,887	70,547	71,800	67,338	69,166	74,893	73,197	
MBPA	25,143	26,927	27,001	24,963	26,650	27,452	26,897	26,406	29,379	29,662	**270,480**
Statewide	112,609	114,000	113,931	112,699	114,318	119,615	112,983	115,608	121,366	120,782	

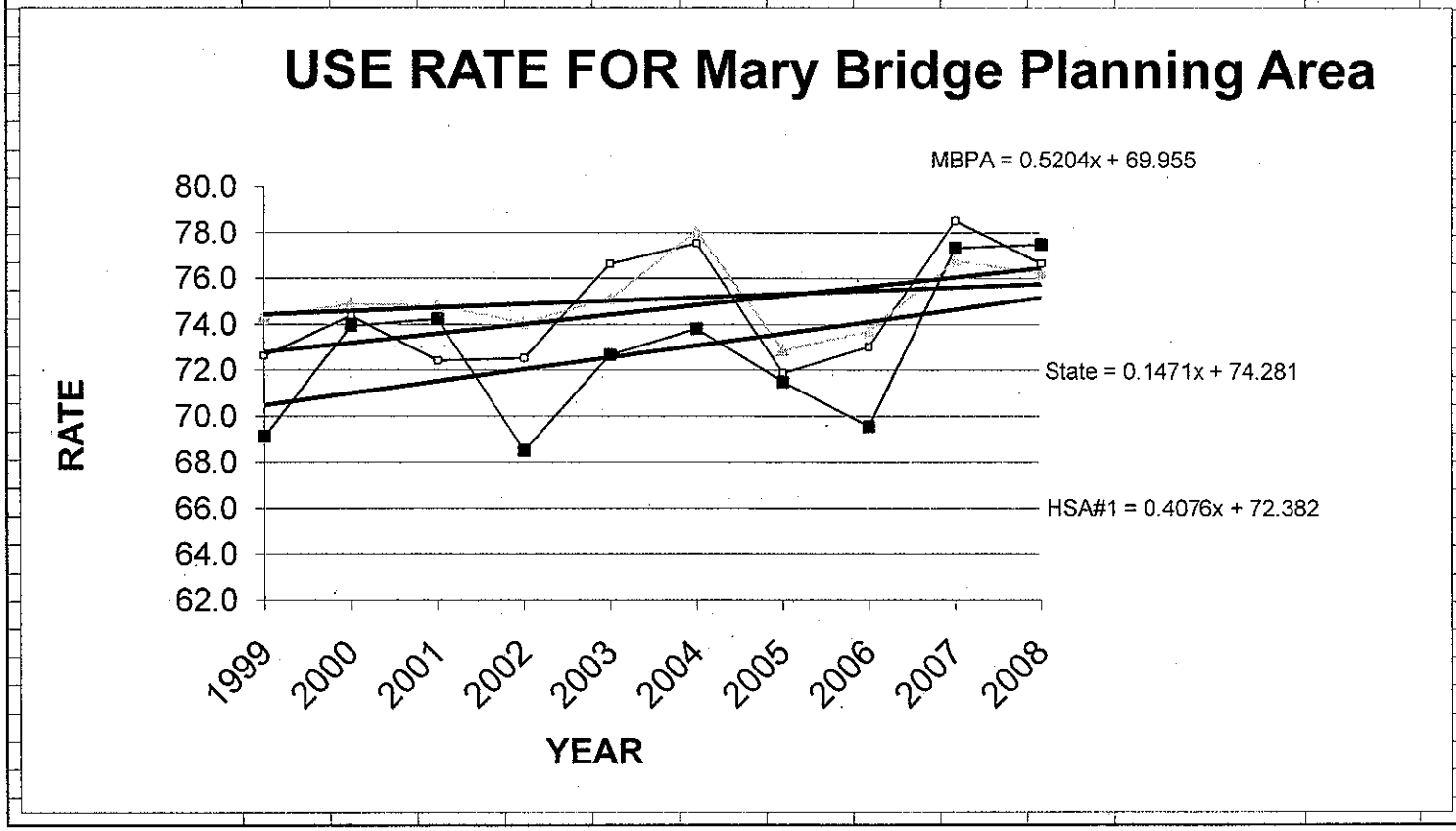
1998-2007 HSA TOTAL NUMBER OF PSYCHIATRIC PATIENT DAYS											
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**10-YEAR TOTAL**
HSA#1	62	92	13	91	12	44	106	124	207	122	
MBPA	2	0	6	0	0	16	2	0	14	41	**81**
Statewide	**65**	**101**	**29**	**91**	**23**	**52**	**106**	**124**	**223**	**143**	

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	66,607	68,601	66,888	66,796	70,535	71,756	67,232	69,042	74,686	73,075	
MBPA	25,141	26,927	26,995	24,963	26,650	27,436	26,895	26,406	29,365	29,621	**270,399**
Statewide	112,544	113,899	113,902	112,608	114,295	119,563	112,877	115,484	121,143	120,639	

As reported by Mary Bridge

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	66,607	68,601	66,888	66,796	70,535	71,756	67,232	69,042	74,686	73,075		
MBPA	25,141	26,927	26,995	24,963	26,650	27,436	26,895	26,406	29,365	29,621	270,399	
Statewide	112,544	113,899	113,902	112,608	114,295	119,563	112,877	115,484	121,143	120,639		
TOTAL POPULATIONS												
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	10-YEAR TOTAL	
HSA#1	916,993	922,246	923,625	921,040	920,318	925,366	935,433	945,395	951,089	953,182		
MBPA	363,690	364,183	363,679	364,376	366,732	371,652	376,243	379,611	379,650	382,259	3,712,075	
Statewide	1,513,843	1,520,895	1,522,764	1,520,127	1,521,956	1,531,410	1,548,978	1,566,409	1,577,661	1,582,495		
USE RATE PER 1,000												
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	10-YEAR TOTAL	
HSA#1	72.64	74.38	72.42	72.52	76.64	77.54	71.87	73.03	78.53	76.66		
MBPA	69.13	73.94	74.23	68.51	72.67	73.82	71.48	69.56	77.35	77.49	728	
Statewide	74.34	74.89	74.80	74.08	75.10	78.07	72.87	73.73	76.79	76.23		
As reported by Mary Bridge												

RESIDENT USE RATE PER 1,000													
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	10-YEAR TOTAL		Trendline
HSA#1	72.6	74.4	72.4	72.5	76.6	77.5	71.9	73.0	78.5	76.7	**746.24**		0.4076
MBPA	69.1	73.9	74.2	68.5	72.7	73.8	71.5	69.6	77.3	77.5	**728.17**		**0.5204**
Statewide	74.3	74.9	74.8	74.1	75.1	78.1	72.9	73.7	76.8	76.2	**750.90**		0.1471



STEP #5								
2009 DATA								
	# of Pat days	Less OOS	TOTAL LESS OOS	%				
MBPA								
0-17	22,773	154	22,619	0.68%				
TOTAL	22,773	154	22,619					
WA - MBPA								
0-17	110,643	12,623	98,020	11.41%				
TOTAL	133,416	12,777	120,639					
	TO MBPA	TO WA Hospitals			TOTAL # OF DAYS FOR RESIDENTS BY HSA (LESS WATS FROM OOS)	ADD DAYS PROVIDED IN OREGON **	TOTAL # OF DAYS FOR RESIDENTS BY HSA	
FROM MBPA								
0-17	19,373	10,248			29,621		29,621	
TOTAL	19,373	10,248			29,621		29,621	
FROM WA								
0-17	3,246	87,772			91,018		91,018	
TOTAL	3,246	87,772			91,018		91,018	
	22,619	98,020				** Patient Days as reported by Applicant		
MARKET SHARE								
PERCENTAGE OF PATIENT DAYS								
	TO MBPA	TO WA Hospitals		TO OREGON				
% OF MBPA RESIDENTS								
0-17	65.40%	34.60%		0.00%				
TOTAL								
% OF WA - MBPA RESIDENTS								
0-17	3.57%	96.43%		0.00%				
TOTAL								
2009 POPULATIONS BY PLANNING AREA								
	MBPA	TO WA Hospitals						
0-17	382,259							
TOTAL	382,259							
STEP #6								
USE RATE BY PLANNING AREA								
	MBPA	TO WA Hospitals						
USE RATES								
0-17	77.49							

USE RATE BY PLANNING AREA FROM STEP 6							
	MBPA						
YEAR 2009 USE RATES							
0-17	77.49						
PROJECTED POPULATION	YEAR 2016						
	MBPA						
0-17	405,258						
TOTALS	**405,258**						
PROJECTED 2016 USE RATE							
	MBPA						
USE RATES*							
0-17 using MBridge Trend	81.13						
* 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 STEP 7A	
PROJECTED USE RATE - 2016	**MBPA**
USE RATES	
0-17	81.13
PROJECTED POPULATION - 2016	
	MBPA
0-17	405,258
TOTALS	**405,258**
PROJECTED # OF PATIENT DAYS	YEAR 2016
	MBPA
0-17	32,879
TOTALS	**32,879**

PROJECTED # OF PATIENT DAYS				
YEAR 2016	MBPA	WA - MBPA	TOTAL	
0-17	32,879	113,094	145,973	
TOTALS	32,879	113,094	145,973	
MARKET SHARE % OF PATIENT DAYS FROM STEP 5				
% OF MBPA RESIDENTS	MBPA	WA - MBPA	TO OREGON	
0-17	65.40%	34.60%	0.00%	
% OF WA - MBPA RESIDENTS	MBPA	WA - MBPA	TO OREGON	
0-17	3.57%	96.43%	0.00%	
# OF MBPA RESIDENTS	MBPA	WA - MBPA	TO OREGON	Total
0-17	21,504	11,375	0	32,879
				32,879
# OF WA - MBPA RESIDENTS	MBPA	WA - MBPA	TO OREGON	Total
0-17	4,033	109,060	0	113,094
				113,094
# OF RESIDENT PAT DAYS PROJECTED IN MBPA				
0-17	25,537			
# OF RESIDENT WAT DAYS PROJECTED IN WA - MBPA				
0-17	120,436			
# OF WA RESIDENT WAT DAYS PROJECTED IN OREGON				
0-17	0			
OUT OF STATE % OF PATIENT DAYS FROM STEP 5				
MBPA	%			
0-17	0.68%			
WA - MBPA				
0-17	12.88%			
PROJECTED # OF PATIENT DAYS 2016				
PLUS OUT OF STATE RESIDENTS				
MBPA				
0-17	25,711	0.78198645	Screening meth - step 9	
TOTAL	25,711			

Deprtment Revison of Mary Bridge Application Methodology
Step 10a
Results for REVISED Population Totals

	2009	2010	2011	2012	2013	2014	2015	2016
Mary Bridge Planning Area								
Population 0-17	382,259	384,917	387,623	390,378	393,182	396,188	400,696	405,258
0-17 Use Rate	77.49	77.64	77.78	77.93	78.08	78.22	78.37	78.52
Total Population	382,259	384,917	387,623	390,378	393,182	396,188	400,696	405,258
Total 8-county MBPA Res Days	29,621	29,884	30,151	30,422	30,699	30,992	31,403	31,820
Total Days in 8-county MBPA Hospitals (1)	23,163	23,369	23,577	23,790	24,006	24,235	24,557	24,883
Available Beds (2)								
Mary Bridge	72	72	72	72	72	72	72	72
Total	72	72	72	72	72	72	72	72
Wtd Occ Std (3)	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%
Gross Bed Need	106	107	108	109	110	111	112	114
Net Bed Need/Surplus	34	35	36	37	38	39	40	42
								7 yr

(1) Adjusted to reflect referral patterns into and out of Mary Bridge Planning Area to other planning areas and Oregon
(2) Source: DOH Reporting
(3) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,

Deprtment Revison of Mary Bridge Application Methodology
Step 10b
Results for REVISED Population Totals WITH MB Market Share

	2009	2010	2011	2012	2013	2014	2015	2016
Mary Bridge Planning Area								
Population 0-17(1)	382,259	384,917	387,623	390,378	393,182	396,188	400,696	405,258
0-17 Use Rate	77.49	78.01	78.53	79.05	79.57	80.09	80.61	81.13
Total Population	382,259	384,917	387,623	390,378	393,182	396,188	400,696	405,258
Total 8-county MBPA Res Days	29,621	30,027	30,440	30,860	31,286	31,731	32,301	32,879
Total Days in 8-county MBPA Hospitals (1)	23,163	23,481	23,804	24,132	24,465	24,813	25,259	25,711
Mary Bridge Market Share	67.42%	67.42%	67.42%	67.42%	67.42%	67.42%	67.42%	67.42%
Market Share Adj. Res. Pat. Days	15,617	15,831	16,048	16,270	16,494	16,729	17,029	17,335
Available Beds (2)								
Mary Bridge	72	72	72	72	72	72	72	72
Total	72	72	72	72	72	72	72	72
Wtd Occ Std (3)	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%
Gross Bed Need	71	72	73	74	75	76	78	79
Net Bed Need/Surplus	(1)	0	1	2	3	4	6	7
								7 yr
(1) Adjusted to reflect referral patterns into and out of Mary Bridge Planning Area to other planning areas and Oregon								
(2) Source: DOH Reporting								
(3) Calculated per 1987 Washington State Health Plan as the sum , across all hospitals in the planning area,								

MB 0-17 Total Pop Worksheet

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
TOTALS	363,690	364,183	363,679	364,376	366,732	371,652	376,243	379,611	379,650	382,259	384,917	387,623	390,378	393,182	396,188	400,696	405,258	409,875

Mary Bridge Historical Market Share

	2009	
0-17 Total PA Days	22,773	
Total MB Days	15,353	App p17
	67.42%	

Appendix C

Children's Psychiatric Need Methodology

Appendix C

Seattle Children's Psychiatric Bed Need

	2010	2011	2012	2013	2014	2015
King County Population 0-20 Years	477,974	480,605	483,236	485,867	488,498	491,129
Need per 100,000 applying 13 from SHP	62	62	63	63	64	64
Current Supply						
Seattle Children's	21	21	21	21	21	21
Fairfax Hospital	20	20	20	20	20	20
Total	**41**	**41**	**41**	**41**	**41**	**41**
Net Need	**21**	**21**	**22**	**22**	**23**	**23**

M. Thomas - Feb 2011